Episode 6: Exploring Tamil Nadu's Public Health Landscape: What is and what can be!

TRANSCRIPTION

Speakers:

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Shivangi Rai:

This is Status of States where we explore health and healthcare across India's diverse regions with a particular focus on policy, programs and ground realities. The Indian Constitution lists public health as the responsibility of states. Join us as we speak with health experts from different states, understanding the unique contexts, challenges and innovations shaping public health. I'm Shivangi Rai, your host for this episode of Status of States, brought to you by the Center for Health Equity Law and Policy, at the Indian Law Society in Pune. Let's dive right in.

In this episode, we explore the state of Tamil Nadu. We are pleased to have Dr. T. Sundararaman with us. Dr. Sundar is the former Dean of School of Health System Studies at the Tata Institute of Social Science. He was the Director at the State Health Resource Centre in Chhattisgarh (2002 to 2007) and was executive director of the National Health Systems Resource Centre (2007 to 2014). He has played an advisory role in formulating public health policies in several states, and had a major role in the design and implementation of the National Rural Health Mission, especially the Asha programme, the Mitanin programme and the Health Technology Assessment programme.

Dr. Sundar was the chairperson of the Technical Advisory Committee of the Health Technology Assessment Board for last 6 years, and is currently the Chairperson of the Advisory Committee for the Chief Minister's Comprehensive Health Insurance Scheme, Tamil Nadu.

Dr. Sundar, Tamil Nadu is often cited as one of the top performing states in public health and some social determinants as well. The indicators related to life expectancy and health as well as determinants of health such as literacy and education, clean drinking water and sanitation are better than the national average.

Can you tell us about the health and related indicators where Tamil Nadu has been performing well?

Dr. T. Sundararaman:

Tamil Nadu is indeed one of the best performers in the health sector, not only with reference to other states in India, but also with respect to most other low and middle income countries. It has been cited as an example of good health at low cost. The most well known achievement of Tamil Nadu is with respect to its performance in maternal and child health and in family planning. It has a crude birth rate of 13.8 and a total fertility rate of 1.4 as compared to all India figures of about 20 and 2.0 respectively. That is, it has achieved a shrinking population.

Earlier, its sex ratio was worrying, but by 2011, it had stabilized. Its maternal mortality rate is 54 per 1 lakh live births. That is in about 7.24 million population there is only about 575 deaths in the whole state. The state aspires to lower it further to a 100 deaths. And indeed, if any state can do it, Tamil Nadu can do it.

Tamil Nadu is known that if its administration sets its mind on an objective, both the general administration and public health administration being remarkably capable, would achieve this

goal. Infant mortality rate is 13 per 1000 live births. Less than half of India's 28 per 1000 live births . Quite remarkable. Under five mortality rate is 13 compared to all India figure of 32 per 1000 live births. And the rate of decline has been good or better for most of these indicators than the all India level.

That Tamil Nadu did so even without the favorable social determinants that mark Kerala's achievement is something that drew attention to the health sector's performance. But this is not to belittle the fact that some of the most common social determinants in Tamil Nadu, though much behind Kerala, are well ahead of the rest of India. Tamil Nadu has done much better on the important proximate social determinants of health, especially on those having immediate relevance to maternal and child health viz. nutrition, drinking water, sanitation, and female literacy.

Shivangi Rai:

The progress in many indicators and outcomes in health and some social determinants, is indeed remarkable as you put it Dr. Sundar. So what are the factors responsible for this good performance in public health and social determinants? In particular, how was Tamil Nadu able to reduce infant and maternal mortality rates? Please comment on factors, policy, programs, or practices that you think have contributed to this good performance and can be replicated in other states or at the national level.

Dr. T. Sundararaman:

I think for this performance I would attribute 3 major reasons. There are many, but I'm just picking up three. First and most important is that for the last few decades, Tamil Nadu has had a strong articulation of social justice. And this has led to a much greater emphasis and performance on social determinants related to nutrition, drinking water and sanitation, female literacy, and affirmative action to ensure access to maternal and child health services. Remember Tamil Nadu was one of the pioneers in the mid-day school meal program, and it had universalized this programme and the ICDS (Integrated Child Development Services) much before it became a part of the national agenda. It provides one of the highest levels of maternity support that any state does.

The second reason is there's a much stronger tradition of public health in the state, notably the existence of a Public Health Act dating back to 1939 and closely associated with it a Directorate of Public Health and a public health cadre. A combination of factors that very few other states have. This provides a professional capacity which few states have had in the first five or six decades, and you can see that it will deliver what it promises to deliver. And this leadership means it takes pride at the local and state levels in their performance.

