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Analyzing the Interface Between Governance Principles and National Health Policy in Tamil Nadu

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"Two requirements of the district health scheme are that the peripheral units of the (health) organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration" (Duggal)

Abstract
The state of a nation's health policy and health infrastructure is considered as a crucial factor in its economic development. Good governance is essential for the enactment of robust health policies, establishing health infrastructure and achieving improved health outcomes. While the Indian National Health Policy (NHP), 2017 mandates universal access to healthcare, the effective implementation of the policy is largely determined by the intricate web of governing bodies at the national, state, and local levels. This research paper focuses on how governance structures impact the implementation of the NHP in Tamil Nadu, which is perceived as one of the best public health systems in India. The study examines the various government mechanisms and institutions in Tamil Nadu that influence the adoption and implementation of the NHP and further highlights the patterns of reflection of good governance principles in the implementation process. Furthermore, the present research will contribute to understanding how the principles of governance impact the implementation of health policy and will help develop strategies to achieve better health outcomes in Tamil Nadu.

Keywords: National Health Policy, Health Governance, Healthcare, Health Infrastructure.

Introduction

Health of a population is paramount, and it is the government's primary responsibility to safeguard and promote their well-being. Healthy populations serve as a positive externality, where their effective functioning contributes significantly to a country's economic growth. The government's interventions to maintain a healthy population involve intricate interactions between various policy components within the broader social, political, and economic contexts.

To implement comprehensive government interventions in the health sector, a national health policy framework is essential. This framework should encompass all levels of governance, from national to state and local, providing clear guidelines for funding mechanisms, human resource development, and capacity

building(Hunt). Such an overarching framework is crucial for ensuring that all government departments and ministries recognize the core importance of health policy, as is common practice in many countries. The National Health Policy delineates the nation's health objectives and provides a procedural roadmap. While the policy is formulated at the national level, its effective implementation primarily occurs at the state and local government levels. The Seventh Schedule of the Indian Constitution categorizes "public health and sanitation; hospitals and dispensaries" as state subjects, reinforcing the imperative for state governments to establish robust institutional frameworks and human resource capacities to achieve the nationally defined health goals.

Moreover, Article 21 of the Indian Constitution guarantees the Right to Life and Personal Liberty, citizens right to access to health, sanitation, water, environment etc. The Supreme Court has consistently interpreted this fundamental right to encompass the right to health. This judicial interpretation underscores the critical role of state governments in ensuring access to adequate healthcare services for their citizens. The Rajasthan government introduced Right to Health Act aimed at ensuring comprehensive healthcare access for all residents in the state. The Act, which is regarded as the first of its kind in India, was passed in 2022 despite strong opposition from private hospitals and physicians employed by private hospitals. It ensures that everyone has access to healthcare as a fundamental right, regardless of their social or economic background. According to the Act, all people residing in Rajasthan are entitled to:

1. Free emergency medical care, including free medical care,
2. Prescription drugs,
3. Diagnostic testing in government hospitals.
4. Emergency Treatment.
5. Free emergency Services.
6. Protecting and promoting Health rights of Marginalized people.
7. Creation of Health Insurance for Economically Weaker Sections.

The Rajasthan's Right to Health Act is considered as a daring move toward resolving inequalities in healthcare access throughout the state, enhancing the general health system, and establishing healthcare as a universally accessible and equitable right. The enactment of the Act is widely perceived as the potential move to improve public health equity and healthcare outcomes, making healthcare a right for everyone rather than a privilege for a select few.

Statement of the Problem

The health of a Nation's population is influenced by numerous factors, some of which are controlled, enabled, or protected by the government, collectively referred to as health governance. Health governance can vary in its functionality. In India, health governance is carried out by the respective federal units at the national, state, and local levels. Each unit has its own distinct governance structure and mechanisms through which it implements or administers nationally formulated health policies. The National Health Policy in India has been adopted and implemented by the state governments, including Tamil Nadu, each with its own governance structure and mechanisms. While the governance mechanisms at the national and state levels may differ, the adherence to good governance principles within the Tamil Nadu health system is a paramount concern.

Governance principles represent the foundational standards inherent in any politico-economic system, evolving over time to reflect the unique contexts and needs of societies. These principles are shaped and operationalized to varying extents across civilizations, influenced by historical, cultural, and socio-

economic factors. Despite this diversity, the academic study of governance, particularly within the discipline of Public Administration, has distilled these varying standards into a set of universal principles. These universal governance principles serve as benchmarks for evaluating the effectiveness, accountability, and inclusiveness of governance structures worldwide.

While political and administrative systems exhibit significant variation in their adherence to these principles due to the interplay of local customs, traditions, and institutional frameworks, a minimum adherence to universal governance principles remains essential. Such adherence ensures the integrity and functionality of governance mechanisms, fostering a more equitable and efficient system of public administration.

In this context, the principles of Good Governance articulated by the United Nations Development Programme (UNDP) gain particular significance. These principles—accountability, transparency, participation, responsiveness, equity, effectiveness, efficiency, and adherence to the rule of law—are widely regarded as universal standards. They serve as a guiding framework for nations to build and sustain robust governance systems that promote human development, social justice, and sustainable progress.

