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A review article: Role of Clinical pharmacist to provide good health care services in India Compare with other developed Countries

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ABSTRACT
The motivation behind this audit article fundamentally is to discuss medical care conveyance arrangement of India in contrast with other created nations like Norway USA ,china and so forth ,with their approaches followed by the significant part of Clinical drug specialist to give great medical services benefits that may diminish diabetes predominance and a couple of proposals to improve medical care association. System embraced that the writing audit search in Pub Med, Cochrane, Embase, Google researcher , science immediate and Official government sites were performed. Admittance to great medical care framework can applies beneficial outcome on monetary and social movement in any nation including India. The general well being status should be tended to through different arrangement of strategy apparatuses comprising short and long haul measures to make sure about improved well being results. The IDF South-East Asia Region as of now where India is one of the 7 nations of the IDF SEA locale. 463 million individuals have diabetes on the planet and 88 million individuals in the SEA Region; by 2045 this will ascend to 153 million. The cooperation of Clinical drug specialists and doctors in the emergency clinic under a similar reason to enhance and follow the treatment of patient can decreased the general wellbeing emergency in India. The Government of India needs to present clinical drug specialist in government emergency clinics so as to improve and give better wellbeing status to its populace. Government needs to present clinical drug specialist in government clinic and viably conveying human asset to develop the vocation of drug store experts.
KEY WORDS: Pharmacy Education; Health policies, Healthcare setup, impact of clinical pharmacist ,Diabetes Mellitus

I. INTRODUCTION

Public health organizations have counted diabetes as one major burden affecting the lives of many people including the citizens of India, by 2030 WHO projected diabetes to be the 7th leading cause of death. [6] Available data revealed that Diabetes Mellitus (DM) is of two types 1 and 2. The type 2 is the leading cause of morbidity and mortality rate, [7] In adults, type 2 diabetes accounts for about 90 to 95 percent of all diagnosed cases of diabetes; the remainder are adult-onset (or adult-diagnosed) type 1 diabetes, a form of diabetes for which the cause is unknown. [8, 9] Generally DM has been related to old peoples, body weight and physical inactivity. But DM-2 is known to be noninsulin dependent, mostly observed in elderly age, and the body in ability to utilize insulin as a result of obesity. Due to sign and similarity with Type I, DM Type II is not easily diagnosed until complications have observed with symptoms. Recently few cases were reported in children. [10] Genetics and environmental factors are linked to DM. Either of the parents have Type II DM; the inheritance risk is 15% and 75% inheritance risk if both parents have Type 2 DM. [11]

Report on the Health Survey and Development Committee, commonly referred to as the Bhore Committee Report, 1946, has been a landmark report for India, from which the current health policy and systems have evolved. [1] The recommendation for three-tiered health-care system to provide preventive and curative health care in rural and urban areas placing health workers on government payrolls and limiting the need for private practitioners became the principles on which the current public health-care systems were founded. This was done to ensure that access to primary care is independent of individual socioeconomic conditions. However, lack of capacity of public health systems to provide access to quality care resulted in a simultaneous evolution of the private health-care systems with a constant and gradual expansion of private health-care services. [2]

Although the first national population program was announced in 1951, the first National Health Policy of India (NHP) got formulated only in 1983 with its main focus on provision of primary health care to all by 2000. [3]

The health care function from the policies made from Federal and Provincial Governments, primarily responsible for preventing disease and provision of therapeutic services to its citizens.

In India , the health care services entailed the team of physicians, nurses , pharmacist and medical laboratory technicians in hospital. In other developed countries like USA , CANADA , CHINA etc the effective health care service involved Clinical pharmacist in the team to improve the patient quality of life . The reason behind is that Clinical pharmacist has versatile knowledge about medication uses; curative and side effect , pharmacoeconomics

Clinical pharmacy is in growing stage in developing countries, especially in populated country like India wherein there is very limited number of hospitals that have clinical pharmacist in decision making to patient. Diseases are increasing gradually putting the population at risk. In current situation in other developed countries with good health care, clinical pharmacy plays contributing role in the improvements towards the patient health. Professional authorities and organizations in developing countries should work together in resolving the issues that hinder the standardization of clinical pharmacy practice in hospital. [4]

II. METHOD OF DATA COLLECTION

A literature search using **Pub Med, Cochrane, science direct, Embase, Google scholar and Official government websites** were performed. The reviewers screened titles, abstracts and do full-text screening of eligible studies. The references from these studies were further screened for additional relevant studies.