And finally, there is a relatively good administrative capacity, both the general administrators and technical leadership. I would say with some confidence that if the administration leadership is convinced of a societal outcome, either due to its internal process or due to political leadership, then it will get there. By the same token, what it has not done is also the lack of conviction amongst the leadership of that goal. And seldom is it an implementation failure.

Shivangi Rai:

Clearly, there are some good strategies there, some of it definitely has been replicated at the national level where there are guidelines on public health. And definitely pointers for the states to also institute some of these strategies.

Dr. Sundar, though Tamil Nadu has performed very well on these health related indicators, there are many indicators where there is a growing challenge and Tamil Nadu is not doing so well. Could you talk about the main challenges faced?

Dr. T. Sundararaman:

The main challenge that Tamil Nadu faces is with respect to non-communicable disease. Over 60 % of all mortality is due to non communicable disease. And of this 60 % is below the age of 70. These deaths below the age of 70 which have been referred to as preventable or amenable mortality constitutes the major proportion of deaths. There is also a huge excess male mortality across all age groups below the age of 70. Contrast it with a high income country where only about 30 % of deaths would be below the age of 70, and you can see the difference.

The other major challenge is the high mortality due to injuries of which road traffic accidents account for the major part. About 14 % of mortality is due to this. In contrast to the very weak program on NCDs, the state has a very robust program on prevention and response to road traffic injuries, but that is not enough. Also, there are challenges due to self harm or suicides, assaults, drowning, gender based violence that are relatively less addressed.

There are new challenges in communicable diseases, especially outbreaks of acute respiratory disease and the old challenge of tuberculosis, which together with diarrheal outbreaks, viral hepatitis, and rising antimicrobial resistance makes communicable diseases still a major contributor to mortality. So I think these are the main areas where the state is challenged.

There is a set of unfinished tasks on reproductive and child health. There is a difference in the achievement between districts in the reduction of maternal and child mortality and the other are issues related to anemia, malnutrition, and access to postnatal care. But these unfinished tasks should not be used as an excuse to refuse to budge from thinking of primary healthcare as if it's only a maternity care system.

Let me explain why I say this. Let me give you some figures. In 2023, there were relatively about 6.9 lakh deaths by both global estimates and by the state governments' own death reporting system. Of these 6.9 lakh deaths, 3.87 lakh deaths were below the age of 70. That gives a high probability of preventable deaths, about 60%. This would compare to less than 30% in most high income countries. A rough estimate could be that of these 3.87 lakh deaths, more than half (or about 2 lakh deaths) could have been reduced by access to good quality, comprehensive primary healthcare. And of these 3.87 lakh deaths, only 11,000 deaths could be due to maternal and under 5 (age) deaths.

So while the system is seized with the challenge and has done remarkably well with respect

to addressing these 3 % of deaths, it has not done very well with respect to addressing 95 % of the causes of mortality and morbidity. And to my mind, the reason is that the political and administrative leadership are yet to come to grips with their need to do so.

The poor coverage of the entire disease profile is also reflected in the challenge of rising out of pocket expenditures and impoverishment due to healthcare expenditures. So despite a wide network of public services, a high degree of incomplete service delivery remains. I must also point out that public perception of the effectiveness of Tamil Nadu's public health system is in line with these figures. A recent CESP well done survey after the parliament elections showed that only 26 % of voters were satisfied with government health services as compared to an all India 39% and above 50 % in some of the states. And this correlated with voters who held the state government responsible for health services and also held health as an important electoral issue.

Clearly, the poorer perception of healthcare and health services in Tamil Nadu is related to better health awareness on part of the average Tamil Nadu voter. The proportion of voters who considered health an important electoral issue was more in this state as compared to the others surveyed. But that is only to be expected. Why I say this is to draw the attention of the leadership to this issue, and hope it is not too lulled into complacence by their rather good achievements in infant mortality and maternal mortality. They just have to move on.

Shivangi Rai:

To me this is surprising. After all, in Tamil Nadu almost 63% of the state's population choose public facilities when a household member is ill, which is higher compared to other states except for Kerala. Of course there are district level variations in this, but overall does not Tamil Nadu do much better? What are the issues with regard to access to primary care services?

Dr. T. Sundararaman:

Overall it is true that access to government health facilities is better in Tamil Nadu. But there is, as you have pointed out, a high inter-district variation ranging from, say, 42% in Kanyakumari to 82% in Nilgiris. But then it is also pro equity, which means that the poor are more likely to seek care at public facilities. 86% of households in the poorest wealth quintile typically seek care at government facilities compared to 27% of households in the richest wealth quintile- as per the NSSO health surveys. And rural households are more likely to use public service sector also. So all this is good.