The reflection of governance principles in the structure and mechanisms of Tamil Nadu's health governance, as manifested in the adoption and implementation of the National Health Policy, constitutes the problem statement. This reflection can manifest at various levels within political and administrative systems. This study aims to analyze the influence of governance mechanisms on the implementation of the National Health Policy in India.

Objectives

1. To examine the interface between governance principles and healthcare policy within the framework of Tamil Nadu's healthcare system.
2. To explore the existing institutional mechanisms and governance structures in Tamil Nadu that influences the adoption and implementation of the National Health Policy of India.
3. To assess the extent to which the Governance principles influence the implementation of National Health Policy in the state of Tamil Nadu.

Research Methodology

The study adopted both descriptive and document analysis methods to examine the interface between governance principles and the implementation of the National Health Policy in the state of Tamil Nadu. Furthermore, the study utilizes Qualitative approach to analyze insights from the implementation of the health policy, stakeholder involvement, and any lacunas in the policy's implementation. Inputs received from concerned government officials, health officials, and workers form a major portion of the data for the present study. Furthermore, the study utilizes secondary data obtained from books, research articles published in journals, newspapers, government and non-government organization reports, web sources, etc.

Conceptual Framework

The study adopts the UNDP's Principles of Good Governance such as Participation, Strategic vision, Responsiveness, Effectiveness & Efficiency, Accountability, Transparency, Equity and Rule of Law, as a conceptual framework for analyzing how these principles are reflected in the adoption and implementation of the National Health Policy in Tamil Nadu. This framework is derived from the UNDP's study report on

the pilot application of the good governance assessment methodology in the Macedonian healthcare system.

National Health Policy in India

In India, the 18th of October 1943 represents a turning point in the development of health policies. Following the Quit-India Movement, the Central Government of British India Provinces, acting on behalf of the Government of India, announced the establishment of the Health Survey and Development Committee, headed by Sir Joseph Bhore. This group, also known as the Bhore committee, had two straightforward mandates: (a) a comprehensive assessment of the current state of health care and health organizations in British India, and (b) recommendations for future development. The Bhore Committee especially built its plan with the rural population in mind since it acknowledged the significant gaps that currently exist between rural and urban health services. The district as a whole was intended to benefit.

There was no official health policy declaration in India till 1982–1983. The majority of the inputs for the creation of health programme designs came from the planning process (and numerous committees constituted periodically), of which the policy was an integral part. Social services, including health, housing, education, and access to clean water and electricity, should have received equal attention in planning since they are crucial equalizing elements in contemporary society. Over the years, these four sub-sectors ought to have gotten at least half of the five-year plan's resources. That was the only thing that could have guaranteed the Directive Principles policy's objectives.

Although, India's first national population programme was established in 1951, the National Health Policy (NHP) was not developed until 1983. The NHP aims to provide primary health care to everybody by 2000. It prioritized the establishment of a network of primary health-care services employing health volunteers and simple technology, as well as the development of well-functioning referral systems and a unified system of specialty institutions. With the goal of providing health services to the broader population through decentralization, the use of the private sector, and an increase in public spending on health care overall, NHP 2002 expanded upon NHP 1983. It emphasized the need of using non-allopathic treatments like ayurveda, Unani, and siddha, as well as enhancing decentralized state processes for making decisions. Owing to India's federalized political structure, the union and state governments oversee different aspects of the country's health system administration. The National AIDS Control Programme, National Tuberculosis Programme, and other National Health and Family Welfare programmes, as well as the prevention and control of major infectious diseases, the promotion of traditional and Indigenous health systems, and the establishment of national standards and guidelines that state governments can follow are all under the purview of the Union Ministry of Health & Family Welfare. Additionally, the Ministry provides technical support to governments in an effort to prevent and control the spread of epidemics and outbreaks of seasonal diseases. However, the state is in charge of public health, hospitals, sanitation, and other related concerns, making health a state matter. However, the union and the state governments work together to oversee matters with more national significance, such as family welfare and population control, medical education, food adulteration prevention, and quality control in drug manufacturing.

Health Governance in Tamil Nadu

Background

Tamil Nadu's public systems are more efficient than those of other Indian states. (Gaitonde et al.)Tamil Nadu, previously was part of Madras Presidency, was the first state to pass the Public Health Act in 1939

and is the only one with a unique public health cadre at the district level. Tamil Nadu has made considerable progress in the last few decades in a number of health-related areas, primarily as a result of substantial health sector reforms that began in the 1980s and saw the state's rural health infrastructure rigorously expanded in addition to the deployment of thousands of multipurpose health workers in rural areas to serve as village health nurses. Tamil Nadu has a multi-tiered healthcare system, similar to the rest of India. There is a health sub-center with an auxiliary nurse midwife for every 5,000 people, a Primary Health Center with two doctors for every 30,000 people, and a First Referral Unit or Community Health Center for every 100,000 people. In urban areas, additional referrals are made to district hospitals and medical college hospitals. Unlike the rest of the nation, where public health expertise is not required for officers overseeing the public health activities, this department is further typical in that its workforce is composed of doctors with training in public health. The state-level Department of Public Health and Preventive Medicine in Tamil Nadu is responsible for developing policies and overseeing their implementation. The execution is at the district level's responsibility(Balabanova et al.).

