ABSTRACT

India’s per capita spending on health is an abysmal $32 or about Rs. 1800 per annum which is among the lowest in the world. The 12th Five Year Plan has proposed an outlay of Rs. 28,560 crore or $6 billion for healthcare. Every state in India has its story of transformation of the public healthcare system, but Tamil Nadu leads the way in providing universal health coverage by setting up an effective drugs procurement and distribution mechanism since 1994. Its Information Technology (IT) enabled supply chain management system ensures delivery to needy patients, transparency to prevent misuse and stringent quality control to eliminate spurious drugs. The Tamil Nadu model shows that e-health care structured around a robust I.T. infrastructure is the key to a successful public health governance system.

Tamil Nadu leads the way with National Rural Health Mission (NRHM: The national flagship programme in the Health Sector) funds being put to very good use to ensure that the Primary Health Centres (PHC’s) work round the clock. The turnaround is seen in the steady decline of Maternal Mortality Ratio (MMR) and Infant Mortality Ratio (IMR) in the state. Since primary health is a subject transferred to Panchayats by the constitution, the NRHM’s framework for implementation provided a very active role for the Panchayats in Tamil Nadu. The original Good Health at Low Cost (GHLC) report way back in 1985 had shown that a combination of political commitment to health, strong societal values of equity, political participation and community involvement, high investments in primary health care and
education combined with inter-sectoral linkages can have remarkable effects on health in low income settings. It will be wise for the Central Government to use the Tamil Nadu model as the blue-print for a National Healthcare policy.

Key Words: Leadership, Health, Tamil Nadu Model, Universal Health Care, Good Health at Low Cost

Introduction

Among peers in the developing world and neighbours in South Asia, India is among the worst performers when it comes to the coverage and outcomes of its public health system. Whether it is life expectancy, maternal or infant mortality, on most counts, India ranks way below China, Brazil and Sri Lanka, just below Bangladesh and Nepal and in some cases even Pakistan (Global Burden of Diseases, Injuries and Risk Factors 2010 Study, Washington). Since independence, India has created a vast health infrastructure and personnel for primary, secondary and tertiary care in the public, voluntary and private sectors. Health spending in the country is estimated to be around 6% of GDP. However India’s per capita public spending on health is an abysmal $32 or about 1800 per annum. Within the country, extreme disparities exist both in terms of health care as well as health outcomes.¹ Kerala’s life expectancy at birth is about ten years more than that of Madhya Pradesh and Assam. Infant mortality ratio in Orissa is about five times that of Kerala. The maternal mortality rate in Uttar Pradesh is more than four times that of Tamil Nadu. Crude death rates in Jharkhand and Chhatisgarh are about twice the crude death rates of Delhi and Nagaland. India is in the throes of an epidemiological and demographic transition with an increasing burden of chronic diseases and decline in mortality and fertility rates. There is lack of synergy among key factors affecting health, and the system has been unable to mobilize action in areas of safe water, sanitation, hygiene and nutrition – the social determinants of health.² The Public health care system is in shambles especially in rural areas and there are extreme variations in access and outcomes within and between states in India.
Table 1: International comparison of government expenditure on health (2000-2007)

<table>
<thead>
<tr>
<th></th>
<th>General govt. expenditure on health as % of GDP*</th>
<th>General govt. expenditure on health as % of total expenditure on health</th>
<th>Per capita govt. expenditure on health (PPP in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>1.0</td>
<td>1.1</td>
<td>38.0</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.9</td>
<td>3.5</td>
<td>40.0</td>
</tr>
<tr>
<td>Chile</td>
<td>3.4</td>
<td>3.6</td>
<td>52.1</td>
</tr>
<tr>
<td>China</td>
<td>1.8</td>
<td>1.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Colombia</td>
<td>5.5</td>
<td>5.1</td>
<td>80.9</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>5.0</td>
<td>5.9</td>
<td>76.8</td>
</tr>
<tr>
<td>Cuba</td>
<td>6.1</td>
<td>9.9</td>
<td>90.9</td>
</tr>
<tr>
<td><strong>India</strong></td>
<td><strong>1.1</strong></td>
<td><strong>1.1</strong></td>
<td><strong>24.5</strong></td>
</tr>
<tr>
<td>Malaysia</td>
<td>1.7</td>
<td>2.0</td>
<td>52.4</td>
</tr>
<tr>
<td>Nepal</td>
<td>1.3</td>
<td>2.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Pakistan</td>
<td>0.6</td>
<td>0.8</td>
<td>21.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>3.4</td>
<td>3.6</td>
<td>40.5</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1.8</td>
<td>2.0</td>
<td>47.9</td>
</tr>
<tr>
<td>Thailand</td>
<td>1.9</td>
<td>2.7</td>
<td>56.1</td>
</tr>
<tr>
<td>South-East Asia Region</td>
<td>1.2</td>
<td>1.3</td>
<td>31.2</td>
</tr>
<tr>
<td>Low income</td>
<td>1.8</td>
<td>2.2</td>
<td>37.6</td>
</tr>
<tr>
<td>Lower middle income</td>
<td>1.6</td>
<td>1.8</td>
<td>37.0</td>
</tr>
</tbody>
</table>


