Government of Tamil Nadu

Health & Family Welfare Department

TN - State Health Policy Vision 2030

TNHSRP
Access, Equity, Quality

Tamil Nadu Health System Reform Program
(Program for Results supported by World Bank)

WORLD BANK

Government of Tamil Nadu

Health & Family Welfare Department

Tamil Nadu State Health Policy

Vision 2030

'A promise towards Right to Health'

Contents

Acronyms and Abbreviations

Addl PHC	Additional Primary Health Centre
AMR	Anti-Microbial Resistance
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Anti- Retroviral Therapy
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BCG	Bacille Calmette Guerin
BEIC	Block Early Intervention Centre
CBE	Clinical Breast Examination
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community health centre
CMCHIS	Chief Minister's Comprehensive Health Insurance Scheme
CME	Continuing Medical Education
CMNND	Communicable-Malnutrition-Maternal-Newborn Diseases
CMS	College Management System
COTPA	Cigarettes and Other Tobacco Products Act
CPD	Continuing Professional Development
CQI	Continuous Quality Improvement
DALYs	Disability-Adjusted Life Years
DEIC	District Early Intervention Centre
DFW	Directorate of Family Welfare
DM	Diabetes Mellitus
DM&RHS	Directorate of Medical & Rural Health Services
DME	Directorate of Medical Education
DMHP	District Mental Health Programme
DPH&PM	Directorate of Public Health & Preventive Medicine
EDSS	Essential Diagnostics Services System
EMTCT	Elimination of Mother to Child Transmission
Endo	Endocrine diseases
EQAS	External Quality Assurance Standards
ESC	Emergency Stabilization centres
FSSAI	Food Safety and Standards Authority of India
GATS	Global Adult Tobacco Survey
GBD	Global Burden of Diseases
GCC	Greater Chennai Corporation
GDP	Gross Domestic Product
GoTN	Government of Tamil Nadu
H&FW	Health & Family Welfare
HAI	Healthcare Associated Infections
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System

HMS	Hospital Management System
HQH	Head Quarters Hospitals
HRH	Human Resources for Health
HSC	Health SubCentre
HT	Hypertension
HWC	Health and Wellness Centre
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron & Folic Acid supplementation
IFT	Interfacility transfers
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
IMH	Institute of Mental Health
ISO	International Organization for Standardisation
IUCD	Intra Uterine Contraceptive Devices
JICA	Japan International Cooperation Agency
LF	Lymphatic Filariasis
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
LIMS	Laboratory Information and Management System
LMIC	Lower and Middle Income Countries
LRI	Lower Respiratory tract Infection
M&E	Monitoring and Evaluation
MAS	Maghila Arokya Samiti
MCCD&CRS	Medical Certification of Cause of Death & Civil Registration System
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MIS	Management Information System
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MRB	Medical Services Recruitment Board
NABH	National Accreditation Board for Hospitals and Healthcare Providers
NACO	National AIDS Control Organisation
NAP-AMR	National Action Plan on Antimicrobial Resistance
NBSU	Newborn Stabilization Unit
NCD	Non Communicable Diseases
NCRB	National Crime Records Bureau
NFHS-4	National Family Health Survey - 4
NGO	Non-Governmental Organisation
NHM	National Health Mission
NHP	National Health Policy
NIMHANS	National Institute of Mental Health and Neurosciences
NITI Aayog	National Institution for Transforming India
NPHCE	National Program for Health Care of Elderly