In terms of progress and physical infrastructure and establishment of facilities, the gap in rural areas and primary care is minimal, but the gap in urban areas is huge. And we must remember that currently close to 50%, about 48%, to be precise, of the population now live in urban areas. Thus, in most rural areas, we would expect one primary healthcare (center) for 30,000 population and 6 subcenters under each 30,000 population, each of them catering to 5,000 population.

In urban areas in contrast, each primary health center caters to 50,000 population and there is a 34% shortfall in primary health centers, and there are no sub-centers. Instead we have health posts or dispensaries which have little primary care orientation. So most of the

primary care needs of the urban poor are met at medical college hospitals, which as a result are hugely overcrowded, making access to the poor a nightmare, while compromising quality of primary care as well as compromising the quality of secondary and tertiary care these larger public hospitals provide.

So Tamil Nadu in a sense recognizes this problem and its expansion of government medical college hospitals to one in every district depressurized these needs. But this is in no way sufficient or a substitute for expanding primary care services. That's what is reflected in much of the data, whether it be on mortality or public satisfaction. This hurts most in access to primary healthcare for non communicable disease and indeed for all non-RCH services.

Of the 3.87 lakh premature deaths, 2.4 lakhs, or about 63 % are males, and this is an excess of 1.16 lakh over the number of female deaths. Meaning that there are 1.16 lakh more male deaths than female deaths in the age group below 70 and most of this is affecting the working population, and among them largely younger working men. We know that the state has introduced a program of monetary payment, a subsistence grant of rupees 1000 per month to single women headed households and spending a few 10,000 crores on this payout, which is welcome. But a proportionate sum invested in primary healthcare would have reduced this requirement considerably, as the biggest reason for single women headed households is excessive premature male mortality.

In some age groups, the number of male deaths could be almost thrice the female deaths. Closely related to this is that Tamil Nadu is one of the poorest performers with regard to the transition of Sub-centres and PHCs to Health and Wellness centers. Not more than one-third of its targets have been reached. And in terms of functionality, it's even less. This Health and Wellness Centre scheme is for moving primary care from the earlier selective care focused on reproductive and child health to comprehensive healthcare where NCDs constitute a major part of service delivery. And Tamil Nadu unfortunately lags behind in this. Altogether, Tamil Nadu's primary care system, I'm afraid to say, is no longer quite fit for purpose.

Shivangi Rai:

Dr. Sundar you have very substantially made the point that Tamil Nadu needs to expand and strengthen urban primary care and galvanise its efforts to transition to comprehensive primary care which are essential for completing the unfinished agenda of reproductive and child health; to effectively address the persisting and resurgent communicable diseases; and to address the rising challenge of non-communicable diseases. With respect to closing the gaps in accessibility and availability of health services, what strides are schemes like Makkal Thedia Maruthuvam, which translates to medical care reaching the people making?

Dr. T. Sundararaman:

I would rather see "Makkalai Thedia Maruthuvam", as a sort of hesitant baby step, a token of awareness of the huge problem of NCDs. But by design, it is falling short of the effort required to achieve the necessary outcomes. This scheme reaches medication for two or three common non-communicable diseases, hypertension and diabetes to the subset of patients who require it and this has received no doubt a huge welcome given the big gap in this area. In some areas it also reaches some peritoneal dialysis fluids to homes- more on a pilot scale. But all this is falling far, far short of the required effort.

To understand the effort required, compare the current Tamil Nadu arrangement for these services with what is envisaged normally for the movement to comprehensive healthcare across the nation as the normative recommendation. The best performing subcenter in Tamil Nadu would be catering to a 5,000 population with 2 staff, 1 ANM (Auxiliary Nurse and Midwife) whose duties are relatively related to RCH (Reproductive and Child Health) and 1 woman health volunteer(WHV) with minimal training and support who is in charge of the NCD dissemination. But the norm for a sub center upgraded to a Health and Wellness Cent at trehe national level is to place 1 community health officer (that's a mid level healthcare provider) plus one or preferably two ANMs, 1 male worker and at least 5 ASHAs (Accredited Social Health Activist).

That means at the national level, you have 8 frontline trained health workers for a population of 5000 as compared to Tamil Nadu's 2. Tamil Nadu refused the ASHA program, taking on the high moral ground that they would opt only for regular workers. Now, the woman health volunteer(WHV) they have brought in is a contractual worker who is overloaded and under-trained and under-remunerated as compared to the ASHA and in the process Tamil Nadu no longer gets the ASHA remuneration under NHM either. Further, Tamil Nadu increases its contractual workers across the board and goes slow on its regular frontline appointments.