III. DISCUSSION

Impact of diabetes; morbidity and mortality in India relative to Developed countries

•Reports by International Diabetes Federations (IDF) chart book in 2019 demonstrated

•The all out number of individuals with diabetes is anticipated to ascend to 578 million by 2030 and to 700 million by 2045. 374 million grown-ups have disabled glucose resilience, putting them at high danger of creating type 2 diabetes.

•Diabetes was liable for an expected USD 760 billion in wellbeing consumption in 2019.

•Diabetes is among the best 10 reasons for death, with practically 50% of passings happening in individuals younger than 60 years.

•One in six live birth are influenced by hyperglycaemia in pregnancy.

•In 2004, 3.4 million assessed passings were because of high glucose, with in excess of 8 passings out of each 10 diabetes related cases in immature nation; low-center salary nations. The greater part of the diabetes cases were undiscovered shockingly in creating countries. By 2030 WHO proposes that passings credited by diabetes would be multiplied with the most noteworthy in age bunch 40-59 and 60-79 [12, 13]

In Asian district, diabetes and disabled glucose resistance (IGT) gauges are high and expected to increment by next twenty years. This pattern shows that Asia has over 60% of diabetic populace and the gigantic cases are practically half not yet analyzed. Along these lines the worldwide diabetes predominance is higher than asserted [14]

With the westernized and sudden lifestyle in China, 2010 China National Diabetes and Metabolic Disorder Study Group reported two groups of people with diabetes cases; 49.3 million in urban areas with higher prevalence of diabetes (11.4%) and 43.1 million in rural residence with 8.2% prevalence. It was carry out by the same study that 148.2 million more Chinese are pre-diabetic thus have the higher chance of developing diabetes if they continue with the sedentary lifestyle. Due to improper data from rural public health records, the projected diabetes case in China by 2030 is 500 million, which characterize that diabetes would be a major public health problem in terms of health care delivery in China. [9, 15, 16]

- More and more people are living with diabetes but the number of new annual cases has stabilised. About 245,000 people (4.7 per cent) have a diabetes diagnosis. In addition, there are a number of unknown cases. 300 children develop type 1 diabetes every year.
- 1 in 20 Norwegians have been diagnosed with diabetes (245,000 individuals). Of these, estimates show that 28,000 have type 1 diabetes and 216,000 have type 2 diabetes.
- In addition, many may be unaware that they have diabetes.
- Among 80-year-olds, 1 in 9 have diabetes.
- Drug statistics suggest that the number of new cases of type 2 diabetes are no longer increasing.
- Type 2 diabetes can be prevented with increased physical activity and weight reduction.
- Approximately 245,000 people (4.7 percent), or 1 in 20 people are known to have diabetes. Of these, approximately 28,000 have type 1 diabetes and 216,000 have type 2 diabetes. [17]

In USA, diabetes remains the 7th leading cause of death in 2010, total of 234,051 death certificates listing diabetes as an underlying or contributing cause of death. About 29.1 million diabetic patients have been discovered, 21.0 million were diagnosed, and 8.1 million were undiagnosed. The incidence of diabetes in 2012 was 1.7 million new diagnoses per year; in 2010 it was 1.9 million. In 2012, 86 million Americans age 20 and older had pre-diabetes; this is up from 79 million in 2010. [18]The IDF South-East Asia Region currently where India is one of the 7 countries of the IDF SEA region. 463 million people have diabetes in the world and 88 million people in the SEA Region; by 2045 this will rise to 153 million. [19]

Total adult population :	859,956,100
Prevalence of diabetes in adults :	8.9%
Total cases of diabetes in adults :	77,005,600

Table 1 - Diabetes in Indian 2020 [19]

What is the impact of a clinical pharmacist in providing health care services?