According to the Indian Constitution, health-related policies must be carried out within a complicated federal structure that includes both the Union and State administrations. This framework covers the formulation, application, and financing of policies. Although the policy is developed at the federal level, state and local governments are mostly responsible for its successful execution. In order to accomplish the nationally established health goals, state governments must build strong institutional frameworks and human resource capacities. This is further supported by the Indian Constitution's Seventh Schedule, which defines "public health and sanitation; hospitals and dispensaries" as state subjects. Additionally, the Right to Life and Personal Liberty are guaranteed under Article 21 of the Indian Constitution. The right to health has always been considered by the Supreme Court judgement in the case of Bandhua Mukti Morcha v. Union of India (1997) as part of this fundamental right. This legal interpretation emphasizes how important state governments are to guaranteeing their residents' access to quality healthcare services. While State employees oversee institutional capacity, governance structures, human resources, and last-mile execution, the Union government sets national-level policies, guidelines, and standards. Central schemes, Centrally Sponsored schemes, and State schemes are among the programme verticals used to distribute funding.

Tamil Nadu has its own unique governance structure for implementing health policies. Prior to 1980, the state's health services were not significantly different from those of other states. However, during the late 1980s and 1990s, Tamil Nadu underwent a substantial transformation in its health infrastructure and workforce. The State government actively participated in the Multipurpose Workers programme, introduced by the Central government during the Fifth Five-Year Plan, to provide healthcare services to every rural community with a population of 5,000 through dedicated multipurpose workers. These multifunctional health workers in Tamil Nadu were females in the majority since the existing maternity helpers were incorporated and recognized as village health nurses (VHNs). The function of VHN was to conduct frequent house visits and give maternity and child care services including advice for contraception and vaccination. The VHN was also assigned the job of enrolling and keeping track of all pregnant women in her service area while working synergistically with other grass root workers like Anganwadi workers. Thousands of VHNs were educated and deployed successfully in primary care services in rural regions which generated considerable improvements in prenatal, postnatal care, institutional birth, vaccination, etc.

A noteworthy milestone is the development of a health policy by the Tamil Nadu government in 2003, which aimed to tackle major health problems, improve health system management, boost the efficiency of public health care services, and prevent accidents and noncommunicable diseases. Over the following 20 years, the policy's main goal was to improve the health of everyone, with a concentration on low-income, underprivileged, and indigenous populations. The state's Health and Family Welfare Department launched the Tamil Nadu Health Systems Project (TNHSP) with the goal of advancing the health of those in lower socioeconomic groups and supporting health policies. The Tamil Nadu Health Systems Project was granted funding by the World Bank in 2005, and it is still operating well throughout the state. (*TNHSP*) The establishment of the Tamil Nadu Medical Services Corporation (TNMSC) in 1995—an independent organization that regulates drug distribution and procurement while encouraging the cost-effective and sensible use of generic medications—was another significant change in the state of Tamil Nadu's health system(*Tamil Nadu Medical Service Corporation*).TNMSC purchases drugs from several sources using an open tender process, and providers ship the medications straight to district warehouses. Other than the computer system that tracks the transfer of goods between warehouses and health facilities, all medical institutions maintain up-to-date records of medicine procurement and usage. All of these actions have made sure that all government health institutions have a steady supply of affordable, high-quality medications, which has raised patient satisfaction and enhanced use of public health facilities.

Structure

The Tamil Nadu Health governance is essentially the same as those of any other state with comparable cadres of medical and non-medical professionals, but other states may also model themselves after Tamil Nadu Model of low cost, high access, well-structured health system. The key differences in Tamil Nadu are as follows: (a) medical officers are divided into public health and medical tracks; (b) public health track members must obtain a public health qualification; (c) public health track members focus their work on managing public health services, whereas medical track members provide hospital care; and (d) the medical officer in charge of the rural health facility has more authority to provide health services to the public.

Even though the Tamil Nadu model has made significant progress in the field of public health, there are still problems and challenges associated with it, such as the concern that the growing private sector will widen the gap between rich and poor people's access to healthcare, the persistence of high rates of anemia and malnutrition, and the public's growing expectations and demands for public health services. However, the approach of Tamil Nadu continues to be a prototype for a health care delivery system suitable for the low-resource environments seen in developing nations(Balabanova et al.). The structural elements of Tamil Nadu's Health Governance are detailed in the below chapters.

Planning at the state level Health Department

Since its establishment in 1922, the State Health Department has maintained a separate Directorate devoted to public health. The Directorates of Public Health, Medical Services, and Medical Education are the three main Directorates of the department that report to the Health Secretary and are administratively equal. Each of these Directorates has a staff and a budget all its own. A professional cadre of qualified public health managers works for the Directorate of Public Health. These managers are promoted to the Directorate after gaining extensive experience in planning and supervising public health services in both urban and rural regions. Before being promoted to state-level positions in the Directorate, other technical

staff members, such statisticians and entomologists, also get significant practical experience in the districts.