I am hesitant to say this, but I think Tamil Nadu's reluctance to invest in the primary healthcare workforce is leading to a shameful setback for a state that was once the leader in primary healthcare. No longer is Tamil Nadu punching about its weight with respect to its GDP as it was doing later. Its performance is now, sort of par with the GDP and is in danger of falling behind.

People's perception on this gap has been more acute than that of the administration. The paradox is that Tamil Nadu was among the first to pilot the Community Health Officer and the Health and Wellness movement. And the feedback from prompt evaluations,which the Tamil Nadu government itself had ordered, showed a remarkable improvement in the functioning of sub centres with this transition. But due to reluctance at senior administrative levels to sanction the increased staff, and the cutbacks on commitments to health and wellness center upgradation, a really unacceptable retreat occurred. An expert committee on health policy, headed by Dr Amalorpavanathan, did call for such an expansion of the primary healthcare workforce, but it's been on the shelf along with other expert reports.

All of this means that most primary care services, people are having to go to the private sector with high out of pocket expenditures, and they come to the public sector only when their simple community-level-manageable problems of hypertension and diabetes have escalated into near-fatal coronary heart disease, strokes, renal failure, or when chronic obstructive pulmonary disease has led on to respiratory failure. So this is really a challenge and why I said the primary care system is becoming unfit-for-purpose or, to put it more positively, needs to be made fit for purpose.

Shivangi Rai:

It is indeed paradoxical and disappointing, that having pioneered the initiative of community health officers and having the evidence of its effectiveness on the ground, Tamil Nadu is choosing not to put in place the necessary and expanded workforce for primary care.

Extending the concern about human resource issues to secondary care, as per the latest Rural Health Statistics Report, which came out this year with the title of "Health Dynamics in India- Infrastructure and Human Resources", several states including Tamil Nadu have up to 80% shortfall in specialists at the Community Health Centre level.

Why do you think this problem is persisting and what measures is Tamil Nadu taking to fill this gap? What do you think of the initiative of the Diplomate of National Board (DNB) course in District Hospitals under the National Health Mission as a means to rectify the shortfall?

Dr. T. Sundararaman:

Tamil Nadu has done remarkably well in expanding its infrastructure for secondary healthcare. It has done very well in expanding the availability of specialists and specialist-provided services in the public sector, both in the district hospital and in the district medical college. One part of the strategy is to opt for a medical college in every district. I am not fully convinced that Tamil Nadu needs to be producing so many doctors. But I'm very sure that the government has correctly perceived and responded to the increased requirement for access to entire range of secondary and tertiary care services within a district. Only quaternary care, and I'm aware this is a new term coming into vogue, needs to go to state level "centers of excellence".

Meanwhile, Tamil Nadu has also strengthened its district hospitals, upgrading taluka hospitals to district hospitals where district hospitals have become medical colleges, as well as upgradation of most Taluka hospitals.

It could do better within CHCs(Community Health Centers), but given Tamil Nadu's huge improvements in road connectivity and modest improvements in patient transport systems, we could overlook this and not bother too much about the national document comment on CHCs in this regard.

In closing the specialist gaps, Tamil Nadu has been richly rewarded for its policy of reservation of 50% of seats in government medical colleges for in-service doctors, along with compulsory postgraduate bonding and other incentives to retain them in public service. This entire arrangement has been threatened by recent moves of the central government, especially by the National Medical Commission's enforcement of NEET exams and the NExT exams for entry into medical and postgraduate education. Despite this move, at this point of time, thanks to the legacy, they are doing very well and I think very few other states would have this level of better performance in terms of specialist care.

Tamil Nadu has also pioneered the introduction of DNB programs and family medicine diploma for programs to better provide skills for medical officers at the CHC and PHC (Primary Health Center) level also. They could take this up to scale with a greater commitment, but on the whole, this has not been a constraint. The leadership is quite seized of this need and addressing it.

There are however, persistent gaps in nursing and support staff and even in general duty medical officers in the secondary and tertiary care hospitals, and a large number of vacancies. Once again, the Tamil Nadu government's proverbial reluctance to have adequate number of public employees comes in the way. To some extent that directorates

are seized of this, and so are unions, and there are efforts to address this issue. Which is unlike the crisis in the workforce for primary healthcare, where the problem does not even have enough acknowledgement.

Tamil Nadu also has long back successfully addressed the problem of logistics and supply chain management to ensure uninterrupted consumables and supplies to the public hospitals. In addition, it now has the CMCHIS, the Chief Minister's Comprehensive Health Insurance Scheme which kicks in to close consumable supply gaps by providing the medical college hospitals with enough flexible funds for upgrading to higher, more technologically demanding care. So, though there are major gaps in both financing and human resources, in terms of design, I think the secondary and tertiary care in public sector is much more fit for purpose than the harsh comments I had to make about primary care

Shivangi Rai:

It is good to know that efforts are being made to fill the gap in human resource and we hope that measures, such as reservation in postgraduate courses for doctors who have served in rural areas and emphasis on DNB and family medicine courses, will go a long way in augmenting human resources for public health services.