NPPC	National Programme for Palliative Care
NQAS	National Quality Assurance Standards
NRC	Nutrition Rehabilitation Centre
NSP	National Strategic Plan
NSSO	National Sample Survey Office
NTD	Neglected Tropical Diseases
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OCP	Oral Contraceptive Pills
OOPE	Out-of-Pocket Expenditure
ORS	Oral Rehydration Solution
PAI	Pre-arrival Implementation
PALS	Paediatric advanced Life Support
PBS	Population Based Screening
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PICME	Pregnancy and Infant Cohort Monitoring and Evaluation
QAC	Quality Assurance Committee
QoC	Quality of Care
QoCS	Quality of Care Strategy
RADMS	Road Accident Data Management System
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH+A	Reproductive Maternal Newborn Child Health and Adolescent Health
RNTCP	Revised National Tuberculosis Control Programme
ROTN	Rest of Tamil Nadu
SAM	Severe Acute Malnutrition
SARS	Severe Acute Respiratory Syndrome
SCRB	State Crime Records Bureau
SDG	Sustainable Development Goals
SDH	Sub-District Hospital
SMHA	State Mental Health Authority
SN	Staff Nurse
SNCU	Special Newborn Care Unit
SOC	Special Outreach Camp
SRS	Sample Registration System
STEPS	WHO STEPwise approach to Surveillance of noncommunicable diseases
TAEI	Tamil Nadu Accident and Emergency Care Initiative
TANII	Tamil Nadu Innovation Initiatives
TAN-QuEST	Tamil Nadu Quality Enhancing Structured Training
TANSACS	Tamil Nadu State AIDS Control Society
TB	Tuberculosis
TNCDW	Tamil Nadu Corporation for Development of Women
TNHSP 2030	Tamil Nadu State Health Policy - Vision 2030
TNHSRP	Tamil Nadu Health System Reform Program
TNMSC	Tamil Nadu Medical Services Corporation

TRIPS	Trade Related Aspects of Intellectual Property Rights
UAS	University Automation System
UG-PHC	Upgraded Primary Health Centre
UHC	Universal Health Coverage
UHND	Urban Health Nutrition Days
Urog	Urogenital diseases
USG	Ultrasonogram
VBDC	Vector Borne Disease Control
VHSNC	Village Health Sanitation and Nutrition Committee
VIA	Visual Inspection with Acetic acid
VPD	Vaccine Preventable Diseases
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WHV	Woman Health Volunteer

1. Introduction

Tamil Nadu is the pioneering state in providing public healthcare facilities in India. The state also has a robust private sector and hence viewed as the ultimate health care destination in India as it attracts medical tourism. Tamil Nadu's healthcare model is highly looked upon as a replicable one in other states and developing countries, since it hinges on an administrative approach that can be used anywhere regardless of prevailing socio-economic and environmental conditions. The success of the model depends on better administration, accountability of health service delivery and political commitment.

Tamil Nadu's strong public health system still has many gaps and challenges that need a renewed policy thrust. Firstly, there is a growing burden of non-communicable diseases due to the ongoing epidemiologic and demographic transition. Second, there is an unfinished agenda on maternal and child health where there has already been substantial progress. Third, a high catastrophic expenditure due to rising health care costs in the private sector which is due to implementation gaps in regulation of private sector. Finally, there is a need to further strengthen public services at all levels of care, address the lacunae in providing quality of care and bringing community ownership and equity-based healthcare delivery. Hence, a new health policy responsive to these contextual changes is required by a state like Tamil Nadu.

The current **Tamil Nadu State Health Policy Vision 2030 (TNSHP-2030)** embraces a systems approach to address the current issues and foreseen challenges in the health sector in the state by creating a necessary policy framework. The policy document has been developed taking into account the Global Burden of Diseases (GBD) Report, 2016- *India: Health of the Nation's States - The India State-Level Disease Burden Initiative*, National Health Policy 2017, Government of India, targets set in Sustainable Development Goals (SDG) and Vision 2023 & 2030 Document of the Government of Tamil Nadu.

2. Situational Analysis

2.1. Health outcomes

Tamil Nadu is the sixth most populous state in India with a population of 721 million as per 2011 Census with Decadal Growth Rate of 15.6%. It is among the most urbanized states – 48 percent of the population resides in urban areas.[1] Tamil Nadu's population is older compared to the national average, and a larger share of the population is of working age (Figure 1). The state's dependency ratio is 43 percent compared to the national average of 57 percent. The total fertility rate has declined from 2.2 in 1998-99 to 1.6 in 2015-16. It is projected that the population will grow to 9 crores in the next 10 years, and the share of those above 60 will increase from 7.2 % to 13 % by 2030.