Clinical pharmacists are professionals that provide guidance about the appropriate use of drug compounds for therapeutic benefit, [18] are knowledgeable about the drug ingredients, dosage for safety and toxicity. Perhaps the patient can be allergic to a drug, the clinical pharmacist know how to do its prevention. They are highly trained and possess clinical competencies to practice in health unit and give advice to physician and patient as well as can work in direct patient care environments. [20, 21]

In most hospital setting clinical pharmacists and physicians work together to ameliorate and follow the treatment of patient. They provide patient history of allergy, guidance to the use of OTC drugs, dietary supplements and alternative systems of medicine. Clinical pharmacists perform review of drug therapy, utilize relevant clinical and laboratory data to find and solve drug related problems such as duplication of therapy, drug-drug and drug-food interactions, contraindications, inappropriate dosage [frequency, strength], lack of basic lab monitoring requirements, potential ADRs, inappropriate drug selection, so medical compound without pre-formation. Also, they can determine the cost effectiveness of medication. [22]

In some pharmacy setting like community pharmacy wherein only clinical pharmacy is available patient with critical health related problems are advice by the pharmacist to see physician, and the pharmacist will provide information to address specific health problem to achieve wellness. [23]

For so long and up till now, in many Indian government hospitals, physicians solely manage most of the diabetic patients, due to their less time and clinical indolence, they hampers to meet effective treatment strategy. The increment in diabetic populations has called for new treatment strategies. Primary health care clinics should provide diabetic patient with education and up to date medication management, and have a medical team comprised of Clinical Pharmacist. [24]. Pharmacists have greater opportunity to provide counseling about medication use and benefit. [25]

In severe diabetic condition detailed observation and review of insulin utilization before dose, the conversion should be done for the patients before assigned for U-500 concentrated insulin therapy. However, detailed patient interview is mandatory to define their perfect treatment strategy. Symphonizing the duties of a clinical pharmacist in the administration of chronic disease such as diabetes can increase patients contact and shorten the follow-up periods, which leads to the up-liftment of measurable patient outcomes and clinical goals. [7, 23, 25]

The drawbacks for clinical pharmacist in government hospital

Clinical pharmacy is an aspect of Pharmacy, similar to the newly Doctor of Pharmacy (Pharm D) program, role is differ from hospital to hospital, generally most clinical pharmacist play important role in hospitals such as drug dispense and advice. [26]

One difficult task the newly graduate with Pharm D in India face in hospital is how to meet the working conditions which have limitation for pharmacy practitioner as drug dispensary. In many public hospitals there is one post for a pharmacist often to be in charge of the medical store together with MBBS doctor, performing a clerical role in its management. The coming of the Pharm D has played a very important role in hospital especially in India . [26] India has an increased number of registered pharmacists. The profession is consider to be more related to industry oriented rather than patient oriented and the role of clinical pharmacist is still obscure between the healthcare professionals and community. [4]

The implementation phase of Pharm D program faced a lot of criticism for initial lack of clinical aspects in the study program, this has been a contributor to it slow acceptance to policy maker, thereby seen as unnecessary upgrading of the B Pharm to Pharm D. Currently the pharm D graduates are facing problems to get hospital job due to lateness of policies in health care setup[26, 27]

Generally, Clinical pharmacy is in growing stage in developing countries. In populated country like India with more number of hospitals and drugs, still chronic diseases increases rapid. The cause has been the lack of Clinical pharmacist in decision making. Professional authorities and organizations in developing countries should work together to resolve and improved the standardization of clinical pharmacy. [28, 29]

Comparison of INDIA health policies to that of other developed Countries

National health policies, is a tool that play an imperative role in defining a Health policy of Indian Republic of India .As Policy is a system, which provides the logical framework and rationality of decision making for the achievements. Ministry of Health identified the need for policy arising out of handling of day-to-day problems related to various health programs and commitment to achieving the goals of HFA by 2000 AD. Ministry appointed a committee to review environment in the health sector and recommended a policy frame after needful consultation.

The NHP-1983 gave a general exposition of the policies which required recommendation in the circumstances prevailing in the health sector.

• NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and underprivileged, had hoped to provide 'Health for All by 2000 through the comprehensive PHC Services.

The Ministry of Health and Family Welfare, Govt. of India, evolved a National Health Policy in 1983 till 2002.

• The policy stresses the need of establishing comprehensive primary health care services to reach the population in the remote area of the country.

• India had its first national health policy in 1983 i.e. 36 years after independence

• National Health Policy 2017

• NHP-2017 also identifies seven priority areas for improving the environment for health. These priority areas needing coordinated action include:

1. The Swachh Bharat Abhiyan
2. Balanced, healthy diets and regular exercises.
3. Addressing tobacco, alcohol and substance abuse
4. Yatri Suraksha - preventing deaths due to rail and road traffic accidents
5. Nirbhaya Nari -action against gender violence
6. Reduced stress and improved safety in the work place
7. Reducing indoor and outdoor air pollution [30]

The objective of Indian health policies

Improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

The policy identifies coordinated action on seven priority areas for improving the environment for health: o The Swachh Bharat Abhiyan o Balanced, healthy diets and regular exercises. o Addressing tobacco, alcohol and substance abuse o Yatri Suraksha – preventing deaths due to rail and road traffic accidents o Nirbhaya Nari –action against gender violence o Reduced stress and improved safety in the work place o Reducing indoor and outdoor air pollution The policy also articulates the need for the development of strategies and institutional mechanisms in each of these seven areas, to create Swasth Nagrik Abhiyan –a social movement for health. It recommends setting indicators, their targets as also mechanisms for achievement in each of these areas.