Dr. Sundar, you mentioned that Tamil nadu has improved its logistics and supply management for drugs and consumables. What are the mainstays of the procurement and distribution policy and should it be replicated in other states?

Dr. T. Sundararaman:

This policy actually came into being in around the mid 1990s and it's a global model. By the turn of the century, the state also had the Transparency Act. The policy came much before the legal support. What the policy does is make entire procurement completely transparent and completely responsive to needs without having any space for political or vested interest intervention at any level. Also built a very, very robust system of quality assurance, wherein the labs that test for quality insurance are already tendered and inspected, and the samples of every batch of medicines supplied is sent for testing, and only with their approvals payment is made. So it's a whole set of processes that have been put in place and a separate institution that functions with an extraordinary degree of efficiency.The cost of administration of this system is less than 2% of the cost of the supplies that are provided.

The mainstays of the procurement policy, can it be replicated? Well, it has been replicated in a few states: Rajasthan, Kerala, Meghalaya more recently, but not in other states. Many states have created corporations similar to Tamil Nadu but not ensured that the good practices in terms of essential protocols are followed. And the reasons are not good. This is mainly because the largest vested interest lies in procurement. The TNMSC is not quite geared to some of the newer challenges, like supplies to the health and wellness centres, or procurement and quality assurance in some of the more recent technologies, but having said that, I think this is really one of Tamil Nadu's strengths and these gaps can be addressed. I have less concerns regarding its procurement and supply system.

Shivangi Rai:

Access to medicines in the public sector, affordability, and out of pocket expenditure are significantly affected by the efficiency of the drug procurement and distribution systems and we hope that more states can strengthen their procurement systems and allied policies like Tamil Nadu has done.

Moving to the issue of government funded health insurance programmes, what do you think is the role and limitations of insurance programmes in achieving health for all – whether it be the Tamil Nadu Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) or the Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana?

Dr. T. Sundararaman:

So both these schemes are integrated in Tamil Nadu. The CMCHIS or the Chief Minister's Comprehensive Health Insurance Scheme is a state sponsored health insurance scheme targeting families with an annual household lower than 72,000. And providing cashless coverage for an explicitly defined package of diagnostic services and secondary and tertiary care services to a maximum of about five lakh rupees. The scheme covers about 62% of the population. That's a very good coverage. And per year it pays for some 6.9 lakh therapeutic procedures and 2.19 lakh diagnostic procedures with 50% or more of the number of claims going to the public sector and a slightly higher amount in value of claims going to the private sector. But about the same, equal divide between public and private sectors. Which, compared to other states, is quite an achievement.

CMCHIS does have an architecture to provide financial protection. However it is limited by a number of challenges. First is that obtaining a card remains a challenge. And that this problem affects the poorest quintile more is a feature that the scheme is seized with.

Second, which the scheme is less able to do something about is budgetary constraints, which seriously limit the scheme. The premium per family that the government is paying for is Rs. 842 per family which is minuscule compared to what most states are paying - the latter is at about Rs 2000 to 3000 per family in each state, and it's about Rs 10,000 per family per year in private health insurance. So therefore, a whole lot of the services fall outside the range of coverage for one reason or the other. And at some times the insurance company that has under-bid, to keep the claims within budgets becomes unduly tight on what it sanctions and therefore there's a lot of rejection on procedural grounds. This leads to a lot of dissatisfaction.

Third, only some of the services are open to the private sector and relatively few private hospitals are empaneled. All public hospitals are always empaneled. Therefore locating a provider is a huge challenge for not all public hospitals provide all health services that are needed, and it is difficult to locate the private hospital that has the desired service.

And fourth, government medical colleges may deny treatment without a card. Officially this is not at all permissible and they know it. But remember that since all these public hospitals are overcrowded, there is always some sort of arbitrary rationing that is inevitable and absence of a card becomes a disadvantage to the access for those without a card and to the provider.

And finally, the big problem is that when it comes to the private hospital, enforcing cashlessness or even a reduction beyond the nominal discount has been next to impossible

and therefore catastrophic health expenditure remains at pre-insurance levels. So efficiency of financial protection in the private sector is very poor. In the public sector, financial protection is good, but in the public sector, it's a top-up financing.

However, on the positive side, this scheme has helped build up mechanisms for engaging with the private sector and with better gatekeeping and monitoring, it could play an invaluable role in universalizing access to secondary care. It could also be a form of ensuring adequate requirement-responsive funding for public hospitals. And therefore in the movement towards universal healthcare and the right to healthcare this scheme is an invaluable step forward. Though, it's very much a work-in-progress.