India has in effect one of the most privatized health care systems in the world. Public expenditure on health has been equivalent to a mere 1.2% of GDP in 2010. That’s against a global average of 6.5%, an OECD average of 8.4%, a middle income countries level of 3.0% and 2.1% for low income countries as a whole. Even sub Saharan Africa with public health expenditure equivalent to 2.9% of GDP does considerably better than India (World Bank data 2010). Therefore, not only does India spend less on health care than most of the world, even what little is spent comes largely from private sources. The deteriorating public health scenario has come under policy attention since the launch of the National Rural Health Mission in 2005. While there is some degree of consensus on the fact that the current moribund public system cannot serve the health needs of our citizens in the 21st century, there is a major divergence in approach regarding the solutions offered. One school of thought would like to continue with the rapidly growing trend of privatization including the facilitation of the privatization processes of current public health institutions. Others argue
that there is a case for strengthening existing public health infrastructure, coverage and services for the average citizen.

The concern for improving the public health system in India has not been a result of domestic compulsions alone. In 2005, WHO member states adopted a resolution encouraging countries to develop health financing systems aimed at providing Universal Health Coverage (UHC). This was defined as securing access for all to appropriate, preventive, curative and rehabilitative services at an affordable cost. \textit{UHC entails strengthening health systems for better outreach, apt governance and management} including financial sufficiency and innovations in resource pooling and spending. Universal coverage provides an essential operational framework for actualizing the \textit{right to health} for citizens.

**Models of global health care**

There is a distinction between the terms ‘universal health system’ and ‘universal health coverage’. While universal health system advocates progressive socialization of health care and gradual undoing of commoditization of health care costs, universal coverage merely means that a financing system is developed to cover majority of people against heavy expenses but provisioning is done essentially through the market. There are three broad models of health financing observed globally: public assistance systems that serve the majority of a nation’s population via government facilities supported by general tax revenues, health insurance systems that rely on public and private third party mechanisms to cover the cost of free–for-service drugs; and national health service systems that cover the entire population by means of salaried health care providers working in public agencies. In the first, the government sets up and runs its own health system, in the second, the services are provided by the private sector or the government or both; while in the third, the government purchases the services and provides insurance to the citizens.

Globally, around 100 countries have health financing systems which are predominantly government tax financed, 60 odd countries have a system of mandatory health insurance financed by pay roll tax. Only a few countries have financing systems which are predominantly private insurance based. Practically all countries have a combination of all three. Developed countries depend heavily on either general taxation or mandated social health insurance contributions. In contrast, low-income countries depend far more on out-of-pocket spending. There are several important lessons that we can draw from the above three models which may help us identify the best suited model for our country. First, public sector led provisioning is a must, in order to curtail cost and ensure equity. This has been demonstrated in all kind of contexts from the most developed countries like UK, Sweden, middle income countries like Costa Rica and Chile or developing countries like Cuba, Sri Lanka, Thailand and Brazil e.g. For a lower-middle income country like Thailand, its 2001 policy of Universal Coverage of Health Insurance (UCS) was a bold political decision. After five years of implementation, defying apprehension by international agencies about its failure, the UCS has a record of success and sustainability and has evolved into a system with strong social involvement and political commitment.\textsuperscript{4}
There is hardly any evidence that a country has been successful in ensuring universal health coverage at a manageable cost in a private dominated health care system. In India, where health provisioning is largely dominated by private sector and with limited capacity and political and bureaucratic will to regulate private sector, a private provisioning led insurance scheme may have disastrous consequences.