National health policy prioritizes addressing the primary health care needs of the urban population with special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. Policy would also prioritize the utilization of AYUSH personnel in urban health care. An important

focus area of the urban health policy will be achieving convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. These dimensions are also important components of smart cities. Healthcare needs of the people living in the peri urban areas would also be addressed under the NUHM. Further, Non-Communicable Diseases (NCDs) like hyper tension, diabetes which are predominant in the urban areas would be addressed under NUHM, through planned early detection. Better secondary prevention would also be an integral part of the urban health strategy. Improved health seeking behavior, influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism, would also be important components of this strategy. [31]

Health policy of the United States of Norway

Norway is a monarchy with a parliamentary form of government. There are three independent government levels – the national government, the county councils and the municipalities. The Norwegian population reached 4.6 million in 2005. The life expectancy in Norway is among the highest in the world. Diseases of the circulatory system are the primary cause of mortality, with cancer being the second largest cause of death. The Norwegian health care system is organized on three levels, i.e. national, regional and local levels. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services. The regional level is represented by five regional health authorities, which have responsibility for specialist health care; and the local level represented by 434 municipalities has responsibility for primary health care (including nursing care).

The social insurance system, managed by the National Insurance Scheme (NIS), provides financial security in the case of sickness and disability. There is no exact definition of the "coverage package" in the Norwegian health care system. The aim of primary care is to improve the general health of the population and to treat diseases and deal with health problems that do not require hospitalization. Each municipality has to decide how best to serve its population with primary care. Primary care is mainly publicly provided. Much of the spending in the municipalities is directed towards nursing, somatic1 health care and mental health care. Regular general practitioners (GPs) are in practice self-employed, but financed by the NIS, the municipalities and by the patient's out-of-pocket payments.

This measure was further expanded in 1999 to include day surgery. Introduction of activity-based funding has been followed by a substantial increase in the number of cases treated and a reduction in waiting times. The reimbursement of a DRG point is consistent throughout the country. But the regional health authorities are allowed to change these reimbursement rates to their health enterprises. The hospital reform of 2002 aimed to increase efficiency and consisted of three main strategies: the ownership of the hospitals was transferred from the counties to the central government sector; hospitals were organized as enterprises; and the day-to-day running of the enterprises became the responsibility of the general manager and the executive board. Preliminary results, following these reforms, point to some positive outcomes, such as decreased waiting lists and improved management skills. In 2001 a new law was passed allowing greater freedom in the establishment of pharmacies. This led to a vertical integration of pharmacy chains owned by wholesale companies and allowed pharmacists to substitute the physicians' prescriptions with another (e.g. generic) brand. Patients' rights have been strengthened with the passing of the Patients' Rights Act in 1999. Its main purpose was to ensure equality of access to good quality health care. The Norwegian health care sector has undergone several important reforms during recent decades. Generally, national reforms that have had an impact on the health care system have focused on three broad areas: the responsibility for providing health care services, priorities and patients' rights and containment. The key strengths of the Norwegian health care system include provision of health care services for all based on need (regardless of personal income), local and regional accountability, public commitment and political interest in improving the health care system. [32]

Health policy of the United States of Ireland

The Irish health care system is unusual within Europe in not providing universal, equitable access to either primary or acute hospital care. [33]There are two main categories of entitlement to public health services. Those in Category I (medical card holders) are entitled to free public health services but pay a copayment for prescription items,[34] and those in Category II are entitled to subsidized public hospital services and prescription medicines, but pay the full cost of general practitioner (GP) and other primary care services. Eligibility for a medical/GP visit card is assessed primarily on the basis of an income means test, with the threshold for GP visit cards about 50% higher than for the medical card. However, in the summer of 2015, a GP visit card was extended to all children under the age of six, as well as to people aged 70 and over. In 2016, 36% of the population had a medical card and 10% had a GP visit card. [35]

Approximately 43% of the population (mainly higher income groups) are covered by private health insurance (PHI), [36] which is mainly used to access private hospital care, supplied in both public and private hospitals. There is a growing body of evidence that some people are experiencing difficulties in accessing health care due to cost, [37, 38] and long waits for public hospital care (in particular for those without private insurance) are a barrier to accessing timely hospital-based services.

