www.pwc.com/india

Addressing the unfinished agenda

Universal healthcare

Confederation of Indian Industry

pwc

Contents

Message

A decade ago, the Confederation for Indian Industry (CII) along with the Indian Health Federation mapped the private healthcare market in India for the very first time. The CII Healthcare summit in 2002 set the agenda for all stakeholders in the healthcare sector including the government.

In the years that followed, the private sector became the engine of growth for Indian healthcare. Medical institutions in the major cities today rival the best in the world. Today, while access to healthcare in urban centres has improved dramatically, it remains woefully poor in the Tier 3 cities and rural areas.

It is now time to evaluate the progress the sector has made so far. This summit aims to develop a score card on what has been achieved in the last decade. I do hope you will find the sessions thought provoking and inspiring and would request you to work with us to draft a blue print for the future of Indian healthcare.

Dr Naresh Trehan
Chairman, CII National Committee on Healthcare,
Chairman, CII 8th India Health Summit,
CMD, Medanta-The Medicity

A reality check
Universal healthcare in India

India's phenomenal economic growth in the last decade has improved overall health standards in the country. But, it has also brought to light the inequities and inefficiencies of our healthcare industry. Our Tier 3 cities and rural areas have very limited access to good quality healthcare. The poor conditions in these cities and villages make it imperative for us to act on improving the healthcare delivery system.

Today, millions of Indians cannot use healthcare services because of their financial constraints. 70% of the payments in India are out-of-pocket[2] (direct payments). This percentage is even higher for people below the poverty line. The first step towards solving the financial hardships faced by the poor is to move away from out-of-pocket payments at the time of utilising services to prepayment for health services.

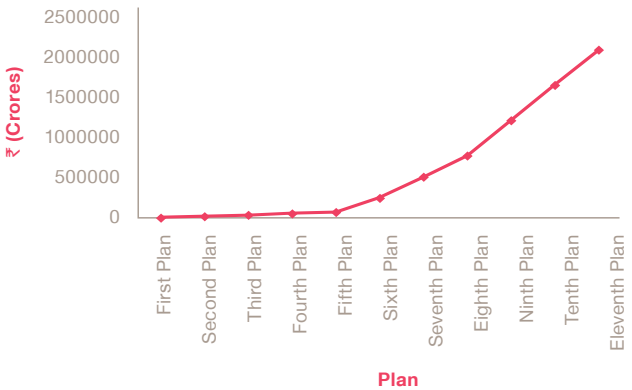
While healthcare facilities in Indian metros are competing with the world's best medical centres, the scenario beyond the urban conglomerates is not encouraging.

- Thirty per cent of Indians don't have access to primary healthcare facilities.
- About 39 million Indians fall below the poverty line each year because of healthcare expenses[2].
- About 70% of Indians spend all their income on healthcare and buying drugs.
- Around 30% in rural India don't visit hospitals afraid of the expenses.
- The healthcare needs of 47% of rural India and 31% of urban India are financed by loans or sale of assets[1].

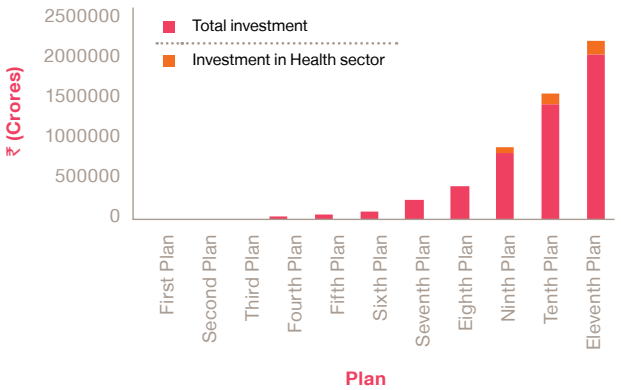
India's healthcare expenditure has been on a rise since the last six Five Year Plans. Schemes that address the health of people below poverty line have been introduced. However, more efforts are needed to use these funds efficiently. Governments should try to pool funds that will increase access to services needed.

Popular by the phrase *"Health for all"*, we all were introduced to *"universal healthcare"* by the Health Planning and Development Committee's report