The Directorate is able to carry out its proactive work in public Health because it has a set budget that enables it to complete every obligation related to service planning and delivery. Further, it comprises not only the male and female grassroots health workers and managers required by the central government, but also a variety of technical personnel like entomologists and staff members of public health laboratories, as well as the laborers and field staff required for environmental sanitation initiatives like removing vector-breeding locations.

Funding the functionaries of Health Department

In Tamil Nadu, public health is not only allocated a distinct budget, but it also has a sizable budget in comparison to what is spent on secondary and tertiary medical care and medical education. Primary healthcare as well as population-wide health services are covered by the public health budget. The Directorate of Public Health has a bigger share in terms of personnel and staff expenditures, since a smaller amount of its budget is allocated to purchasing supplies, medications, and other items.

Legal Frameworks for Tamil Nadu Health Governance

The Public Health Act in Tamil Nadu considerably facilitates the provision of public health services. First, it outlines the administrative and legislative frameworks that control public health systems, delineates the roles and authorities of various governmental levels and agencies, and identifies the sources of financing that these organizations receive to carry out their mandates. Second, it lays out authorities for safeguarding public health, such as the authority to regulate and inspect. It also imposes duties on the use of these authorities to keep an eye out for any circumstances or actions that might endanger public health and, if necessary, take appropriate action to address them. Thirdly, public health laws provide criteria for things like water quality, food cleanliness, market and abattoir hygiene, and local government initiatives for environmental health and sanitation. Additionally, it has benefits over the Municipalities Act and Panchayati Raj Act since its requirements are more thorough and precise, and they apply consistently throughout the state rather than only in particular regions.

Human Resource

Careful training is provided to the managerial cadre in public health. Their orientation is towards an administrative and managerial position as opposed to a clinical role, and they focus on population-wide health concerns rather than individual patient requirements. Those who want to work in this field after receiving their medical degree are required to complete three months of preplacement training in public health and receive a post-graduate diploma or degree in public health within four years. Since their job is nonclinical, they are not allowed to practice private medicine and are unlikely to draw in clients.

The DDHS oversees all employees who work in rural health, including those employed by Primary Health Centers and subcenters, at the district and block levels and below. The Medical Officer of the PHC (MO-PHC) and the Block Medical Officer (BMO) both offer primary healthcare, but they also focus on issues affecting the entire population. For instance, health centres are supposed to have its Health Inspectors follow up to look into contacts and sources of infection when instances of communicable diseases show up, in order to stop the sickness from spreading further. Despite being a part of the medical cadre, they oversee all of the Block public health employees. Most of them choose to work as clinicians or instructors

in the medical cadre for the duration of their careers after receiving their initial assignment under the DDHS. The 15-day intensive training covers public health acts and food safety, environmental health issues, national health programmes, prevention and control of epidemic outbreaks, administrative and financial powers, and community health education before they are posted as BMO/PHC-MO and assigned to their public health supervisory duties.

Description of UNDP's of Governance Principles

This study utilizes a conceptual framework that integrates the Six Good Governance Principles and the UNDP-based Principles, along with their accompanying explanatory text. This framework is grounded in the findings of the UNDP's research on the Macedonian healthcare system. By combining these principles and their associated explanations, the study aims to provide a comprehensive and insightful analysis of the healthcare system under examination.

The principles and their associated explanations:

a. **Participation** – all men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively.
b. **Strategic Vision** – leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural, and social complexities in which that perspective is grounded.
c. **Responsiveness** – institutions and processes try to serve all stakeholders**.**
d. **Effectiveness and Efficiency** – processes and institutions produce results that meet needs while making the best use of resources.
e. **Accountability** – decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organizations and whether the decision is internal or external
f. **Transparency** – transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.
g. **Equity** – all women and men have equal opportunities to improve or maintain their wellbeing.
h. **Rule of Law** – legal frameworks should be fair and enforced impartially, particularly the regulation on human rights.

Results and Analysis

The UNDP-based Principles are applied to the structure and context of Tamil Nadu for analyzing the influence and reflections of those Governance principles

Community Participation - NRHM

The tenets and cornerstones of primary health care have been identified as equity, intersectoral coordination, community involvement, and suitable technology(S. Maheshwari). Numerous surveys conducted as India's health care system progressed highlighted the value of community involvement in improving people's health, particularly in rural regions. As a result, the National Rural Health Mission was

established as a crucial element of the eleventh five-year plan, which ran from 2005 to 2012(Gopalakrishnan and Immanuel).

National Rural Health Mission (NRHM) was launched in 2005 with the goal of improving the availability of and access to quality health care by people in rural areas, especially the poor, women and children(Garg and Laskar). Furthermore, mainstreaming of AYUSH—Ayurvedic, Yoga, Unani, Siddha, and Homeopathic—was made possible by NRHM. The mission was founded on the ideas of community involvement and intersectoral coordination, with an emphasis on mother and child health and family welfare. NRHM was introduced throughout India to improve health care indicators by offering basic, secondary, and tertiary healthcare at low costs.(Gopalakrishnan and Immanuel). It is important to note ASHA's contribution to NRHM's accomplishments. ASHAs have two roles: they are "social activists" and "health activists," educating the rural population about health issues and encouraging community involvement, both of which are essential to any programme's success. (Gopalakrishnan and Immanuel)

Community based Monitoring

In community-based monitoring, the community and its representatives—such as community-based organizations (CBOs), people's movements, voluntary organizations, and Panchayat representatives—are encouraged to participate, engage, be motivated, and build capacity in order to provide direct input on how public health services are operating. A three-way collaboration including the community, Healthcare providers and administrators (health system), community-based organizations, non-governmental organizations, and Panchayati Raj institutions would be part of the community monitoring process. Instead of focusing on "fault finding," the developmental mindset of "fact-finding" and "learning lessons for improvement" will be emphasized. (*Part One – Introduction to Community Monitoring*).