This inequitable and complex mixed public–private system has persisted in Ireland despite much criticism and repeated reform attempts over the past 100 years. However, there is increasing interest in and desire for a fundamental reform of the Irish health care system, including the introduction of universal health care. Though there is some ambiguity about the meaning of universal health care within Ireland and beyond, one commonly used definition relates universal health care to a health system in which patients are treated based on need rather than ability to pay. [39]

Health policy of the United States of America

In 2010, USA, Patient Protection and Affordable Care Acts were presented to provide an economical and quality health insurance as a combined liability of government, owners and individuals. Although there is non-government health care's organization, majority of health care facilities are provided through the department of Health and Human Services (HHS). HHS covers various organizations including the Centers for Medicare and Medicaid Services (CMS), Disease Control and Prevention center (CDC) that supervise research activities for the protection of public health, the National Institute of Health (NIH) that conduct research based on biomedical and health issues, the Health Resources and Services Administration (HRSA) that assist the accessibility of health care facilities to individuals who are not insured or medically unprotected individuals; Agency for Healthcare Research and Quality (AHRQ) [40] that assist and conduct research for improving the standards and safeness of health care services; Food and Drug Administration (FDA) that supervise the regulation of food, pharmaceutical drug products, vaccines, medical devices and various other products for the purpose of promoting public health. The Institute of Medicine (IOM) is a self-governing profitless organization that is not under the control of federal government, plays a role of consultant in policy making to refine the nation health Stakeholder associations and pronouncement of such policies which affect the health system. [41]

The Center for Medicare and Medicaid Innovation is founded by ACA; working on service delivery models for improving quality and reduced expenses also to minimize hospital acquired infections through collaboration with patients. AHRQ supported by federal government to involved in research activities, result outcomes, clinical effectiveness, clinical guidelines and strategies and Health Information Technology. PCORI is a Patient Centered Outcomes Research Institute that is created under the Affordable Care Act involved in clinical comparative effectiveness research activities and managing the resources for research regarding illness and injury. Such research findings are not permitted to be used for denying coverage. CMS has improved the quality by maximizing public reporting. Hospital Compare is an important initiative and refers to the service that analyzes the process of care, resultant outcomes and patient experiences for more than 4,000 hospital settings. These initiatives are taken to ensure the availability of Medicare data to "qualified entities" comprising of health organizations and health institutions so that they can record the performance, generating data on payment to physicians by Medicare and reporting the data of payments compensated by pharmaceutical companies to hospitals and physicians. Various pay-for-performance programs are implemented by Medicare along with other private insurance givers. [42]

People's Health cares are funded by private insurance companies as well as government. The National Health Care Disparities by AHRQ highlights the health care discrepancies at various levels and the areas requiring attention. Federally Qualified Health Centers (FQHCs) present various ways of public remuneration and presents a mean of providing basic and preventive care to the patients irrespective of their ability to pay. Initially it was a source of providing health care services to the desired population. FQHCs provide services to uninsured population. Medicaid and CHIP are involved in providing services to population with less income. The ACA provides subsidies on purchasing insurance to low income Americans thereby reducing discrepancies and improving health care facilities in undeserved population. [42]

The "patient-centered Medical Home" has been design to provide and target constant, collaborated and family oriented care to a patient from a personal physician, has emerged as a point of interest in US experts and policy-makers to improve health care services. Accountable Care Organizations (ACOs) serve as another mean among private and public payers. ACOs comprising of hospitals and physicians are playing an important role in providing health care services to the defined population according to quality standards thereby saving the amount spent on health care by the population. CMS supports various local programs that are focused on the provision of better health and social services.