The question about what kind of health insurance mechanism we should adopt has to be decided by a political consensus as in most democratic countries. The experiences of developing countries have shown that it is only through political mobilization that progressive health reforms have taken place. In India, where the corporate lobby is also strong, universal health rights will not be guaranteed to its citizens without strong political will, civil society activism and strong implementation mechanisms guaranteed by the government.

**Health Financing in India**

In India the largest source of financing health care is out of pocket or in the self-financing mode. Latest estimates based on National Accounts statistics indicate that private expenditure, on health care in India is about Rs. 275,000 crore and 98% of this is self-financed. Public expenditures amount to Rs. 60,000 crore additionally. Together this adds up to 5.7% of GDP with out-of-pocket expenses accounting for 78% of the share in total health expenditures or 4.3% of GDP. Further, this burden is largely self-financed by households, a very large proportion of this does not come from current incomes. A very large portion specially hospitalization expenses come from debt and sale of assets.\(^5\)

In countries where near universal access to health care is available, the major mechanism of financing is usually a single payer system like tax revenues, social or national insurance or some such combination administered by an autonomous health authority which is mandated by law and provided through a public-private mix organized under a regulated system. Canada, Sweden, UK, Germany, South Korea, Australia and Japan are few examples. Experiences from these countries indicate that the crucial factor in establishing equity in access to healthcare and health outcomes is the proportion of public spending in total health expenditures. Most of these countries have public expenditures averaging 80% of total health expenditures. Thus India, where public finance accounts for only 20% of total health expenditures has poor equity in access to health care and outcomes in comparison to China, Malaysia, South Korea and Sri Lanka where public finance accounts for more than half of total health expenditures. Thus if India has to improve health care outcomes and equity in access, then increasing public expenditures to at-least 3% of GDP is critical. The healthcare System needs to be organized into a regulated system that is accountable and pools together the various collective resources and manages autonomously the working of the system towards the goal of providing comprehensive healthcare to all. This will happen only if the entire health care system, public and private, is organized under a common umbrella through a single payer mechanism which operates in a decentralized way.
Table 2: India’s Health Expenditure (in %)

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>NHA 01-02</th>
<th>Share of GDP</th>
<th>NHA 04-05</th>
<th>Share of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public funds</td>
<td>20.3</td>
<td>0.94</td>
<td>19.67</td>
<td>0.84</td>
</tr>
<tr>
<td>Private</td>
<td>77.4</td>
<td>3.58</td>
<td>78.05</td>
<td>3.32</td>
</tr>
<tr>
<td>External</td>
<td>2.3</td>
<td>0.11</td>
<td>2.28</td>
<td>0.10</td>
</tr>
</tbody>
</table>

Source: National Health Accounts 2004-05, Ministry of Health and Family Welfare, Govt. of India

The journey towards UHC

India, has had on paper at-least, a universal health system since Independence. From the Bhore Committee of 1946 on, there have been a series of committees – Sokhey sub-committee (1948) Mudaliar Committee (1962) Chaddha Committee (1963), Kartar Singh Committee (1974), Srivastava Committee (1975), ICMR-ICSSR Joint Panel (1980) – which have focused on different aspects of the issue, and together resulted in the three tier system of health centres in the public sector for primary, secondary and tertiary care. These have been complemented by two enunciations of the National Health Policy (1983 and 2002) a National Population Policy (2000) the Report of the National Commission on Macroeconomics and Health (2005) and most recently the High Level Expert Group on Universal Health Coverage (HLEG 2011).

The Bhore Committee’s (1946) focus was on building a health infrastructure in the rural areas while enunciating the principle that nobody should be denied access to health services for his inability to pay. The Sokhey sub-committee of the National Planning Committee (1948) recommended one community health worker for every 1000 village population and reinforced the Bhore Committee’s recommendations. The five year plans and the Mudaliar Committee (1962) focused on building infrastructure and launching vertical disease control programmes. The Alma Ata Declaration in 1978 and the Indian Council of Medical Research/Indian Council of Social Science Research Joint Panel (1980) resulted in a National Health Policy that was approved by Parliament in 1983. The Alma Ata vision had comprehensive preventive and curative care as its ultimate goal. The 1990s saw tax and other incentives being given to private sector which led to an unregulated expansion of the private health sector. This period also saw a steady erosion of drug price control in line with the policy changes in government. The number of drugs on the controlled list fell from more than 300 at its peak in the 1970s to around 30 at present. The second National Health Policy in 2002 began by acknowledging that 13 of the 17 goals of the first one had remained unfulfilled. The new policy argued for raising government health spending to 2% of G.D.P.
chipping health goals more realistically to financial and administrative capacities and an enhanced role for the private sector.