Five Year Plan outlays in India



Source: Planning Commission of India



Source: National health profile 2010

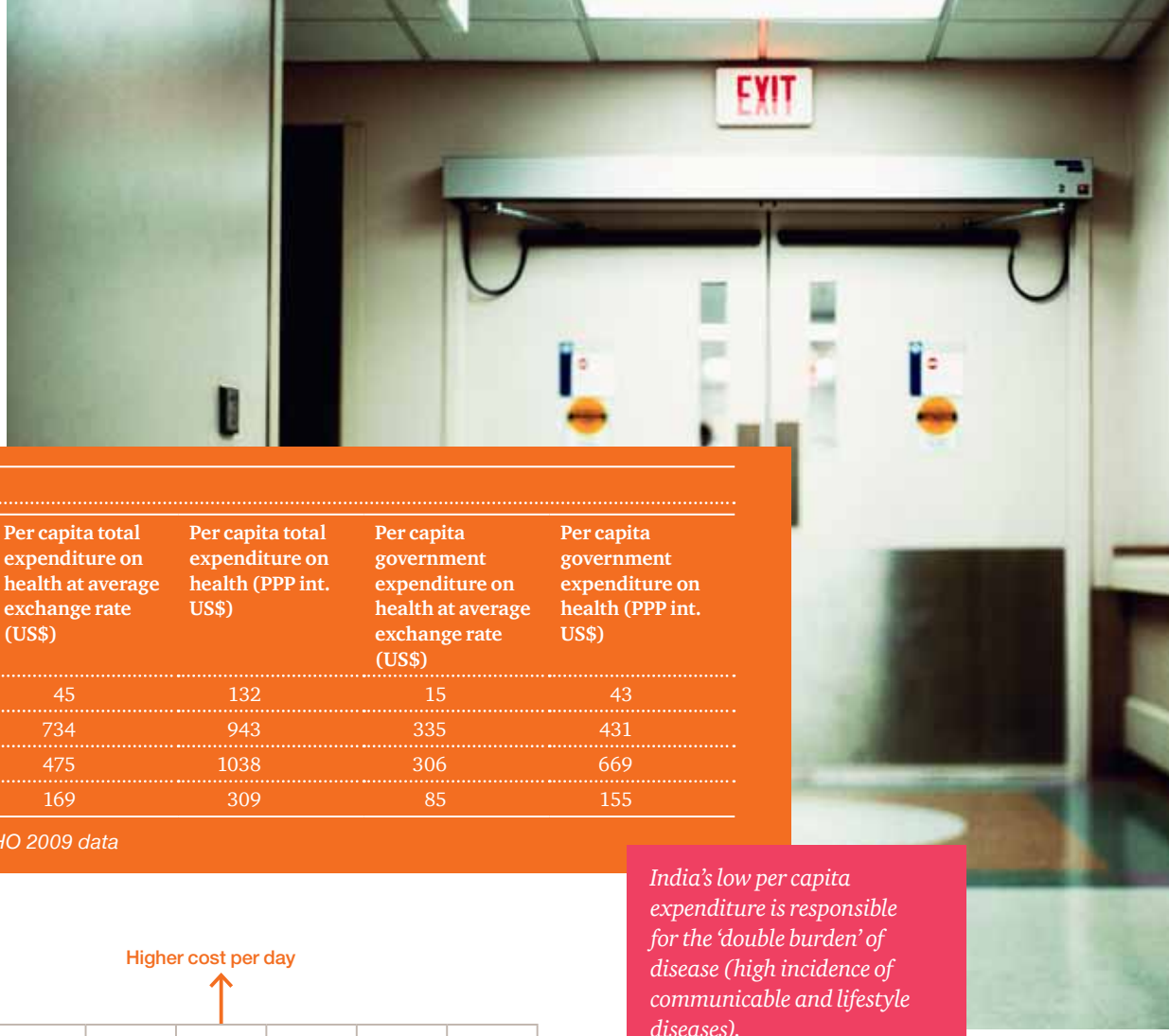
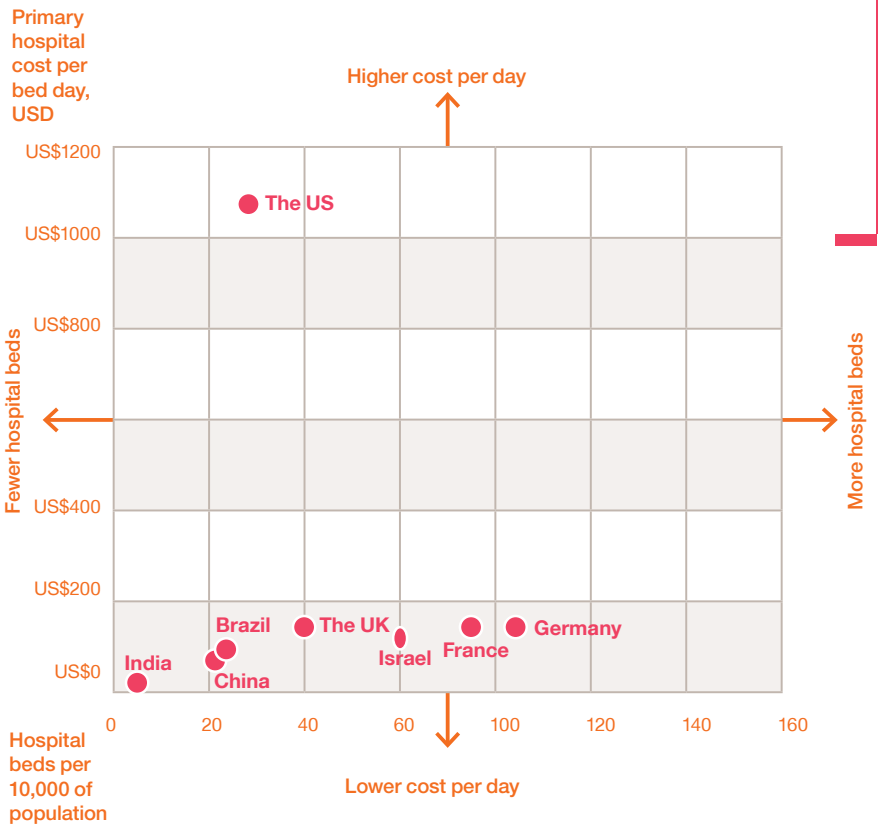


Table 1

BRIC nations	Per capita total expenditure on health at average exchange rate (US$)	Per capita total expenditure on health (PPP int. US$)	Per capita government expenditure on health at average exchange rate (US$)	Per capita government expenditure on health (PPP int. US$)
India	45	132	15	43
Brazil	734	943	335	431
Russia	475	1038	306	669
China	169	309	85	155

Source: WHO 2009 data

India's low per capita expenditure is responsible for the 'double burden' of disease (high incidence of communicable and lifestyle diseases).



Source: PwC internal research

(popularly known as the Bhore Committee). The report gave recommendations and set goals to improve the health conditions of the country. This report highlighted that no individual should fail to secure adequate curative and preventive medical care, because of the inability to pay for it. The next impetus came from the Primary Healthcare Declaration at Alma Ata in 1978, where India was a signatory. The Alma Ata declaration along with the ICMR/ICSSR report on *"health for all by 2000"* influenced the Sixth Five Year Plan (1980-84). The focus on healthcare during this period led to the drafting of the National Health Policy, 1983, which had universal comprehensive primary health services as its goal. The emphasis of this policy was to build the primary healthcare system, which lacked implementation and also missed out on creating a strong referral system. The report recommended that state governments spend 15% of its revenues on healthcare. But in India this percentage never went above 2%. Though the government's healthcare expenditure has increased in the last decade, the per capita government expenditure is still too low when compared to the BRIC nations. (Refer to table 1)

Central and state governments have taken many initiatives to improve the health and living conditions of its people over the years. Emphasis has been given to various aspects of healthcare in all the five-year plans. Of all, the National Rural Health Mission in 2005 has stood out as the most noteworthy government-led initiative. This initiative has led to the repositioning and resurgence of the public health system. This has resulted in the inclusion of the health needs for the individuals below poverty line. However, the success of these schemes such as, the National Rural Health Mission, Rashtriya Swasthiya Bima Yojana, and state-government-funded health insurance schemes (e.g., Rajiv Aarogyashri Scheme in Andhra Pradesh, Kalainger Life-Saving Health Insurance Scheme in Tamil Nadu, Yeshashwini Scheme in Karnataka, and Chief Minister's Life Saving Health Insurance Scheme in Rajasthan) in achieving their claims and reducing inequities in healthcare is still to be measured[3].