The National Rural Health Mission uses CBM of health services as a primary tactic to guarantee that the services are received by the intended beneficiaries. Because it centers the process around the health rights of the community, this framework aligns with the "Right to Health Care" approach. It aims to close the gaps in the manner that different initiatives are implemented, improving transparency all the way down to the local level. It is also seen to be a crucial component in encouraging community-led initiatives.(Garg and Laskar).

Participation in Maternal Care

A fundamental transformation in norms and behavior is necessary for any maternal health intervention to be successful on multiple fronts. These include changes in government policies, investments, initiatives, community support, and health-seeking behavior.

One of the Deputy Director of Health Services (DDHS) said

"The Block level meetings for all the Panchayat members and local leaders were conducted and brought them to the PHCs and briefed them about the available services leading to use of PHC services by more families" (Pandian et al.)

Strategic Vision

The National Health Policy, 2017 aims to inform, clarify, strengthen, and give priority to the role of the government in forming health systems in all of their aspects, including investments in healthcare, the organization of healthcare services, disease prevention and promotion through cross-sectoral actions, technology access, human resource development, medical pluralism encouragement, knowledge base

building, improved financial protection strategies, regulation, and health assurance(*NHP_2017_Policy Document.Pdf*).

The major goal of National Health Policy, 2017 is for everyone, regardless of age, to achieve the highest possible level of health and wellbeing. To this end, all developmental policies should have a preventive and promotional health care orientation, and everyone should have universal access to high-quality health care services without experiencing financial hardship(*NHP_2017_Policy Document.Pdf*). This would be accomplished by bringing down the cost of healthcare delivery, raising access, and enhancing quality.

Further, the significance of the UNO's Sustainable Development Goals (SDGs) is acknowledged by the policy by stipulated list of time-bound quantitative targets that are in line with current national initiatives as well as global strategic directions. The policy document outlines the governance framework necessary to achieve its stated objectives. In this regard, the policy delineates the distribution of responsibilities between the central and state governments and the role of local self-governments.

"The policy recommends equity sensitive resource allocation, strengthening institutional mechanisms for consultative decision-making and coordinated implementation, as the way forward. Besides, better management of fiduciary risks, provision of capacity building, technical assistance to States to develop State-specific strategic plans, through the active involvement of local self-government and through community-based monitoring of health outputs is also recommended"

Furthermore, the policy specifies about the strengthening of HR policies, *which has been done by* the state of Tamil Nadu. One such step is the creation and filling of positions for health workers in primary care. For instance, maternity care is now available around-the-clock following an increase in the number of nurse positions from one to three in each Primary Health Centre (PHC). To recruit and retain medical professionals in the system, the state has put in place several regulations, rewards programmes, and supportive laws. One such example is the 50% postgraduate seat reservation for physicians working in the public health system. After finishing their postgraduate studies in the state, medical students are required to serve for at least two years in government hospitals. The ability to fill positions quickly was made possible by proactive and centralized personnel management initiatives like effective regularizations, promotions, a system of counselling for postings, staff recruitment processes using merit lists, and the ability to hire medical officers temporarily(Narayana).

Responsiveness

Disease Surveillance Mechanism in Tamil Nadu

Given that fever is the primary indicator and symptom of seasonal outbreaks, data on fever was gathered using the resources available through both active (door-to-door search) and passive (institutional surveillance) surveillance. Field workers, health inspectors, and village health nurses conducted active surveillance, or a door-to-door search, while on field trips. A blood smear test was performed using the data gathered. At the primary health center (PHC), the test results were forwarded to the medical officer. An institutional monitoring method called "passive surveillance" can be used to gather data on a variety of diseases(Basker et al.). Passive monitoring was employed in the current study to gather daily fever data from patients receiving PHCs as well as inpatients from government, private, and tertiary care institutions in the district, including medical college hospitals. The entomological surveillance was given priority based on this data.

Various information education and communication activities were carried out during the dengue outbreak to encourage the communities to participate in vector-control measures. These included showing people

Aedes larvae in their homes, educating them about the variety of habitats, stressing the importance of source reduction, scrubbing water-stored vessels because the mosquitoes' eggs can withstand humidity for up to a year and can resume life when the container gets wet with water, and emphasizing the importance of weekly interventions of these activities because mosquito life cycles are only 7–10 days.(Basker et al.)