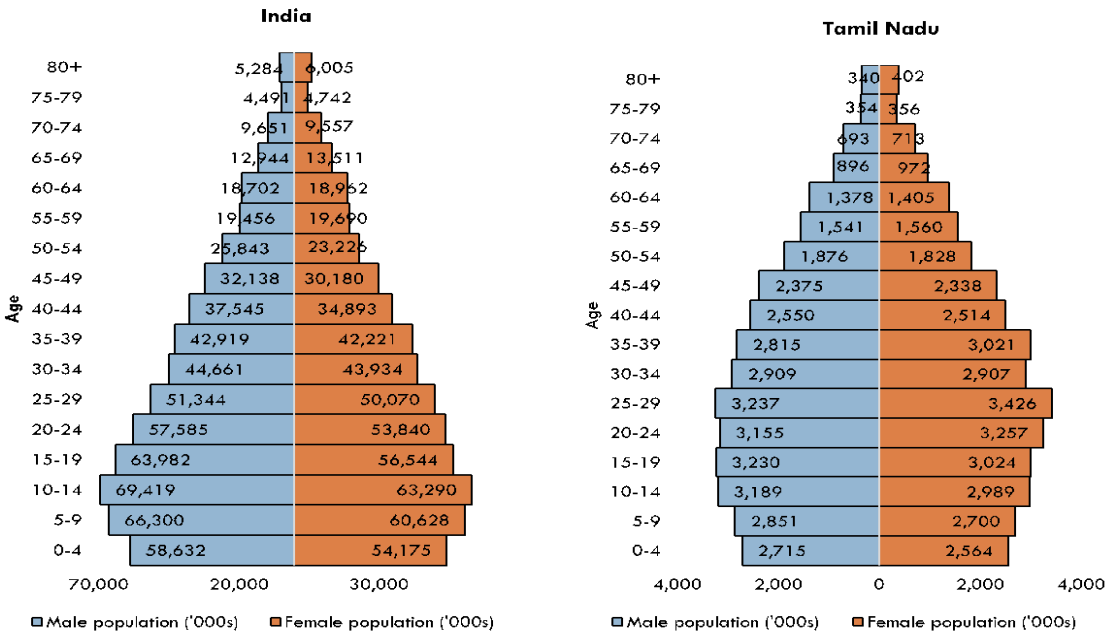


Figure 1: Population pyramids for India and Tamil Nadu, 2017

Source: Projections based on 2011 India Census

Tamil Nadu has already achieved the Millennium Development Goals (MDG), and the state is also far ahead of other Indian states in progressing towards achievement

[1]Ariyalur is the least urbanized district (only 11 percent of the population resides in urban settings), while Kanyakumari has the highest proportion of urban population (83 percent of the population lives in urban areas).

of the Sustainable Development Goals (SDG). As per Sample Registration System (SRS) data, between 2010 and 2017, infant mortality has declined from 24 to 16 deaths per 1000 live births, respectively, and is significantly below the national infant mortality rate of 33 deaths per 1000 live births. Maternal Mortality Ratio (MMR) declined from 90 deaths per 100,000 live births in 2010-2012 to 63 in 2018-19 compared to the National MMR of 122.

Despite the impressive gains in Reproductive and Child Health (RCH) outcomes, challenges in RCH service delivery remain. Aggregated state-level performance also masks significant variations across districts. While RCH service utilization has increased significantly, quality of care remains a challenge. Despite near-universal facility-based delivery, and recent reduction in maternal deaths, the MMR remains higher than in countries at similar levels of development. Rates of caesarean section births stand at 34 percent, which is substantially higher than global recommendations of 15 percent. As caesarean sections are associated with increased short-term risks, increased risks for future pregnancies, and higher costs, the elevated rate of caesarean sections is another indication of challenges in the quality of maternal health care. In addition, there is also scope for improvement in age-appropriate immunization and an uptake of modern methods of family planning services.