India with 17% of the global population, also accounts for a substantial proportion of the global disease burden. With nearly 18% of deaths and 20% of disability-adjusted life-years (DALYs)[4], India's geographical inequalities in health outcomes are higher than the provincial differences in life expectancy in China and the interstate differences in the US. The difference is as wide as 18 years. E.g., life expectancy is 56 years in Madhya Pradesh and 74 years in Kerala[5].

The rapid development of private hospitals in urban areas has resulted in an unplanned and unequal geographical distribution of healthcare delivery services. Although the concentration of facilities in urban areas might encourage economies of scale, the distribution of services is an important factor that affects equity in healthcare. This is mainly because many vulnerable groups tend to be clustered in areas where services are scarce. In 2008, an estimated 11,289 government hospitals had 494,510 beds. The regional variation ranged from 533 people per bed in a government hospital in Arunachal Pradesh to 5,494 people per bed in Jharkhand[5].

Overall, the benefits of the country's progress in bringing the latest procedures and technology to its citizens haven't percolated to the smaller cities and rural India. The government needs to invest in research to develop models both successful and financially viable. Private players need to also build newer models to provide efficient healthcare delivery services beyond the Tier 1 and Tier 2 cities.

#1

Collaborating for success

Public-private partnership

There is no country in the world where healthcare is financed entirely by the government. While it is primarily seen as the responsibility of the government to provide healthcare facilities, private capital and expertise are viewed as ways to induce efficiency and innovation. However, the key debate here is the role of private resources in financing and managing healthcare services and achieving the appropriate balance of public to private resources. Discussions are centred on determining various structures that ensure the best possible return for both tax payers and the private sector.

One such structure is a public-private partnership (PPP). Building on two decades of experience in PPPs for health infrastructure, governments are increasingly looking to this model to solve larger problems in care delivery and wellness. As PPPs move from replacing crumbling inpatient structures to managing care delivery, the impact on overall costs is more

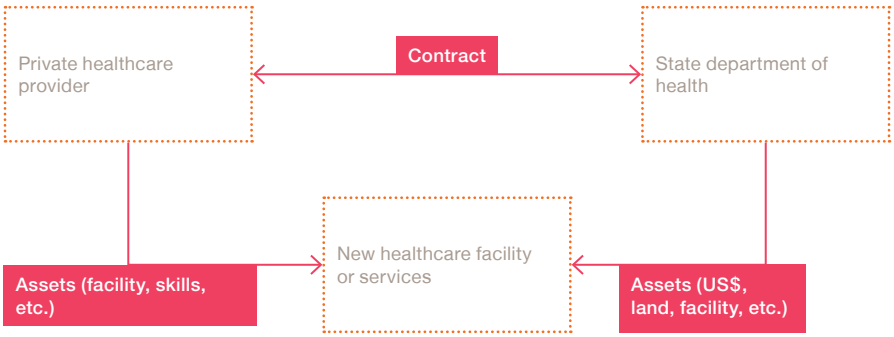
86% of the world's health spending is accounted by OECD countries, which represent only 18% of the global population.

Source: WHO universal health 2010

US$5.3 trillion is the current global annual expenditure on health.

Source: WHO universal health 2010

PPP structure



substantive and sustainable. However, bringing down the rapid pace of medical costs adds a higher level of difficulty and complexity.

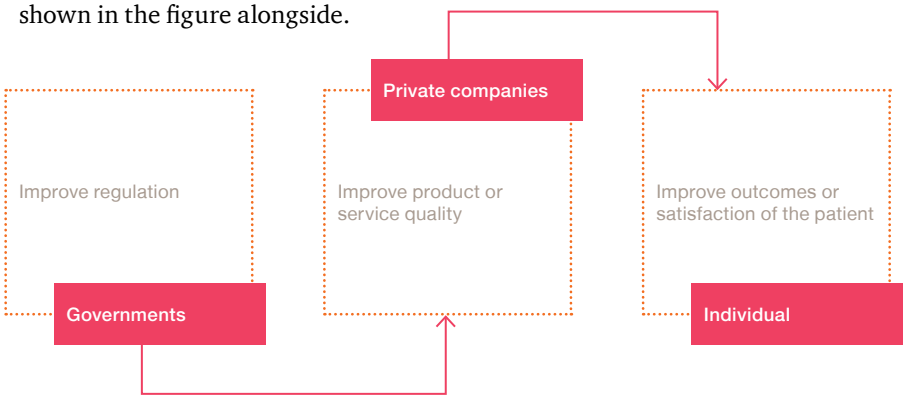
PPPs in Indian healthcare have traditionally been infrastructure projects. They have only recently transformed to include clinical service delivery. The success of PPPs is now being measured by health outcomes and patient satisfaction. PPPs with the right frameworks have the potential to reduce inequities in care.

The final responsibility of service delivery lies with the government. In case of any inefficiency on the part of the private sector, the responsibility for the failure of services falls back on the government.

A PPP creates:

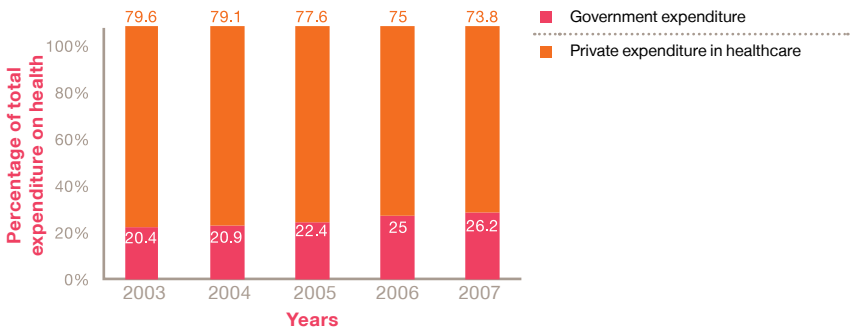
- *A more sustainable means for government to provide for the health of its citizens*
- *An enormous market with a reliable, multi-year revenue stream for private investors*
- *Better outcomes, value and accessibility for patients, especially, historically under-served populations*
- *Reduced financial burden on tax payers*

The PPP model aims at bringing quality and affordable healthcare, enlarge the reach and expand the services offered by public healthcare institutions across the country. The key role played by each player is shown in the figure alongside.