Monitoring of Pregnant Women in Tamil Nadu

The state of Tamil Nadu has a new registration system for pregnant women and infants, called the Pregnancy and Infant Cohort Monitoring and Evaluation (PICME) system. ("New Software to Help Bring down Maternity Mortality Rate in State"). This system was first introduced in Tamil Nadu in April 2008 in all rural areas and also in urban areas in 2012.(Gaitonde). Information has always been a high priority in the health system in Tamil Nadu, since the state is one of the few in India to have a dedicated public health cadre overseeing primary and first referral level treatment.(Gaitonde).The state initially implemented a DANIDA-funded Institutional Service Monitoring Report in 1998, and it developed into a useful monitoring tool over the years("Govt Will Keep Tab on Health of Moms-to-Be").In a similar vein, early pregnancy registration with the Village Health Nurse was highly encouraged, with a focus on registering by the third month.(*Safer Pregnancy in Tamil Nadu*).This was done, among other things, to enable the Village Health Nurse to schedule her work according on the number of prenatal women who have registered.

Thus, with encouragement from a number of officials, PICME was created by the National Informatics Centre for the state's Department of Public Health and Preventive Medicine. Four modules make up the pregnancy cohort in the system, while five modules make up the newborn cohort.(Gaitonde).

Accountability

In India, accountability has taken center stage because to the National Rural Health Mission (NRHM), a hallmark national health system reform. This mission set out to implement a "architectural correction" of the healthcare system in order to guarantee that everyone has access to healthcare, acknowledging the pervasive unfairness and the fact that a significant portion of the population lacks access to high-quality healthcare(*National Rural Health Mission | Indian Journal of Pediatrics*).

The community-based health worker, the village health and sanitation committee, and the community-based monitoring and planning process (later renamed as Community Action for Health, CAH) are just a few of the community-level interventions that the NRHM introduced. A key component of these initiatives is the increased accountability of health systems to the people(Gaitonde et al.).

The National Rural Health Mission in Tamil Nadu has seen various interpretations of accountability, each influencing its implementation at the state level. One perspective views accountability as the achievement of predefined targets, which are often determined by expert assessments of community needs. Another interpretation focuses on the efficiency with which implementing institutions reach these targets, recognizing the importance of community feedback. A radically different conceptualization of accountability emphasizes transformation, considering broader social determinants of health such as caste, class, and gender rather than solely focusing on meeting predetermined targets.

Transparency

Through press releases, official websites, and social media, the government frequently updates the public on health policies, initiatives, and accomplishments.The principle of transparency in governance is

demonstrated by the dissemination of information from official X accounts (formerly known as Twitter) maintained by the Tamil Nadu Directorate of Public Health & Preventive Medicine (TNDPHPM), the Tamil Nadu Department of Information and Public Relations (TNDIPR), and the National Health Mission – Tamil Nadu.

A transparent tendering process is used to acquire medical supplies, equipment, and services. Contracts, bids, and tenders are all open to the public. Audits of procurement procedures are conducted on a regular basis to make sure transparency requirements are being met. As the case of this matter, TNMSC obtains pharmaceuticals through an open tender process from multiple suppliers, and the suppliers deliver the drugs directly to district warehouses. Every medical facility, aside from the computer system that monitors the movement of supplies between warehouses and hospitals, keeps current records on the purchase and application of medications. By ensuring that all government-run healthcare facilities have a consistent supply of reasonably priced, superior quality pharmaceuticals, these initiatives have improved patient satisfaction and increased utilization of public health facilities.

Equity

Due to the NRHM initiative, the public health system has been repositioned and revitalized, putting health equity and the needs of underprivileged people at the forefront of the discussion.(*NRHM Framework for Implementation :: National Health Mission*). It remains to be seen, though, if the National Rural Health Missionand state-funded health insurance schemes (like the Chief Minister's Life Saving Health Insurance Scheme in Rajasthan, the Rajiv Aarogyashri Scheme in Andhra Pradesh, the Kalainger Life-Saving Health Insurance Scheme in Tamil Nadu, and the Yesheshwini Scheme in Karnataka) will succeed in their goals and overcome the obstacles to achieving equity in healthcare.(Bajpai et al.).

Rule of law

The laws pertaining to the administration and governance of healthcare sector in Tamil Nadu are as follows,

- **Tamil Nadu Public Health Act, 1939**
  This was India's first public health act, creating a foundation for state-wide public health management. It gives the government the authority to control public health emergencies and stop the spread of diseases.
- **Transplantation of Human Organs Act, 1994**
  This act regulates the transplantation of human organs and tissues to ensure ethical practices and protect donor rights.
- **Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994**
  This central act is enforced in Tamil Nadu to prevent sex-selective abortions and regulate prenatal diagnostic techniques.
- **Tamil Nadu Clinical Establishments (Regulation) Act, 1997**
  In order to guarantee high-quality healthcare services and safeguard patients' rights, this act governs the creation and operation of clinical establishments in the state.
- **Tamil Nadu Food Safety and Standards Act, 2006**
  This act guarantees that food safety regulations are met throughout the state and is enforced by the Food Safety and Drug Administration Department.

- **Tamil Nadu Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2008**

This law makes certain offenses cognizable and non-bailable in an effort to stop violence against medical personnel and damage to medical facilities.

These laws, designed to uphold the principle of the Rule of Law, provide a framework for the administration and governance of the health sector, ultimately aiming to enhance service delivery.