In addition to the unfinished agenda on RCH, Tamil Nadu is dealing with a growing burden of non-communicable diseases (NCDs). NCDs account for nearly 69 percent of deaths and 65 percent of disability-adjusted life years (DALYs) in Tamil Nadu. In 2017, cardiovascular disease, diabetes, and cancer were the leading causes of death among those above the age of 40. Almost one-third of the adult population is overweight, and 12 percent of women and 10 percent of men have hypertension (NFHS-4, 2015–16). NCDs are the leading cause of death for individuals above the age of 40, while suicide and violence, cardiovascular disease and transport injuries are the leading causes among ages 15-39 (Fig 2). The incidence of suicide and violence is particularly high among those aged 15-39.[2]

[2]ICMR, PHFI, and IHME (2017).

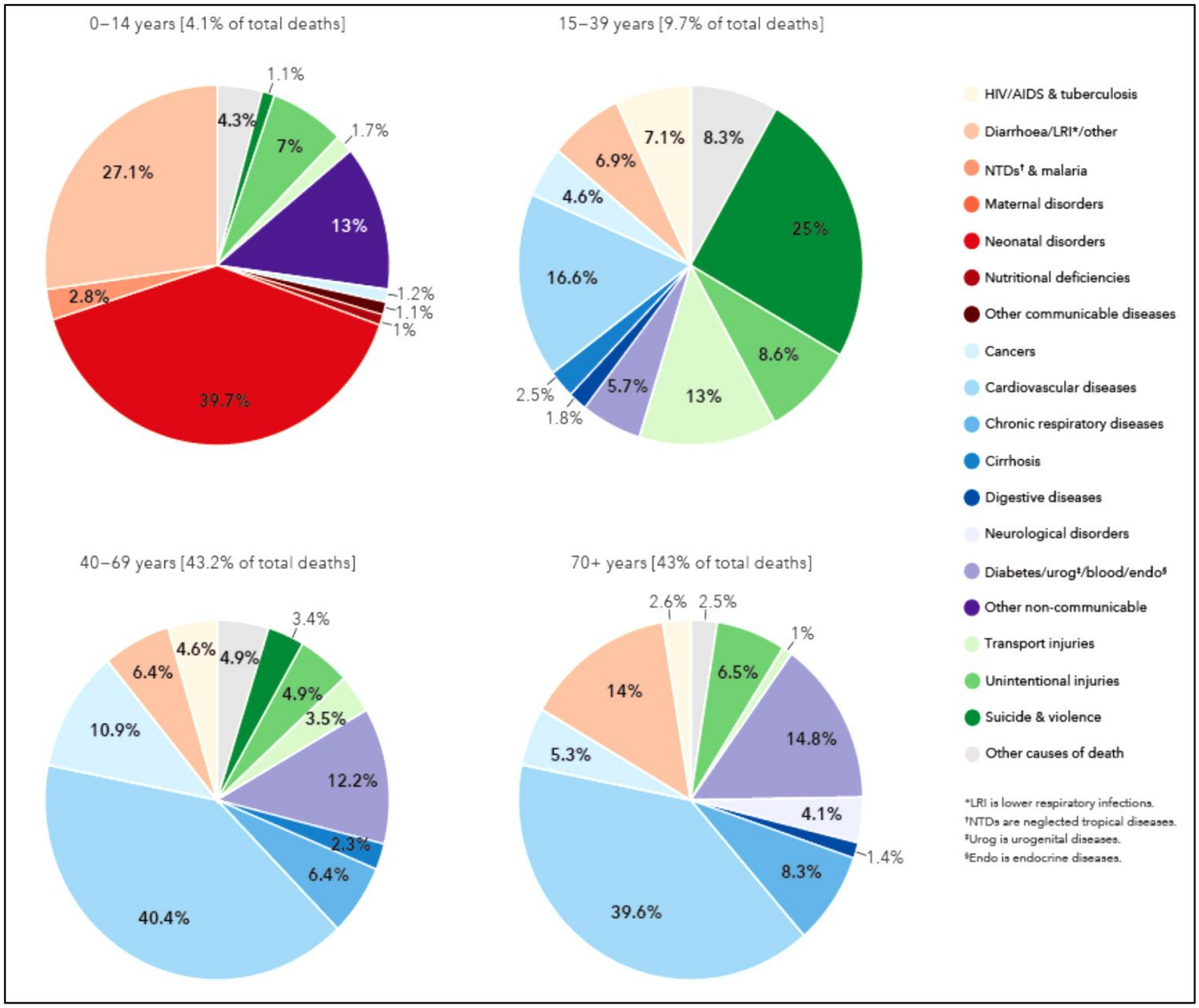


Figure 2: Cause of Death by Age Group, 2016

Source: Institute for Health Metrics and Evaluation (2018)

The National Mental Health Survey estimates that nearly 6.7 million adults (18 years and above) and 380,000 adolescents are likely to be suffering from one or more mental health problems in Tamil Nadu. More than 11 percent of the population

suffers from a common mental health problem, including depression, anxiety disorders, and substance use disorders.

Tamil Nadu has the highest number of road traffic accident deaths per capita in India. The number of road traffic accident cases has increased significantly since 2011–12, rising from 130,226 to 228,549 cases in 2017–18, although the number of deaths has fluctuated around 16,000 annually over this period. The mortality rate from road traffic accidents at 22.4 deaths per 100,000 population is substantially higher than the India average of 16.6 deaths per 100,000 and is also above the rates observed in neighboring states.

2.2. Health Financing

The Government of Tamil Nadu is providing a total budget which amounts to nearly Rs. 13,000 crores per year for the health sector, which includes primary, secondary and tertiary level of services. Government of Tamil Nadu is providing assured healthcare services to all the walk-ins in all public sector institutions.