Table 3: Financing National Rural Health Mission
(amount in Rs. Crore)

<table>
<thead>
<tr>
<th>Year</th>
<th>Central Government Resource Allocation</th>
<th>State Contribution</th>
<th>Total</th>
<th>Allocation</th>
<th>Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-2006</td>
<td>6500</td>
<td>--</td>
<td>6500</td>
<td>6731.16</td>
<td>5862.57</td>
</tr>
<tr>
<td>2006-2007</td>
<td>9500</td>
<td>--</td>
<td>9500</td>
<td>9065.00</td>
<td>7361.08</td>
</tr>
<tr>
<td>2007-2008</td>
<td>12350</td>
<td>2179</td>
<td>14529</td>
<td>11010.00</td>
<td>10189.03</td>
</tr>
<tr>
<td>2008-2009</td>
<td>17290</td>
<td>3051</td>
<td>20341</td>
<td>12050.00</td>
<td>11229.47</td>
</tr>
<tr>
<td>2009-2010</td>
<td>24206</td>
<td>4272</td>
<td>28478</td>
<td>14050.00</td>
<td>11631.39</td>
</tr>
<tr>
<td>2010-2011</td>
<td>33884</td>
<td>5980</td>
<td>39864</td>
<td>15440.00</td>
<td>11631.39</td>
</tr>
<tr>
<td>2011-2012</td>
<td>47439</td>
<td>8372</td>
<td>55811</td>
<td>16140.00</td>
<td></td>
</tr>
</tbody>
</table>

Source: www.mohfw.nic.in

With the establishment of the National Rural Health Mission (NRHM) in 2005, the focus shifted to the demand side, although supply side attempts to improve infrastructure, build the capacity of health personnel, create a cadre of accredited social health activists (ASHAs) and improve health management information systems (MIS) were also given attention. Cash transfers have been part of the country’s anti-poverty programmes for decades, but it is only with the JananiSuraksha Yojana (JSY) that they have been linked to health specific behavior for the first time. Two policy shifts are important to an understanding of our health policy – one, a very sharp reduction in the number of drugs on the controlled list, leading to significant increases in drug prices, and two, the introduction of user fees for the non BPL (Below Poverty Line) population in public hospitals.

India is called the world’s pharmacy because it exports quality medicines to about 200 countries. It is the third largest drug producing country in the world. Yet ironically about 65% of Indian citizens do not have access to essential medicines. Currently the per capita public expenditure on medicine\(^6\) in different states of India, range from Rs. 2 to Rs. 22 per annum.\(^7\)
Recommendations of HLEG

It is clear from the above discussion that any policy movement towards Universal Health Coverage (UHC) addresses the questions of access and affordability. This in turn means addressing in a central way the questions of financing, the respective roles of the public and the private sectors and of Public Private Partnerships, the cost and availability of drugs and diagnostics, and of health promotion and prevention of illness. It also requires meeting the challenges of accountability to citizens and ensuring that the people’s right to health is effectively guaranteed. The High Level Expert Group (HLEG) on UHC with Srinath Reddy as Chairperson was set up by the Planning Commission in October 2010 whose express purpose was to develop a blue print and investment plan for meeting the human resource requirements to achieve the goal of health for all by 2020.

The HLEG held extensive discussions with a range of stakeholders – public, private, civil society, national and international – before finalizing its report, which is now on the website of the Planning Commission (HLEG 2011). Some of its key recommendations are as follows:

The HLEG has called for provision of universal financial protection and access to good health care without involving insurance companies or any independent agencies to purchase health care services on behalf of the government. Instead, the HLEG proposes general taxation as the principal source of health care financing complemented by additional mandatory deductions from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary. Government funded health insurance schemes should be integrated into the UHC system and government expenditure on health should rise from the current 1.4% of GDP to at-least 2.5% by the end of the 12th Plan, and to at-least 3% of GDP by 2022. Public spending on generic drug procurement should rise to 0.5% of GDP from the current 0.1% and thus ensure availability of free essential medicines.
Table 4: Regulatory Architecture (Proposed) by HLEG

Even assuming the total spending on health remains at the current level of around 4.5% of GDP, the HLEG hopes there will be a sharp decline in the proportion of private out-of-pocket spending on health from 67% to 33% by 2020. There will be no sector specific taxes for health financing. However, specific purpose transfers will equalize levels of per capita public spending on health by different states to offset general disability and mobilize resources to ensure all citizens an uniform level of essential health care. States can have flexible and differential norms for financing, but there will be no user fees for UHC services, primary health care and health promotion targeted towards specific risk factors, and should account for 70% of all government healthcare expenditure.