Such programs include Massachusetts General Hospital Care Management Program where a nurse case manager collaborates with the patients having chronic illness and with patient's caregivers to improve the social and medical care. Medicaid ACOs are also playing role in primary as well as behavioral health. ACOs also discover financing models apart from providing clinical and social facilities. Despite of all these initiatives and efforts of many policy-makers several deficiencies in health care services are still there. The American Recovery and Reinvestment Act of 2009 have established financial incentives for hospitals as well as physicians leading to remarkable investment in HIT. HIT has established Regional Extension Centers for providing direction and enlightenment on best practices; by providing funding and thereby assistance in improving quality of health services and population health; and also providing guidance to research networks. One major and important initiative is development of electronic record system for setting standards as well as measure of the success. The Patient Protection and Affordable Act signed by president Obama in March 2010 served as another step towards health system reform. This reform has various aims including 1- Gain wide-spread coverage. 2- Improve the availability of coverage. 3- Reducing undesired cost thereby improving quality of services. 4- Enhance basic and primary care services. 5- Increasing investment in public health to achieve these targets. With all these initiatives and efforts of ACA from JulySeptember 2013 to April-June 2014 there are number of uninsured individuals by almost 9.5 million. Medicare ACOs also played a vital role in quality improvement and savings. [42]

Health policy of People's Republic of China

The Ministry of Health (MOH) is largely accountable within the Government for health matters. It has central committee that design health care system reform from the Communist Party and the State Council. Through these committees the government pledges to provide all health services by 2020. The State Council also issued the Implementation Plan for the Recent Priorities of Health Care System Reform (2009-2011). [5]

In 2011 the China Health delivery system announces their versatile health-care facilities which consist of government hospitals, public health care systems and other health amenities. The hospitals is the primary care system, is of two types; district hospital health centers and provincial city hospitals. The public health care system includes maternal and child health centers; bid inpatient medical care. [43]

China has a Health insurance system arrange in categories based on urban and rural; Urban Employee Basic Medical Insurance (UEBMI), Urban Residents Basic Medical Insurance (URBMI) and the New Rural Cooperative Medical System (NRCMS). However, refugees often do not have medical insurance in the place of work. An urban–rural medical assistance system has been conventionally built, which make available health facilities to those who are severely ill and have low income, disabled, senior citizens from lowincome families, and several other fractions with special difficulties. [44]

If all the policies are similar ? Then objective will be where India lacks? Is there any problem with the implementation of the health policy?

All of these policies are not similar; there is a big difference between India and USA Health policy and as well as some difference with other Developed countries health policy. Practically in India , the center of attention is delegation of responsibility, involvement of clinical pharmacy role within the government hospital and in public health policy, and the extension and expansion of hospital in some areas. [8 However much consideration shall be given to current research spearheaded by other developed countries pharmaceutical scientists in combating current public health issues in other to salvage the diabetes and other disease that are of public health emergency in India . [45] USA health policy is feasible for adoption into Indian health care delivery system. However it depends on the availability of resources like funding, health professionals and health facilities. Given the limitations of resources only the basic health care delivery strategies can be marginalized for adoption.

IV. RECOMMENDATIONS:

I. Strength and empower the role of Clinical pharmacist.

II. Proper implementation of National health policy and appropriate utilization of Government funds to be provided universally good health care to public

III. Improve the capacity of clinical pharmacist and effectively deploying human resource to grow the career of pharmacy professionals.

IV. Provide an incentive to staff and initiating measures that health care team; work collectively in delivering health services to public.

V. Introduce health insurance schemes as part of comprehensive health care delivery systems.

VI. Effective management and monitoring of healthcare system should be owned by bringing clinical pharmacy set up in hospitals to improve public health.
VII. Government should introduce Clinical settings and policies for research and development in medical sciences to further their knowledge, creation and growth.
VIII. Establish primary health care centers with cost effective strategies for increasing number of population to sustain long term positive impact on health status on the public.
IX. Availability of clinical pharmacists in hospitals with effective health care delivery strategies will sustain long term positive impact on health status on the public.
X. Government should give more priority to clinical pharmacists in health sector so that the clinical pharmacist have chance to deliver good health services.
XI. Government need to increase their health budget for the provision of quality health care services to the public.
XII. Government should create health awareness for the betterment of its citizenry.

V. CONCLUSION

Good health policy and delegation of responsible are necessary for advancement in health sector, and is responsible for the smooth functioning health organization including hospital, that is prerequisite for salvage public health emergency and to foster economic and social progression in a country. The health system in India need modernization when compare to other Developed countries . The government needs involve clinical pharmacist in public hospital to ascertain good curative for all patient irrespective of Gender, race, ethnic or region. The high prevalence of diabetes in India and it's environ have great chance to reduce if hospital clinical team involve clinical pharmacist in making drug decision, sensitization and counseling.Because India is one of the largest population in the world so it is not possible to Physician is available in every place to treat diabetes or other Disease .Clinical pharmacists play a vital role together with other medical health professionals including Physicians, Nurses and laboratory scientists. Importantly, a clinical pharmacist knows more about combination drugs therapy which is appropriate for some pathological disease, and can provide counseling to patients about medicines use and effect. It is necessary for the government of India to involve clinical pharmacist in hospital, encourage internship programs for doctor of pharmacy students.