Conclusion

The health policy in India has been a revolutionized one since the mid-20th century. The Bhore Committee report in 1943 formed a stepping stone for the future health policies, but that was implemented only when a National Health Policy was evolved in the 1980s, which was prepared with the objective of providing primary health care to everybody. This policy was an exercise in establishing a basic health infrastructure, including primary and referral systems. The goals set for the next National Health Policy in 2002 include decentralization, public-private partnerships and integration of traditional medicine with mainstream health care. Preventive healthcare and control of infections have also been put high on the agenda.

The federal structure of India assigns health-related responsibilities to both the central and state authorities. The central authority manages national health programs, while state authorities are in charge of public health, healthcare facilities, and sanitation services. The two tiers of government cooperate on issues of national significance, such as family welfare and disease control.

Case of Tamil Nadu

Tamil Nadu is considered one of the few states in India with a robust healthcare system capable of addressing health issues even during times of distress. This is attributed to sufficient fund allocation, a strong bureaucratic structure, transparency and accountability in health administration, and the availability of adequate physicians, health workers, and professionals associated with health services. Additionally, initiatives such as *Makkalai Thedi Maruthuvam* (MTM), the Chief Minister's Comprehensive Health Insurance Scheme, the widespread network of PHCs, and accessible and affordable healthcare facilities for common people, coupled with robust health-related welfare policies and the commitment of doctors and health workers to addressing health issues, even in remote villages, have significantly contributed to the state's record of development and achievements in the health sector.

The state has achieved low rates of infant mortality, malnutrition, and casualties from epidemics, including COVID-19, along with significant progress in screening and detecting communicable diseases, controlling infectious diseases, implementing vibrant health welfare schemes, and achieving 90% coverage of the immunization program. These accomplishments are a result of the governance principles embedded in Tamil Nadu's health policy. The launch of the National Health Policy 2017 provides an opportunity for further development. The primary aims of this study are to examine the interface between governance principles and healthcare policy within the framework of Tamil Nadu's healthcare system, explore the existing institutional mechanisms and governance structures in Tamil Nadu that influence the adoption and implementation of the National Health Policy, and assess the extent to which governance principles impact the policy's implementation in the state. Additionally, the study investigates whether other Indian states can emulate Tamil Nadu's healthcare structure to enhance public health facilities, reduce infant mortality, combat malnutrition, achieve higher immunization coverage, and introduce robust health-related welfare policies and programs.

The following are the major findings of the study:

1. Tamil Nadu's experience serves as a reflection of the crucial role that government plays in fostering a shift in health. By doing this, the state used political commitment, decentralization, accountability, transparency, and equity to foster a culture of trust and efficiency inside the healthcare system. These guiding concepts have not only made it possible to implement the NHP but have also improved important health metrics.
2. The state's decentralized governance system has made it possible for more locally managed, more contextually tailored health treatments to be planned and delivered.
3. Tamil Nadu has made significant investments in human resources, particularly the public health cadre, which was essential to the effective operationalization of health initiatives.
4. The effective implementation of NHP in Tamil Nadu for improved health outcomes was driven by good governance. Policymakers and healthcare providers worldwide can learn a lot from the state's experience. Key strategies of Tamil Nadu included:
    - Dedicated Public Health Cadre: Establishing a specialized cadre focused on preventive health and sanitation.
    - Robust Disease Surveillance System: Building a strong institutional framework for monitoring diseases and health trends.
    - Community Health Workers: Deploying community-based health workers to reach the most underserved populations.
    - Maternal Health Monitoring: Implementing dedicated institutional and human resource mechanisms for monitoring pregnant women.
    - Health Insurance: Providing health insurance to the population through state-funded or public-private partnership models.
5. The study found that the strategies mentioned above emphasize the importance of establishing strong leadership and a commitment to transparency, accountability, and equity to build resilient health systems. These systems ensure the convergence of infrastructure components necessary to deliver high-quality healthcare services suitable for all citizens.
6. The study identified that while Tamil Nadu's public health system has made notable advancements, several challenges remain unaddressed, such as:
    - Ensuring healthcare services are accessible to all social groups.
    - Shortage of healthcare staff working in remote villages, such as those Dharmapuri, Krishnagiri, and other districts,
    - Overcrowding in government hospitals and PHCs,
    - Urban-rural disparities in the quality of healthcare facilities provided to the population,
    - The burden of non-communicable diseases,
    - Lack of awareness among people about available healthcare facilities, especially in rural areas,
    - Lukewarm responses to addressing environmental and health risks.
    - The unruly behavior of people towards doctors and health workers has resulted in physical and verbal assaults against them.

The situation has now come to the forefront, highlighting the need to address the aforementioned shortcomings and challenges in Tamil Nadu's healthcare system in order to resolve vital issues that undermine the true spirit of providing quality healthcare facilities to the public. It is concluded that by

ensuring the establishment of these essential healthcare facilities in the state, one can reasonably conclude that the benefits of the National Health Policy (NHP) will undoubtedly reach everyone in Tamil Nadu.