Shivangi Rai:

It is notable that presently the number of cases being referred to the public and private empanelled hospitals, at the secondary care level under the health insurance scheme is almost equal. It is different from some other states where most of the cases are being referred to the private empanelled hospitals. The concern with that being that public money is being funnelled into private sector service provision, resulting in the weakening of the public health system in the long run.

Dr. Sundar, the NITI Aayog had issued a concession document in 2018, advising states to lease out District Hospitals to large corporate hospitals to manage them and provide health services. Is Tamil Nadu implementing it? What do you think of this policy direction taken by NITI Aayog? How is it going to impact access to affordable health services for the people?

Dr. T. Sundararaman:

Fortunately, Tamil Nadu has not taken that route. Much to Tamil Nadu's credit, its officers have a pride in running its public health hospitals well, and its directorates have the competence to do a good job, and they do a good job. Except to some extent at the CHC level, there is no underutilization of capacity, rather excessive utilization. In fact, I don't think such outsourcing is a solution anywhere, though in Tamil Nadu they are not even looking at it.

Even in other states, there is no pressure from the public or even from the state government to outsource its district hospitals. This leasing out is done more to bail out private medical colleges who charge huge fees but are unable to secure a patient load to teach their candidates and district hospitals provide access to the poor and sick, for teaching purposes. It's a very cynical way of doing it, but that's been so for a long time. This pressure to lend the district hospitals to the teaching requirements of private medical colleges which charge exorbitant fees is present even in Tamil Nadu. But it is the CMCHIS that assists the private medical colleges in being able to use their marginal capacity. Their marginal capacity may be as much as 60 to 80% of beds. So at least this is not one of the problems that Tamil Nadu is faced with or a direction that it seems to be taking. But that risk is always there.

Shivangi Rai:

Thank you for your response Dr. Sundar. Moving to the area of communitisaiton in health, How strong is community participation in health services in Tamil Nadu? What has been the

role of Village Health, Sanitation and Nutrition Committees, Panchayati Raj institutions and Civil Society in health planning, implementation and monitoring?

Dr. T. Sundararaman:

Well, unfortunately, Tamil Nadu is not a leader in community participation at any level. As I said, it's a state with a great confidence and competence in its administrative abilities. And it traditionally has not given much space to community participation. Yet, this role is extremely important if we are to address challenges or inequity, and we have to recognize and acknowledge that there are challenges of health inequity in Tamil Nadu.

So, the good news is that there has been a change in recent years, and in the last 3 to 5 years, the state government has actively taken up the organization of health assemblies at the state level, at the district level, and in some of the blocks. In this, it has been inspired by the model from Thailand, and it has been inspired by earlier experiences in community based monitoring. And it's been doing well. There has been a very good response. A whole lot of gaps pertaining largely to infrastructure has been flagged in these meetings. And quite surprisingly, even junior government health employees are some of the most active participants in these assemblies, using the occasion to point out gaps in their facilities which need to be covered.

Tamil Nadu's achievements in village health and sanitation and nutrition committees, I would rather not talk about. Its panchayats have been involved in the district health assemblies very well, but have a more limited role to play in public health management. Role of civil society is also very limited. There are very good non-profit hospitals, but except for a few hospitals, even survival within the CMCHIS scheme for these hospitals has been very difficult. I think a lot more can be done in this area of engagement of civil society in the transition to addressing non communicable diseases and comprehensive primary care, through fostering grassroots awareness and accountability. That need not always take a contestational form, it could be a complimentary form, for example, preventing irrational consumption of medicines. In a public system where the market is not guiding consumption and supply, you need both community based systems and other non-market based interventions to ensure that service delivery is responsive to real needs. So I think, there is a much greater role to be played by civil society and community engagement. But the good news is it has made a start. I hope it continues. Such community based interventions have come through with great difficulty, and they may not sustain unless there is some championing of the initiatives that have been working well.

Shivangi Rai:

I note that Tamil Nadu is the first state in India to adopt a participatory health governance model through an approach of organising Health Assemblies at the Village, Block, District and finally culminating at the State level. It is, however, a new initiative but we hope that it will be effective in strengthening community and civil society voices in health planning and improvement.

Dr. Sundar, are there other best practices in Tamil Nadu, beyond its success in reproductive and child health that you would like to highlight?

Dr. T. Sundararaman:

Well, there is one, which I think it's a bit early to comment on the eventual outcome, but I'm reasonably sure it will lead to a big change. I think it's something that countries could follow. I'm particularly impressed with what is called the *Innuyir Kappom-Nammai Kakkum 48 scheme*. That's a tongue twister for anybody who is not Tamil. Basically it means, "Life saving 48 hour scheme." This is referring to the scheme on road safety and response to road traffic injury.