A report on medical education by the Minister of Health and Family Welfare (MoHFW) says that the private sector that accounts for 29% of hospital beds caters to 78% of the patients in rural areas and 82% in urban areas. (Source: NSSO 60th round report)[6]. This highlights the low bed utilisation in public sector hospitals. For these reasons, both private and public sectors recognise the urgent need for PPPs as a tool for enhancing public health system by maintaining optimum utilisation. The private sector could also benefit by utilising the manpower and infrastructure of the public sector. Such partnerships also facilitate in strengthening the relationships between the two parties, thus increasing the role of private players in policymaking.

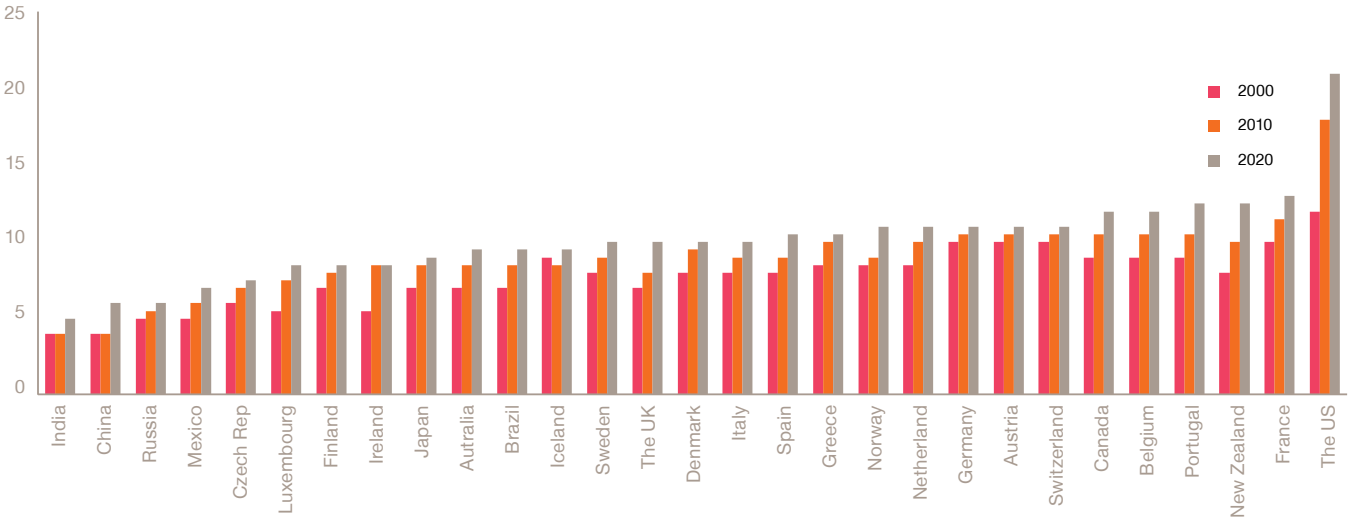
Government versus private expenditure



Source: National health profile 2010

Currently, the government expenditure on healthcare is about 26% of the total expenditure on health.

Health expenditure as % of GDP



Source: PwC Health Research Institute

Currently, there is no standard PPP model in healthcare. It varies from state to state since health is a state subject. There is a need for a standard template. "In a PPP model, there should be a standard framework that acts as a policy document." Specific agreements for each PPP can be drafted around the policy document taking into condsideration the requirements of each PPP model and the type of assignment.

Every PPP stems from a clear and well-articulated need. The need is defined as the gap between the current situation and the optimal status, e.g., the gap between current and optimal health outcomes. Secondly, there must be a willingness to work together in a real partnership. Thirdly, to bring that willingness into action, there must be appropriate incentives for each player. The fourth characteristic of a successful PPP is the ability of each player to perform to the required standard. All of these issues revolve around the need for flexibility. Whilst PPPs clearly need to be controlled by detailed contracts, the contract structure must accommodate technological innovations, IT, demographical development and the resulting changes in the strategic aims of the governments over time. Such PPPs with detail contracts could help governments move towards providing health for all.

#2

Enhancing accessibility and affordability of healthcare

The Indian healthcare sector has transformed in the last decade. The country has achieved global standards in the field of medicine, specifically in tertiary and quaternary care. However, in terms of primary care, we are lagging behind in a lot of parameters.

Here are some startling numbers:

- In 2005-06, national immunisation coverage was just 44%.
- The coverage for children of mothers with more than five years of education was 64% and for children of mothers with no education was 26%[2].

Almost 30% **of Indians don't have access to primary healthcare facilities.**

Source: The Lancett, Feb 2011

80,000 hospital beds **are required to be added each year to meet increasing healthcare demands for the next five years.**

Source: WHO

- The rate of institutional deliveries is 40%. While this has increased over the years, it still remains dismally low.
- Women in the richest quartile are six times more likely to deliver in an institution than those in the poorest quintile.

The accessibility of primary healthcare facilities in India is poor for two reasons. Firstly, there is low government expenditure on health and secondly, resources are not allocated efficiently. Also a major concern is the different allocations made by the state governments for healthcare. While Bihar spends the least on healthcare, Himachal Pradesh spends the most. Also, most of the expenditure on healthcare is skewed towards providing curative services in urban areas. This results in expenditure on primary healthcare being minimal.

Almost 150 million

people a year face catastrophic healthcare costs because of direct payments such as user fees, while 100 million are driven below the poverty line.

Source: WHO

39 million

Indians fall below the poverty line each year because of healthcare expenses.

Source: WHO Universal coverage 2010

Can the healthcare industry learn from the telecom industry?