A major recommendation is for introducing a specialized state level health systems management cadre and all India and state level public health service cadres to strengthen the management of the UHC system. Another key recommendation is to develop an IT enriched system with a specialized body that will oversee adoption of health information systems and define standards of meaningful health management systems. At the centre of the new regulatory architecture for health and for the mixed public private UHC system will be a
National Health Regulatory and Development Authority, statutorily empowered to regulate and monitor/audit both the public and the private sectors. This authority will be supported at the state level by state Health Regulatory and Development Authorities with corresponding powers.

In addition to the above, the Drugs and Medical Devices Regulatory Authority will be strengthened and expanded in scope to include a development function so as to better regulate the pharmaceutical and medical devices sectors. Last but not the least, a National Health Promotion and Protection Trust (NHPPT) is envisioned to play a catalytic role in the promotion of a better health culture among people, health providers and policy makers through knowledge and information.

**Importance of the Tamil Nadu Model**

Health is a state subject and it is the leadership at the state level that makes all the difference.

Every state in India has its own story – of successes and failures in the public health sector. However, Tamil Nadu leads the way in transformation of its public health system and is far ahead of others in the totality of its innovations in the health sector. Therefore the Tamil Nadu model has gained respectability and recognition in government circles and can be discussed as a possible role model for a National Health Policy – and scheme for universal coverage of health care.

Tamil Nadu is again centre stage in the way it has used NRHM funds to ensure that the Primary Health Centres (PHCs) work round the clock and are fit for quality institutional deliveries. The turnaround seen was in the resultant decline of maternal and infant mortality ratios in the state.

Tamil Nadu took the lead in providing universal health coverage by setting up an effective drugs procurement and distribution mechanism since 1994. Its IT enabled supply chain management system ensures delivery to needy patients, transparency to prevent misuse and stringent quality control to eliminate spurious drugs. Kerala and Rajasthan are successfully emulating this model. The central government has also announced that it will provide 52% of the population with 350 free essential drugs by April 2017 at a cost of Rs. 300 billion. The cost will be shared by the centre and state governments in a 75:25 ratio.

The Tamil Nadu Medical Services Corporation (TNMSC) a state owned company, was set up with the mission to ensure availability of essential affordable drugs to all. The TNMSC built its procurement and distribution system on a well designed IT architecture ensuring that the supply chain from manufacturer to warehouse to pharmacy and finally to the patient is tracked. The IT system ensures quality compliance, transparency in procurement and distribution. Today states in India are learning from each other to adopt innovations that have worked. Over 6 states have set up corporations like the TNMSC to provide quality generic drugs and experiments at reasonable costs.
The challenge to UHC is still huge but as the Tamil Nadu model shows, e-health care structured around a robust IT infrastructure is the key. It ensures transparency and accountability along with efficient supply and inventory management. In a country where a huge chunk of the population falls below the poverty line due to high medical costs, effective delivery of free essential drugs can change the quality of lives of our people.

Tamil Nadu spends the most on drugs among all states.\(^{10}\) While Tamil Nadu spends the maximum, that of Rajasthan is the lowest followed by states which have poor health indicators, such as Bihar, Uttar Pradesh, Madhya Pradesh, Odisha, Chhattisgarh and Jharkhand. Some estimates of the fund requirements have been worked out by the Commission on Macro Economics and Health (CMEH) based on national burden of diseases, treatment cost per episode based on standard treatment procedures with use of quality generic medicines available at the lowest cost. Other estimates are based on market calculations. Both these calculations suggest that about Rs. 75 per capita or Rs. 9000 crore would be required to provide free medicines to all out patients. This is one seventh of the annual allocation for government interventions like the National Rural Employment Guarantee Scheme. This additional allocation will not still lead to an increase in public expenditures on health beyond 2% of GDP.

Tamil Nadu spends the most on drugs among all states. But its spending on buying medicines declined from 15.3% (2001) to 12.2% (2010) of its total healthcare budget. By procuring drugs at around 3-10% of their retail price, the real beneficiaries are the patients.