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References

1. Bajpai, Nirupam, et al. *Improving Access, Service Delivery and Efficiency of the Public Health System in Rural India*. *academiccommons.columbia.edu*, https://doi.org/10.7916/D8NK3DCT. Accessed 18 Sept. 2024.
2. Balabanova, Dina, et al. "Good Health at Low Cost 25 Years on: Lessons for the Future of Health Systems Strengthening." *The Lancet*, vol. 381, no. 9883, June 2013, pp. 2118–33. *www.thelancet.com*, https://doi.org/10.1016/S0140-6736(12)62000-5.
3. Basker, Parasuraman, et al. "Study on Entomological Surveillance and Its Significance during a Dengue Outbreak in the District of Tirunelveli in Tamil Nadu, India." *Osong Public Health and Research Perspectives*, vol. 4, no. 3, June 2013, pp. 152–58. *ScienceDirect*, https://doi.org/10.1016/j.phrp.2013.04.005.
4. Duggal, Ravi. "Bhore Committee (1946) and Its Relevance Today." *The Indian Journal of Pediatrics*, vol. 58, July 1991, pp. 395–406. *ResearchGate*, https://doi.org/10.1007/BF02750917.
5. Gaitonde, Rakhal, et al. "Accountability in the Health System of Tamil Nadu, India: Exploring Its Multiple Meanings." *Health Research Policy and Systems*, vol. 17, no. 1, 1, Apr. 2019, pp. 1–11. *link.springer.com*, https://doi.org/10.1186/s12961-019-0448-8.
6. ---. "Registration and Monitoring of Pregnant Women in Tamil Nadu, India: A Critique." *Reproductive Health Matters*, vol. 20, no. 39, Jan. 2012, pp. 118–24. *Taylor and Francis+NEJM*, https://doi.org/10.1016/S0968-8080(12)39619-5.
7. Garg, Suneela, and Ananya Ray Laskar. "Community-Based Monitoring: Key to Success of National Health Programmes." *Indian Journal of Community Medicine*, vol. 35, no. 2, Apr. 2010, p. 214. *journals.lww.com*, https://doi.org/10.4103/0970-0218.66857.
8. Gopalakrishnan, S., and A. Immanuel. "Progress of Health Care in Rural India: A Critical Review of National Rural Health Mission." *International Journal Of Community Medicine And Public Health*, vol. 5, no. 1, Dec. 2017, p. 4. *Crossref*, https://doi.org/10.18203/2394-6040.ijcmph20175758.
9. "Govt Will Keep Tab on Health of Moms-to-Be." *The Times of India*, 5 Jan. 2012. *The Economic Times - The Times of India*, https://timesofindia.indiatimes.com/city/chennai/govt-will-keep-tab-on-health-of-moms-to-be/articleshow/11370955.cms.
10. Hunt, Phillip. "Health and Well-Being: The Role of Government." *Public Health*, vol. 126, Sept. 2012, pp. S19–23. *ScienceDirect*, https://doi.org/10.1016/j.puhe.2012.05.017.
11. Narayana, Bhyrovabhotla V. L. *Transition of Health Systems: How Change Is Effected - A Comparative Study of Two State Health Systems in India*. 1820806, 23 Apr. 2011. *Social Science Research Network*, https://doi.org/10.2139/ssrn.1820806.

12. *National Rural Health Mission | Indian Journal of Pediatrics*. https://link.springer.com/article/10.1007/BF02825478. Accessed 18 Sept. 2024.
13. "New Software to Help Bring down Maternity Mortality Rate in State." *The Hindu*, 16 Feb. 2011. *www.thehindu.com*, https://www.thehindu.com/news/cities/chennai/New-software-to-help-bring-down-maternity-mortality-rate-in-State/article15447039.ece.
14. *NHP_2017_Policy Document.Pdf*.
15. *NRHM Framework for Implementation :: National Health Mission*. https://nhm.gov.in/index4.php?lang=1&level=0&linkid=452&lid=138. Accessed 17 Sept. 2024.
16. Pandian, Jayanthi, et al. "Increased Utilization of Primary Health Care Centers for Birthing Care in Tamil Nadu, India: A Visible Impact of Policies, Initiatives, and Innovations." *Journal of Family Medicine and Primary Care*, vol. 2, no. 4, Dec. 2013, p. 329. *journals.lww.com*, https://doi.org/10.4103/2249-4863.123781.
17. *Part One – Introduction to Community Monitoring*.
18. S. Maheshwari, Dr T. Saravanakumar. "Effective Utilization of Health Care Services Provided by Primary Health Centre and Sub-Centres in Rural Tamilnadu, India." *Mathematical Statistician and Engineering Applications*, vol. 71, no. 4, 4, Dec. 2022, pp. 7000–09. *www.philstat.org*, https://doi.org/10.17762/msea.v71i4.1316.
19. *Safer Pregnancy in Tamil Nadu: From Vision to Reality*. https://www.who.int/publications/i/item/9789290223566. Accessed 17 Sept. 2024.
20. *Tamil Nadu Medical Service Corporation*. https://www.tnmsc.tn.gov.in/. Accessed 16 Sept. 2024.
21. *TNHSP*. https://tnhsp.org/tnhsp/. Accessed 16 Sept. 2024.
22. UNDP. *Governance for Sustainable Human Development :digitallibrary.un.org*, https://digitallibrary.un.org/record/492551. Accessed 23 Aug. 2024.