Most of the growth seen in the healthcare delivery services in India has been in the metros and Tier 1 cities. The governments' focus on rural areas has resulted in alleviating the health conditions but there is more that needs to be accomplished. The healthcare infrastructure in rural areas is non-existent and the problem is exacerbated by out-of-pocket payments and poor paying capacity of the people. Business models are being worked out to penetrate these markets. Health insurance companies are taking the lead to change the scenario by getting more people insured. It is in this area that they could emulate the model created by the telecom sector, in the following way:

- *Build the infrastructure.*
- *Study customer needs and design product accordingly. Introduce cheap plans that even rural poor can afford and provide attractive incentives like high no-claim bonuses.*
- *Take initiative such as, going door-to-door with irresistible products and prices.*

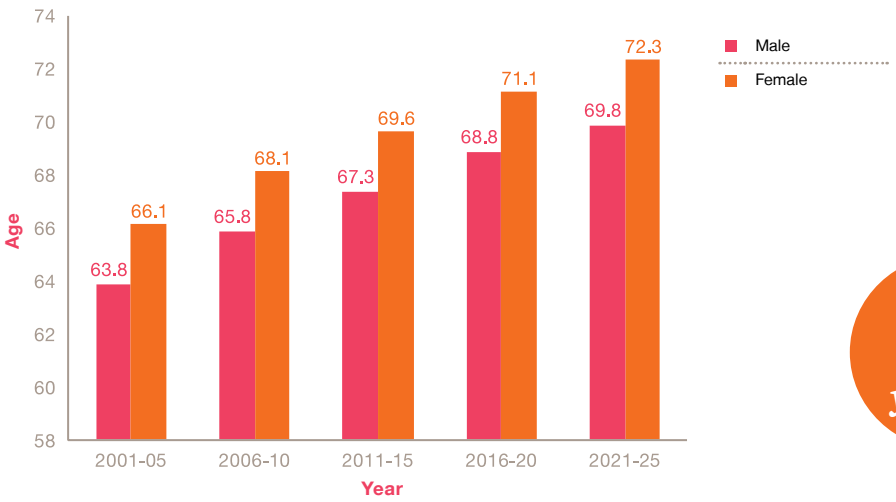
Addressing primary healthcare concerns: Upgradation of existing private facilities in rural areas

The expectation of quality care is relatively low in Tier 3 cities and rural areas. This leads to a lower cost of care offered in these regions. A balance between the quality expected and the cost at which it is offered is the key for success in these areas. Many nursing homes, that are majorly doctor-entrepreneur led facilities, have been successfully doing this over the years. But, with the economic growth and rising consumerism, the quality of care provided by these nursing homes has fallen short of the market expectations. Additionally, availability of specialists in these areas has limited the quality of care being offered.

Rising the quality of care could increase the costs for the providers. These costs can be managed by tweaking processes, driving hard bargains, negotiating creative partnership deals, achieving economies of scale and introducing process and product innovation.

In India, accessibility is majorly limited by affordability. To manage these costs, a multitude of economic models are also being tested in these areas. However, a scalable and successful model that can be replicated across regions hasn't been created. An ideal model should be cost-effective, operationally efficient and in line with market expectations.

Projected life expectancy



70 years is the average life expectancy of an Indian male.

Source: Report of the Technical Group on Population Projections May 2006,National Commission on Population/MOHFW/GOI.

#3

Up-skilling the healthcare workforce

India has more physicians and nurses today than ever before. However, most of our trained healthcare specialists work in urban areas, with very few deployed at rural centres in the country.

Nearly 30,000 doctors, 20,000 dentists and 45,000 nurses graduate from medical colleges across India every year. The doctor-to-patient ratio in India is six for 10,000 people, way below Australia (1:249), the UK (5: 1,665) and the US (9:548). The global ratio stands at 15 doctors for 10,000 people[6]. The distribution of these doctors is uneven with low ratio in states like Chhattisgarh and Jharkhand-just two doctors for 1,00,000 people.

According to the Planning Commission's 2008 report[6] India still faces a shortage of about six lakh doctors, ten lakh nurses, two lakh dental surgeons and a large number of paramedical staff. It is pertinent to note that these shortage projections are built around today's dysfunctional healthcare system, which makes them problematic. However, while future shortages are certainly worrisome, the bigger issue for health industry leaders today lies in orchestrating care in an increasingly complex and converging healthcare labour market.

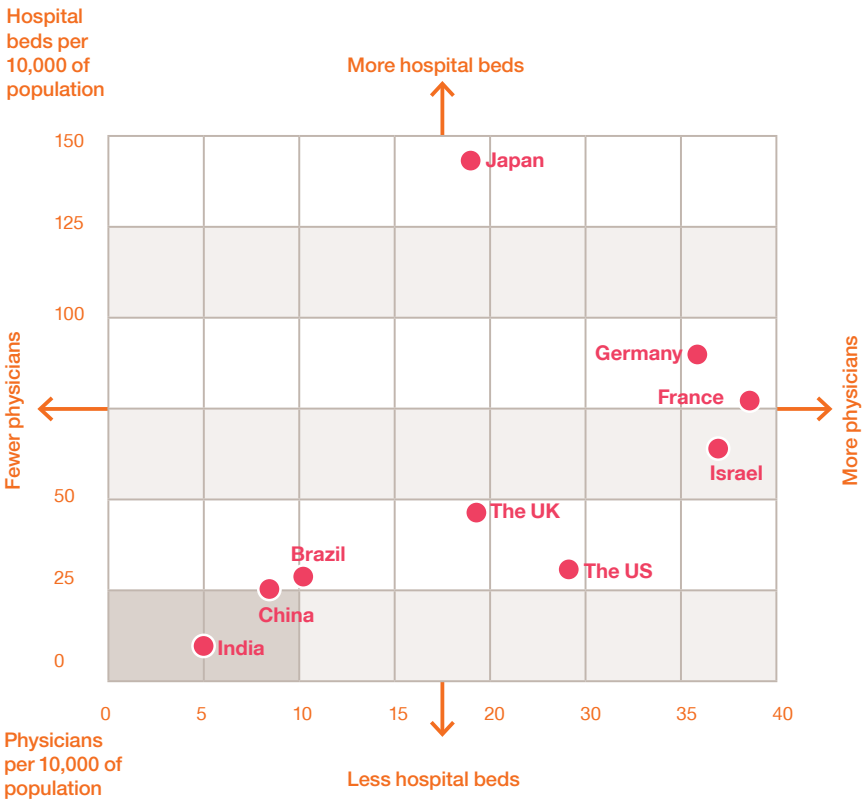
About **76%** **of Fortune 50 companies are either in the health industry or have health divisions.**

Source: PwC internal research

This shortage of healthcare professionals can be addressed by opening up the medical education sector to greater private sector participation. This could help establish many medical and dental colleges in the country. India is planning to attract 60,000 Indian doctors from the US, UK, Canada and Australia by allowing them to practise and teach in India. This will help in not only addressing a shortage, but also retaining future Indian doctors. Additionally, in the 11th Five Year Plan, 60 new medical colleges and 225 new nursing colleges are being planned under a public-private partnership.