As far as quality control and transparency goes, TNMSC’s efficient tendering process helped to discover the lowest possible price. It purchases only from manufacturers holding Good Manufacturing Practice Certificates and follows stringent procedures for testing products. Its procurement process is equally effective. Tendered drugs received at the central ware house undergo testing and on approval, TNMSC releases them to its 23 district ware houses. A centralized computerized management information system tracks inventory and places orders, ensuring drug availability without over stocking in every part or region of the state for needy patients.

In the final stage of distribution, all government run clinics and hospitals are issued a passbook – the central pillar of the system’s architecture. When they require a drug, it is noted in the passbook and the system informs the nearest ware house to fulfill the demand. Since primary health is a subject transferred to panchayats by the constitution, the NRHM’s framework for implementation provided a very active role for the Panchayats. There are umpteen examples of rural Panchayats performing a commendable leadership role in Tamil Nadu in building up a culture of good health governance by helping to manage all the health related schemes (primarily NRHM fund based) at the rural level. Some examples may be quoted here:
Entire Gram Panchayats have been fully sanitized with the support of Panchayat leaders to make the Tamil Nadu government’s scheme on sanitation successful. Thousands of toilets were constructed with government funding in villages. Malnutrition has been reduced among children and the ban on plastics enforced in rural areas with complete success. By involving the staff of health departments in the planning process, the staff are made to commit themselves to delivering the services and implementing the prioritized activities. Having started a new culture of working with officials, Panchayat leaders are able to make the officials deliver services with regard to water supply, street lighting, primary health centers and public distribution systems by monitoring their performance. The Panchayat leadership in Tamil Nadu has really become effective agents of health service delivery and real change makers at grassroots.12

In Tamil Nadu the success of the state healthcare system, which functions more effectively than most states has been attributed to greater political will and the administrative commitment to the subaltern population constituted of various castes and communities over a period of time built by grass roots movements of the under-privileged. Besides the contribution of Panchayat leaders to the health goals have been used for operationalising a universal health care system in the state.

Tamil Nadu’s health care system has become a role model for others because it has achieved universal health care within the same administrative structure and finances as that of other states. The key difference however is that Tamil Nadu (a) separates the medical officers into public health and those in the medical tracks (b) mandates those in the public health track to secure a public health qualification in addition to their medical degree; and (c) orients their work towards managing public health centres-while others in the medical track to provide hospital services. Tamil Nadu uses a mere 1% of its government medical doctors to be trained as public health managers. With adequate incentives, Tamil Nadu’s per capita health expenditure is close to the national average. Kerala spends 2.8 times more than the national average on private expenditures bringing its total per capita expenditure to 2.5 times the national average (GOI 2009). Authority commensurate with responsibility has been granted to the medical officers-in-charge of rural and urban health facilities to professionalize management of public health facilities at all levels in Tamil Nadu. Here, as in other Indian states, government funding is based on inputs – such as the quantity of drugs supplied, the number of staff employed and salaries paid, the kind of medical equipment provided etc. But Tamil Nadu has succeeded where others have failed because the system has strict internal controls and accountability mechanisms to oversee the delivery of services with requisite standards.

Tamil Nadu therefore offers an organizational model for operationalising a universal health care system within the existing administrative and fiscal resources available to other states of India.13

It is widely recognized that good public health services is a key to improving health outcomes. Tamil Nadu performs better than all other states in key indicators of maternal and
child health care. Tamil Nadu is better organized than most Indian states to manage public health threats and its health department seeks actively to protect public health in urban as well as rural areas.

**Good Health at Low Cost**

There is continuing evidence of the possibility of ‘good health at low cost’ (GHLC) in a variety of socio-political settings and in a number of low income contexts. (BalaBanova, McKee and Mills 2011). The GHLC reports have repeatedly shown that a combination of political commitment to health as a worthy social goal, strong societal values of equity, political participation and community involvement, high investments in primary education and health care with inter-sectoral linkages had remarkable effects on health in low income settings such as China, Sri Lanka and Kerala (Halstead, Walsh and Warren 1985). Today there are newer examples such as Thailand, Kyrgyzstan and Tamil Nadu where these factors have been complemented by good e-health monitoring and public governance.