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REFERENCES

[1]. Ma S, Sood N, "A Comparison of the Health Systems in China and India.," *Rand Corporation: CA, USA,*, 2008. .
[2]. Peters DH, Rao KS, Fryatt R. , "Lumping and splitting: the health policy agenda in India.," *Health Policy Plan* , vol. 18, no. (3), p. 249–26, 2003.
[3]. "MOHFW National Health Policy.," *New Delhi Ministry of Health and Family Welfare, Govt. of India,* 1983. .
[4]. Bhagavathula AS,Sarkar BR, Patel I., "Clinical pharmacy practice in developing countries: Focus on India and Pakistan.," *Archives of Pharmacy Practice* , vol. 5, no. 91, 2014.
[5]. Shaikh BT, Hatcher J., " Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers.," *Journal of Public Health* , vol. 27, pp. 49-54, 2005;.
[6]. Mathers CD, Loncar D., " Projections of global mortality and burden of disease from 2002 to 2030.," *PLoSMed,* vol. 3, no. e442., 2006;.
[7]. Fowler MJ, "Diabetes treatment. Part 2: Oral agents for glycemic management. ;," *Clinical Diabetes,* vol. 25:, pp. 131-4., 2007.
[8]. W. K., " A Perspective of One Important Risk Factor of Type 2 Diabetes in Hispanic and AsianMinorities.," *Global J of Immun and Aller Dis* , vol. 3:, pp. 1-5., 2015;.
[9]. U. N. G. S. I. D. F. . Simmons R, "Simmons R, Unwin N, Griffin S. International Diabetes Federation: An update of the evidenceconcerning the prevention of type 2 diabetes.," *Diabetes Res and Clin Pract* , vol. 87:, pp. 143-9., 2010;.
[10]. A. J., "The burden of diabetes in Pakistan: the national diabetes survey.," *J Pak Med Assoc,* vol. 49, pp. :205-6, 1999.
[11]. A. A. N. H. Stratton IM, " Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): Prospective observational study.," *BMJ* , vol. 321, pp. 405-12., 2000.