The Union Health Ministry is working towards modifying regulations under the Indian Medical Council Act, 1956 to facilitate establishment of medical colleges by private players in India. The new Act will relax land norms, operating and staffing regulations. The government also plans to build six institutions like the All India Institute of Medical Sciences (AIIMS) and to upgrade 13 existing medical facilities. The Ministry has paid special attention to states such as Bihar, Uttar Pradesh and Madhya Pradesh that face a major shortage of specialised doctors and other healthcare manpower.

Enhancing skills of healthcare professionals or multi-skilling though not the most viable solution, can deliver excellent care in a manpower crunched scenario. The role of the National Skills Development Corporation (NSDC) has been to catalyse the training of skilled manpower not only in the cities but also in the rural areas.



Source: PwC internal research

Considering the current scenario, PwC's Health Research Institute has developed a roadmap for a new workforce model based on the following recommendations:

Develop public-private partnerships
Widespread shortages have created an environment in which key healthcare players may no longer operate in silos. Rather, these groups must work collectively to promote nursing and physician programmes, forging alliances to provide not only education but also required funding.

Encourage technology-driven training

Improving clinical outcomes requires the seamless co-ordination of treatment among all clinical professionals. Advances in technology have enabled care-givers to work in concert with one another, allowing the focus to remain on quality patient care. Providers, for their part, must maximise available technology and encourage the adoption of and adherence to technical innovations to increase the productivity of medical staff.

Design flexible roles

Today, physicians and nurses are placed in a stronger position to dictate the terms of their employment. Employers are increasingly finding that flexibility is central to attracting and retaining quality medical staff. The most successful employers will provide clinicians with options and integrate flexible work arrangements into their staffing models.

Establish performance-based metrics

Unlike other industries, healthcare has been able to delay the adoption of performance-based standards. Traditionally, reimbursement did not depend on quality or operational efficiency but only on the volume of services delivered. However, the landscape of reimbursement is evolving, with performance based metrics such as clinical quality outcomes and patient satisfaction—as its centrepiece.

#4

Innovations in mobile health redefining healthcare

Mobile technologies have played a key role in keeping people healthy, managing diseases, and lowering healthcare costs. For years, telemedicine has provided clinical services for individuals who lacked physical access, such as, farmers in remote communities, soldiers near the battlefield, and inmates in prison. Now, these technologies have demonstrated the ability to benefit almost any individual. Today, mobile devices are the most personal technology that consumers own. They enable consumers to establish personal preferences for sharing and communicating. Going ahead, they can enable health and wellness to be delivered through mass personalisation.

India is expected to be one of the largest mobile health markets in the Asia Pacific by 2017, next only to China and Japan. The mobile health opportunity in India is being shaped by the healthcare challenges of accessibility and affordability in the country. Also, the disease profile in the country is complex considering the high incidence of non-communicable and communicable diseases. As a result, the growing private and public expenditure on healthcare is ensuring a greater focus on technology-enabled healthcare delivery solutions in the country. The mobile operator and device manufacturers' ecosystem is also playing an important and integral role in shaping the mobile health market in the country. Assisting all stakeholders, the regulatory environment is also expected to have a more active approach in promoting mobile health for healthcare delivery.

In the next five years, the mobile health market in India will be led by diagnosis and monitoring services.

Diagnosis services, through the mobile health platform, are expected to bridge India's healthcare deficit, particularly in rural areas. India's increasing affluence and consequently increasing incidence of non-communicable diseases such as diabetes, hypertension and heart diseases has resulted in an opportunity for mobile enabled monitoring services. At present there are 21 sizeable live and in-pilot deployments of the mobile health platform in the country[8]. One of these, the 'Freedom HIV/AIDS' mobile gaming services for HIV awareness has reached 42 million people in India with a download of 10.3 million game sessions[9]. Most of the current deployments are challenged with scaling up, reporting less than 10, 000 subscribers at present[10].

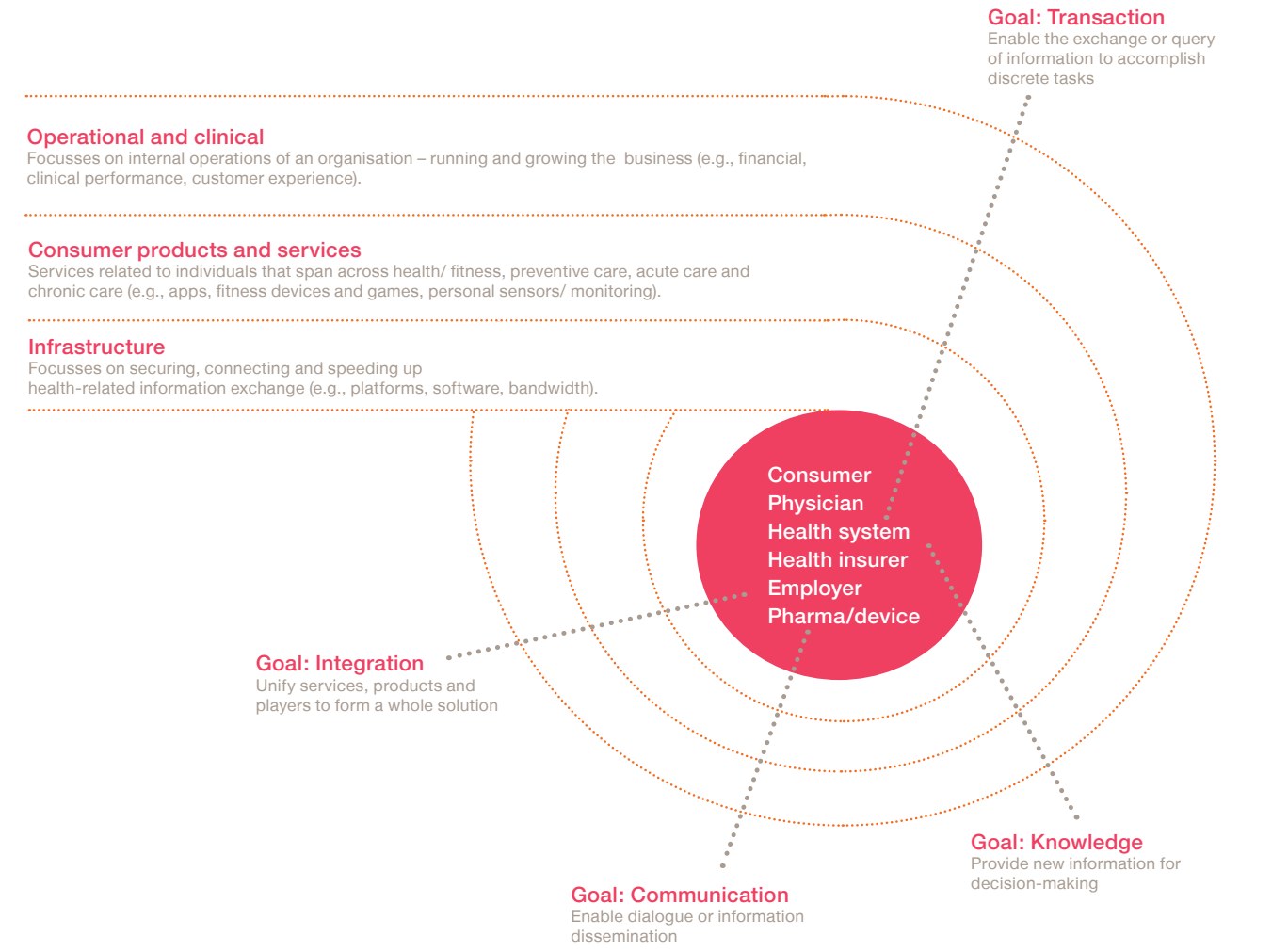
To increase the reach of mobile health, some issues need to be addressed. Key among them is the challenge of payments for services. Healthcare providers and hospitals get paid based on the volume of services delivered and mobile health has been shown to reduce the need for hospital admissions and visits to physicians. Why would providers adopt technologies that eat into their incomes? An industry that is paid based on volume will not adopt technologies that reduce volume. But new payment models that focus on outcomes rather than volumes can help address these concerns.