*What is significant for us is that two of the globally recognized GHLC models are from 2 Indian states.* While Kerala’s consistently better than average performance in health, education and other human development parameters has long been attributed to non-replicable historical and political factors, it is the Tamil Nadu model which has a healthy mix of public/private partnerships which has become more relevant to post liberalized India. Certainly, Tamil Nadu has had its historical legacy of social reform movements, but the state’s recent experience also provides clear policy, legal and management lessons that other states and the Central government can emulate.

**MDG Goals are achievable**

Millennium Development Goals (2000) are entirely achievable with an efficient and monitored public health system, if the declining infant and maternal mortality ratios are sustained and improved and a significant effort at fighting malnutrition are adopted. India can certainly achieve the health MDGS of 30 IMR and 100 MMR. By a small increase in public expenditure on health to a little above 1% GDP, the gains of the NRHM are perceptible. Therefore, it is clearly understood why a 3% public expenditure on health is required for universal health coverage. There can be partnerships with the non-governmental sector but they should be within a framework of a credible public system with public accountability.

Significantly, innovations in the health sector are also coming in from other states in India as well with the NRHM’s united grants: e.g. innovations and partnerships for emergency transport, diagnostics, drug availability, recruitment and training of new health workers. The JananiSurakshaYojna (JSY) has brought women to health facilities for institutional deliveries on an unprecedented scale, taking the national coverage to over 70% from a low of 44% just five years ago. Besides, the thrust on decentralized planning and need based provision of human resources and flexible untied funds to cover gaps, created confidence in the failing
public systems to start delivering quality services. While the HLEG has clearly recognized
an important role for the private sector in the provision of health services, it has insisted that a
strong regulatory framework is essential and an effective process for building in
accountability to the country’s citizens is equally important. Most of the recommendations of
HLEG have been complied within the Tamil Nadu Model. It is for these reasons alone that
Tamil Nadu has emerged as a leader in the health sector in India worthy of emulation by
other states.

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Endnotes

1 In India, in terms of access to medical care the best five serving states are : Tamil Nadu, Kerala, Himachal Pradesh, Gujarat and Haryana.

2 Social determinants of health, broadly refers to the conditions in which people live and work that affect their opportunities to lead healthy lives. Good medical care is vital, but unless, the root social causes that undermine people’s health are addressed, the opportunity for well being will not be achieved.

3 Abhijit Das and Moumita Das ‘How far are we from universal health coverage in India’? in CBGA Budget Track vol. 8, August 2011, p.12.


5 Ravi Duggal ‘Reforming financing strategies for equity and universal access to healthcare’ CBGA Budget Track, vol. 8, Track 2, Aug. 2011.

6 http://app.who.int/medicinedocs/en/d/js6160e

7 Market calculations suggest that about Rs. 75 per capita or Rs. 9000 crore would be required to provide free medicines to all out patients. Even this additional allocation will not jack up the public spending to 2% of GDP. Therefore it could be implemented.


9 See Kiran Majumdar Shaw, ‘Healing Touch Needed’ Times of India August 22, 2012 on the Tamil Nadu model.

10 See Amarjeet Sinha ‘Health evidence from the states’ EPW, vol XLVII no:6, February 11, 2012


12 See G. Palanithurai, ‘Role of Panchayats in Development’ Indian Journal of Public Administration vol LII, no.3 July-Sept. 2006 to get examples of Panchayat leadership in the Health Sector in Tamil Nadu.


References

• Balabanova, D., Mckee and A Mills ed 2011, good health at low cost: 25 years on-what makes a successful health system, London School of Hygiene and Tropical Medicine


• Duggal R. 2006. ‘Utilisation of Health Services’, in ‘Securing Health for All: Dimensions and Challenges’, in S. Prasad and C. Sathyamala (eds), New Delhi, IHD pp.11-45


• Halstead, S., J Walsh and K Warren (ed): Good Health at low cost, New York, Rockefeller Foundation


• INDIAN JOURNAL OF PUBLIC ADMINISTRATION VOL LVII, NO.1, JANUARY-MARCH 2011


• Sen Gita, 2012 ‘Universal Health Coverage in India’ EPW Vol XLVII no 8, Feb 25


Undertaking

‘I affirm that the paper titled ‘Leadership in the Health Sector: The importance of the Tamil Nadu Model for a Universal Public Health Care System in India’ is my original work. It has not been published anywhere. I have acknowledged all sections quoted from other writings and firmly assure that it has at no point been plagiarized’

RUMKI BASU