[12]. W. K., " A Perspective of One Important Risk Factor of Type 2 Diabetes in Hispanic and Asian Minorities.," *Global J of Immun and Aller Dis,* vol. 3, pp. 1-5. , 2015;.
[13]. U. N. G. S. Simmons R, "International Diabetes Federation: An update of the evidence concerning the prevention of type 2 diabetes.," *Diabetes Res and Clin Pract,* vol. 87, pp. 143-9, 2010.
[14]. A. J., " The burden of diabetes in Pakistan: the national diabetes survey.," *J Pak Med Assoc* , vol. 49:, pp. 205-6., 1999;.
[15]. Stratton IM, Adler AI, Neil HAW, "W. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): Prospective observational study.," *BMJ ;,* vol. 321, pp. 405-12, 2000.
[16]. W. J. N. H. Xue W, "Assessment of air quality improvement effect under the national total emissioncontrol program during the twelfth national five-year plan in China.," *Atmos Envi,* vol. 68, pp. 74-81., 2013;.
[17]. "Diabetes in Norway," *Norwegian Institute of,* 08.08.2017.
[18]. E.-L. S. Barry MJ, " Shared decision making-the pinnacle of patient-centered care.," *New Eng J of Med* , vol. 366, pp. 780-1, 2012.
[19]. "IDF SEA members INDIA," *International Diabetes Federation,* 03/03/2020.
[20]. Mitchell P, Wynia M, Golden R. , "Core principles and values of effective team-based health care. Washington,," *DC: Institute of Medicine,* 2012.
[21]. "Who Are A.," *What is Clinical Pharmacy. Pharmacotherapy,* no. 28, pp. :816-7, 2008;.
[22]. H. C. Yee GC, "Standards of practice for clinical pharmacists: the time has come.," *Pharmacotherapy,* vol. 34, pp. ;:769-70., 2014.
[23]. Cotter SM, Barber ND, McKee M, " Survey of clinical pharmacy services in United Kingdom National Health Service hospitals.," *Am J Health Syst Pharm* ., vol. 51, pp. 2676-84, 1994.
[24]. Hudson K, Taylor LA, Kozachik SL, Shaefer SJ, Wilson ML. , "Second Life simulation as a strategy to enhance decision- making in diabetes care: a case study.," *J of Clin Nurs,* vol. 24, pp. :797-804., 2015;.
[25]. G. T. Sonnett TE, " Impact of a clinical pharmacist regarding correction of insulin use beforepossible conversion from traditional insulin to U-500 regular insulin in a patient with uncontrolled type 2 diabetes.," *Clin Diabetes* ., vol. 31, pp. 171-4, 2013;.
[26]. H. K., "Unstandardized and defective evaluation practices in the examination system in pharmacy institutes of Pakistan.," *Am J Pharm Educ* , vol. ;74:, no. 16c, 2010.
[27]. H. A., " Pharmacoeconomics and outcomes research in Pakistan.," *ISPOR 2nd Asia-Pacific conference* , pp. 5-7, 2006:.
[28]. K. T., "Challenges to pharmacy and pharmacy practice in Pakistan.," *The Aus Med J,* vol. 4, p. 230, 2011.
[29]. Yang W, Lu J, Weng J., " Prevalence of diabetes among men and women in China.," *New Eng J of Med,* vol. 362, pp. 1090-101, 2010;.
[30]. D. M. V. K. SHARMA, "NATIONAL HEALTHPOLICY (1983, 2002, 2017)NATIONAL HEALTH PROGRAMME SWRK4021," *Dept. Of Social Work MGCU, Bihar.*
[31]. "NATIONAL HEALTH POLICY,," 2017.
[32]. J. R. Johnsen, "Health Systemsin In Transition," *Copenhagen,WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies,,* vol. 8 , no. No. 1, pp. 1817-6127 , 2006.
[33]. Wren MA, Connolly S., " A European late starter: lessons from the history of reform in Irish health care.," *Health Econ Policy Law,* no. doi:10.1017/S1744133117000275., p. 1–19, . 2017;.
[34]. N. Hudson E, " A. Public health care eligibility and the utilisation of GP services by older people in Ireland.," *J Econ Ageing.* , vol. 6:, no. doi:10.1016/j.jeoa.2014.08.005. , p. 24–43. , 2015;.
[35]. "Department of Health. Health in Ireland: ;," *key trends 2017. Dublin (Ireland): Department of Health,* 2017..
[36]. "Department of Health. Health in Ireland: key trends 2017.," *Dublin (Ireland): Department of Health;,* 2017..
[37]. O'Reilly D, O'Dowd T, Galway KJ, Murphy AW, O'Neill C, Shryane E, Steele K, Bury G, Gilliland A, Kelly A. , "Consultation charges in Ireland deter a large proportion of patients from seeing the GP: results of a cross-sectional survey.," *Eur J Gen Pract.,* vol. 1, 2007;.
[38]. Schneider S, Devitt C., " Accessing health care in times of economic growth and economic downturn: evidence from Ireland.," *J Eur Soc Policy.,* vol. 28, no. 4, p. 357–369, 2018.
[39]. "Council of the European Union. Council conclusions on common values and principles in EU health systems. Brussels (Belgium): .," *Council of the European Union;,* 2006.
[40]. Health UD, Services H. , "Agency for Healthcare Research and Quality (AHRQ)," *NationalHealthcare Disparities Report,* . 2014.

[41]. Rice T, Rosenau P, Unruh LY, Barnes AJ, Saltman RB, van Ginneken E, " United States of America: Health system review.," *Health Systems in Transition,* vol. 15, no. 1, p. 431, 2012;.
[42]. R. S., "The Patient Protection and Affordable Care Act: Implications for public health policy and practice.," *Public Health Reports,* vol. 126, pp. 130-5., 2011;.
[43]. Gong P, Liang S, Carlton EJ. , "Urbanisation and health in China.," *The Lancet,* vol. 379:, pp. 843-52, 2012;.
[44]. W. G., " Diabetes in China.".
[45]. "WHO. The world health report 2003: shaping the future.," *World Health Organization;,* 2003.

Mohb.Tousib, et. al. "A review article: Role of Clinical pharmacist to provide good health care services in India Compare with other developed Countries." *IOSR Journal of Pharmacy (IOSRPHR),* 10(9), 2020, pp. 01-10.