For India, the mobile health initiative will impact many stakeholders:

- Patients who delay care because they're too busy to wait in a doctor's office
- Physicians who don't have enough time to spend with patients
- Device companies that want to monitor the performance of their devices
- Pharmaceutical companies that want to ensure patients are taking the medicines they need
- Hospitals that don't have the capital to build more beds

To address the needs of these stakeholders, PwC's Health Research Institute has designed various mobile business models. Going ahead, these models that enable provider, payer, employer, medical device and drug companies as well as non-traditional healthcare organisations to run their business operations better and more efficiently are expected to rise. As a result, they will make healthcare both accessible and affordable to people in Tier 3 cities and rural areas.

Mobile health business models

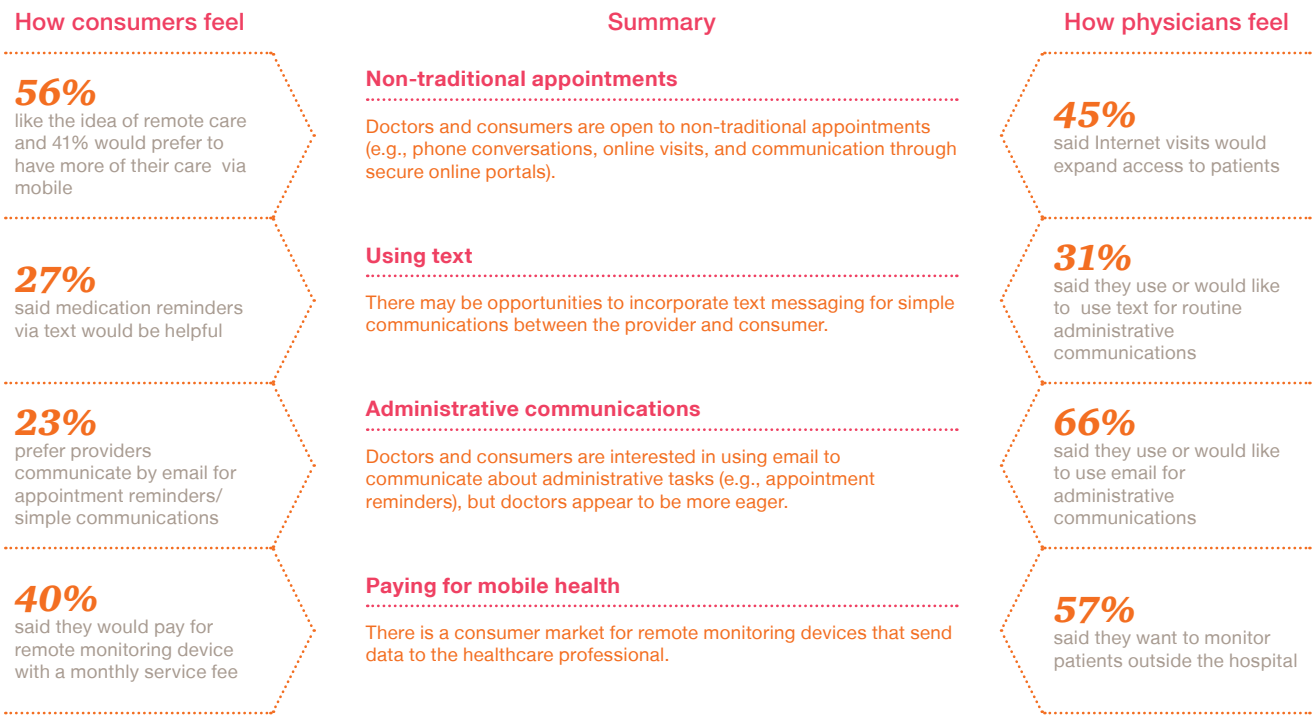


Source: PricewaterhouseCoopers Health Research Institute

The US is one of the most advanced mobile health markets globally. A survey among physicians and consumers in the US shows that both see mutual value in mobile health. And those intersections have led to opportunities. For example, physicians are interested in remote monitoring and consumers are willing to pay for it. The figure below depicts consumer and physician attitudes.

To address these opportunities, a host of new players are developing affordable, easy-to-use, 'care anywhere' devices, services, solutions and networks that are attractive to consumers.

As our survey shows, mobile health can improve the use and the value of physicians' time. One-third of physicians surveyed by the PwC Health Research Institute said they make decisions based on incomplete information. They believe the greatest benefit of mobile devices will be to help them make decisions faster as they access more accurate data in real-time.