So we stated earlier that in terms of mortality, road traffic injury is the second or third highest cause of mortality. The leading cause of mortality is cardiovascular diseases, and then you have either communicable diseases or road traffic accidents. Of course, if you were to consider morbidity rather than mortality, road traffic accidents will fall to the much lower rank, as the proportion of morbidity is less. A large proportion of reported incidents are fatal.

This scheme has gone about it very scientifically. It started with a dynamic identification of hot spots because accidents, injuries are concentrated around some sites. It has led to a dynamic allocation of ambulances so that they are more dense, where the hot spots are more dense. There is a mapping of ambulances to both hot spots and emergency care providers leading to very effective district level plans. There is a scheme for pre-arrival, intimation of the emergency care provider that a sick patient, injured patient is on its way. There is a development of a network of 692 emergency response hospitals. Of these, 237 are in public hospitals and 455 are private providers with assured reimbursement of expenses of care on agreed-to terms under an MOU. These hospitals are categorized into level 1 to level 3 of emergency response management, paid accordingly and referred patients accordingly. There are few complaints.

In many states emergency ambulance systems are providing universal coverage, but most do not have such an emergency response hospital system in place. This system is expected to have saved close to 1.86 lakh lives since it's been put in place. It costs about Rs163 crores, well spent, I would say.

Along with this response system, the state government is working on a task force on road safety. It turns out there are 14 to 15 different department authorities who have to coordinate to reduce the accidents at these hot-spots. And there is a need for better road safety laws, policies and implementation.

Of course, given Tamil Nadu's geometric expansion in the number of vehicles on the road and in its coverage by roadways, whether it will still lead to a net reduction in mortality rates in the immediate period is open to question. But it is, no doubt, quite well planned. And over time its results would be visible. A very scientific planning, where in a systematic way they have mapped out the problem and allocated resources rationally, and addressed the problem holistically. I think this is not only a very good example for road safety, but even in how public health needs to be practiced.

Shivangi Rai:

As we discuss the successes, challenges and unique initiatives in health that Tamil Nadu is undertaking, I would like to also discuss the issue of the health budget. Similar to national

trends, government health spending in Tamil Nadu has been quite low, representing only 1 % of the state's GDP. Although it is remarkable that Tamil Nadu has consistently produced better health outcomes with the same average per capita expenditure on health as India, and probably a little lower than India. But do you think it's time for the government to increase its health budget?

Dr. T. Sundararaman:

Certainly, I think the state can afford to double its expenditure on healthcare and further invest this largely in public health facilities And within that in human resources, where it currently has the greatest reluctance. Unless you have more feet on the ground, you're not going to get more services with just spending on consumables. So it does require a much greater investment.

Tamil Nadu can do so. It has the fiscal space to do so. Its GDP per capita is one of the highest among states. In parallel it can also improve the efficiency of what it spends. One way of doing so is to merge the risk pools of government expenditure on health insurance from the state government and with the ESI and the government servants insurance programs. So that they complement and do not overlap or duplicate or substitute each other. This makes available a larger poor of providers and resources.

But I also think there are some more efficiencies to be gained in the way in which care-seeking is streamlined so that people are able to save their time and effort and their money in shopping for the right provider. These are savings on the societal side, on what people spend out of pocket.

The state government has an ambition to be a 5 trillion economy. But the purpose of such economic growth should be improved health and healthcare. Why else would you want to be wealthy, if you're not interested in making use of that for being more healthy. And as healthier people lead to increasing productivity, the health of people must be seen as an important type of investment. Much as we are willing to make investment in roadways and highways and power plants, which all take over 20 years to break even. Healthcare investments could break even much earlier. So I think the challenge is for governance to recognize the economic value of investing in human resources for health. Further it should be seen as one of the most pro equity and high return forms of any public expenditure that is possible. There is a big way to go for Tamil Nadu to achieve adequate levels of public health financing. But Tamil Nadu can do so.

I would add one more point. You know, when I was in Thailand and I was asking them what had motivated them. In the 1990s they had been motivated by Tamil Nadu's example. In 2002, they went further and passed the equivalent of a Right to Healthcare Act (called the National Health Security Act) and since then they have gone far ahead, such that now their figures are comparable to the best in the high income countries, whereas Tamil Nadu is just happy with being the best among the states of India. The reason the Thais have gone ahead while once they were on par with Tamil Nadu is really because they had the right to healthcare laws in place and because they were willing to step up their public health expenditure in a way that Tamil Nadu has not been able to do.

Shivangi Rai:

You mentioned that the National Health Security Act, and allied laws and policies helped Thailand advance and progress to universal health care. It is a nice segue to the last question I want to put to you. What is the situation with regard to any movement towards a right to health law in Tamil Nadu? Can we expect Tamil Nadu to set a leadership role in this regard?

Dr. T. Sundararaman:

I wish so. I wish the leadership recognizes that they are at a level of economic development, which is more than what Thailand was when it adopted the Right to Healthcare Act. I think Tamil Nadu has the entire architecture, and the technological competence, and the capacity it needs to bring about the right to health and healthcare.

It's there in every way. It has the finances. It has the technical competence. It has the experience to do so. Further, the right to healthcare is a subset of the right to health and the latter includes the right to a set of underlying determinants of health. Tamil Nadu has the one of oldest Acts in this regard. The Public Health Act of Tamil Nadu in 1939 is a very live act, being modified and amended as required to keep it relevant. This law places a considerable burden of accountability on local bodies for many of the proximate determinants of health, and has been in fact a model for other states also. It has had 13 amendments after its first promulgation in 1939. It's more urban oriented, which is not a problem, but we need to have better implementation in rural areas. But being a colonial era act, even in urban areas it is much more about making the citizen accountable to the state, rather than the state accountable to the citizen. So some more tweaks are required.

A second strength is that Tamil Nadu enacted a Clinical Establishment Act way back in 1997 and after a huge delay passed the rules in 2018. Now, this is a very sad story as the Act is very poorly implemented. However a space has been created to address the issues of regulation in the private sector. So when we propose a Right to Healthcare Act, I would not recommend bringing private sector regulation into it because there's a separate Act in place which should be amended and strengthened and that will take care of it. That discussion need not confuse the discussion for the Right to Healthcare Act.

But a Right to Healthcare Act is absolutely necessary. It is necessary since there has to be a way in which people know where their entitlement to healthcare lies and for the state to assure such access. Access as entitlement is assured through registration with a primary public care provider and this not only assures primary care at that level, but the entire range of essential healthcare services that are required at every level through appropriate support and facilitation. The primary care provider should be understood not as a gatekeeper but more like a facilitator, more like a guarantor, to ensure that the entire range of secondary and tertiary care can actually be also obtained *with* financial protection. And everybody is considered to have pre-paid for this healthcare as the “premium” is inherently paid as part of taxes in tax based financing. A lot of the taxes are indirect taxes and the poor also pay this. So I think that basically a law is a necessity for people to understand and access their entitlements and for the state to guarantee it. And that brings a lot of energy and efficiency and value for money.

What does it mean in practical terms? If I go to a public hospital and the public hospital does not have the capacity because it's overcrowded. Then it becomes incumbent on the hospital

to ensure that I am referred to another hospital where the necessary services are available. Be it the public sector or a contracted-in private hospital. A hospital just cannot say to a care seeker that “my time for the day is up, or my beds are fully occupied and you have to go elsewhere…” This system of informal rationing that prevails must cease. And further hopefully a law will ensure that this public hospitals are paid on base of “charged expenses” not budget allocations. In other words the government as single payer reimburses providers for the care they provide, while ensuring efficiency and rational consumption. This is possible only if most of the care sought under the act is provided through the public network and or contracted-in private sector that supplements it. The state is in a good situation to be able to do this, and we saw this in action during the Covid Pandemic.

Is the current leadership motivated to do so? Yes. I think this government is more seized with this proposal and better seized with it than any other government.It should learn from the Rajasthan and Assam Acts and not rush into something that will just provoke the private sector and be non-implemented. It should also learn from the Thai example as to how this can lead to a better efficiency in public expenditure. Like I keep saying about the Tamil Nadu government… they may hesitate, they may not be convinced as of now; but if they are convinced, I really believe this government leadership can actually deliver it on the ground. That is the unique strength of Tamil Nadu. It takes hell of a lot of time to convince these guys to take that risk. And that's in part the limitation of the fact that the interest in a legal right to healthcare act in Tamil Nadu is still largely-administrator driven and not fully politically driven. Because then there is an inherent tendency in the bureaucracy not to take that leap of faith, not to take that risk. But if political leadership can push them into doing so, I think the Tamil Nadu government will develop a universal health care system that can deliver the right to health and health care as good as the Thais or even better.

Tamil Nadu can do it. It's about high time it did it.

Shivangi Rai:

With that, we thank you Dr Sundar, for your valuable time. There is indeed lots to learn from the laws, policies and practices in Tamil Nadu as well as from your vast experience, expertise and insights on public health.

Thanks for joining us for this episode of Status of States. Stay tuned for more such conversations. This is your host, Shivangi Rai, signing off.