Source: PwC Health Resource Institute Physician and Consumer Surveys, 2010

Key results of the mobile health survey in the US

- *Forty percent of physicians surveyed said they could eliminate 11% to 30% of office visits through the use of mobile health technologies like remote monitoring, emails or text messaging with patients. Such shifts would rewrite physician supply and shortage forecasts in the next decade.*
- *Physicians are interested in different types of applications. Primary care physicians (PCPs) are interested in prescribing medications and specialists in accessing electronic medical records (EMRs) wirelessly.*
- *In-person consultations are still the main method of reimbursement, but physicians are getting limited reimbursement for phone and email consultations, tele-health and text. Payment models that address how mobile health reduces costs are more effective, but require changes in delivery-care processes.*
- *Healthcare providers in search of additional funding should consider marketing mobile health solutions. According to the survey, consumers said hospitals are the preferred place to buy mobile health products. An overwhelming response voted doctors as the most trusted in terms of getting health information.*

Conclusion

Indian healthcare services have evolved over the last few years, making the country a popular destination in medical tourism. Our healthcare facilities have grown significantly, in terms of numbers and the expertise of our professionals. But mass access continues to remain a challenge.

For the private sector, affordability in Tier 3 cities and rural areas is a critical limiting factor for further expansion. This situation is further complicated by the low penetration of insurance players in these areas. Deferred payment and insurance coverage can boost the access of healthcare services in rural India.

The government also has a key role to play in ensuring the access and affordability of healthcare services. It must initiate insurance coverage for its citizens. Along with private players, the government must address the shortage of healthcare professionals and expand facilities in remote areas. Lastly, incentives to mobile health technology players can also address the concerns of accessibility that exist in this vast country.

Getting all stakeholders to work collaboratively will take us close to our goal of universal healthcare. In the next decade, India's healthcare sector needs to be on par with other more successful social sectors.

References

1 Indians' medicine bills concern WHO, The Times of India

2 India: Towards universal health coverage 4, Healthcare & Equity in India: The Lancet 5 Feb 2011

3 Deepening Health Insecurity in India: Evidence from National Sample Surveys since 1980s

4 WHO. Disease and injury country estimates. Death and DALY estimates for 2004 by cause for WHO Member States. Department of Measurement and Health Information. 2009. http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html

5 CBHI. Health Infrastructure, national health profile (NHP) of India–2008. New Delhi: Central Bureau Of Health Intelligence, Government of India, 2008

6 Express Healthcare Feb 2009

7 Telecom Model can work for Health Insurance, Business Line, The Hindu.

8 Wireless intelligence

9 MedIndia

10 PwC analysis

Acknowledgements

We would like to express our gratitude for the input and help we received from the following experts so generously donated their time towards the survey conducted for the report:

Dr Naresh Trehan, Chairman, CII, National Committee on Healthcare
All Members of CII National Committee on Healthcare
Marut Sen Gupta, Deputy Director General, CII

We also take this opportunity to thank all the following team members from PwC for their contributions to this report:

Nandini Chatterjee, Director, Brand & Communication
Sonali Mitra, Manager - Media, Brand & Communication
Seema Siddiqui, Assistant Manager - Media, Brand & Communication
Nidhi Jain, Designer, Brand & Communication

The views expressed herein are personal and do not reflect the views of the organisations represented by the individuals concerned.

About CII

The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the growth of industry in India, partnering industry and government alike through advisory and consultative processes.

CII is a non-government, not-for-profit, industry led and industry managed organisation, playing a proactive role in India's development process. Founded over 116 years ago, it is India's premier business association, with a direct membership of over 8100 organisations from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 90,000 companies from around 400 national and regional sectoral associations.

CII catalyses change by working closely with government on policy issues, enhancing efficiency, competitiveness and expanding business opportunities for industry through a range of specialised services and global linkages. It also provides a platform for sectoral consensus building and networking. Major emphasis is laid on projecting a positive image of business, assisting industry to identify and execute corporate citizenship programmes. Partnerships with over 120 NGOs across the country carry forward our initiatives in integrated and inclusive development, which include health, education, livelihood, diversity management, skill development and water, to name a few.

CII has taken up the agenda of "Business for Livelihood" for the year 2011-12. This converges the fundamental themes of spreading growth to disadvantaged sections of society, building skills for meeting emerging economic compulsions, and fostering a climate of good governance. In line with this, CII is placing increased focus on Affirmative Action, Skills Development and Governance during the year.

With 63 offices and 10 Centres of Excellence in India, and 7 overseas offices in Australia, China, France, Singapore, South Africa, UK, and USA, as well as institutional partnerships with 223 counterpart organisations in 90 countries, CII serves as a reference point for Indian industry and the international business community.

Mahesh Natarajan,
Director

Confederation of Indian Industry
The Mantosh Sondhi Centre
23 Institutional Area
Lodi Road, New Delhi - 110 003
Tel : 011- 24629994-7
Fax: 011-24626149 / 24615693
Email : mahesh.natarajan@cii.in

About PwC

PwC firms help organisations and individuals create the value they're looking for. We're a network of firms in 158 countries with close to 169,000 people who are committed to delivering quality in assurance, tax and advisory services. Tell us what matters to you and find out more by visiting us at www.pwc.com.

In India, PwC (www.pwc.com/India) offers a comprehensive portfolio of Advisory and Tax & Regulatory services; each, in turn, presents a basket of finely defined deliverables. Network firms of PwC in India also provide services in Assurance as per the relevant rules and regulations in India.

Providing organisations with the advice they need, wherever they may be located, our highly qualified, experienced professionals, who have sound knowledge of the Indian business environment, listen to different points of view to help organisations solve their business issues and identify and maximise the opportunities they seek. Our industry specialisation allows us to help co-create solutions with our clients for their sector of interest.

We are located in these cities: Ahmedabad, Bangalore, Bhubaneshwar, Chennai, Delhi NCR, Hyderabad, Kolkata, Mumbai and Pune.

Dr. Rana Mehta,
Executive Director
Leader Healthcare Practice, PwC India.

PricewaterhouseCoopers Pvt. Ltd.
Building no. 10, 17th Floor Tower-C, DLF Cyber City, Gurgaon - 122 002
T: +91 (124) 330 6000 | D: +91 (124) 330 6006
F: +91 (124) 330 6999 | M: +91 99 10 511 577
Email: rana.mehta@in.pwc.com

pwc.com/india

NJ 245 November 2011 Healthcare background paper.indd
Designed by: PwC Brand and Communications, India