It also provides support to the individuals with annual family income less than Rs 72,000 through strategic purchasing under the state sponsored insurance scheme- the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS). The CMCHIS provides coverage for primarily various inpatient services both in public and private hospitals in order to reduce out-of-pocket and catastrophic health expenditure. CMCHIS provides non-contributory cashless coverage of explicitly defined diagnostic, secondary and tertiary procedures at empanelled public and private facilities up to a maximum annual amount of INR 500,000 per family.

The state has also been a forerunner in bringing many international stakeholders to address certain key areas in health care delivery. Tamil Nadu Urban Health Care Project funded by the Japan International Cooperation Agency (JICA), is an example in this regard. The World Bank has also come forward for the second time in 2019 to provide funding support of Rs. 2000 crores over five years for implementing the Tamil Nadu Health System Reforms Program (TNHSRP).

2.3. Organization of the health system

The state has 37 Revenue Districts. For the management of public health services, the State has been divided into 42 Health Unit Districts in addition to Chennai Corporation. Tamil Nadu State has emerged as a model state in the country to provide quality health care to its entire population and health systems strengthening of the state is seen both as a developmental imperative and as an ethical commitment to its people. The Tamil Nadu model of public health is not only renowned for its historicity but also in providing quality public health services to its people.

The Department of Health & Family Welfare (H&FW) has three key Directorates - the Directorate of Medical Education, Directorate of Medical and Rural Health Services and Directorate of Public Health and Preventive Medicine which are functioning respectively for delivering tertiary, secondary and primary health care services to the people, integrated with Commissionerate of Indian Medicine and Homeopathy. These are also supported by other directorates, Limited Companies, Societies and Corporations under Health & Family Welfare department. The department has staff strength of over 1,23,000 health work force catering for an average of 650 thousand outpatients and 70 thousand inpatients per day. The Doctor patient ratio is 1: 593 and Nurse Patient ratio for the state is 1: 226.

Primary health care is provided by community health centers, primary health centers, and health sub-centers (Table 2). Secondary care is delivered at taluk and non-taluk hospitals and district hospitals, while tertiary care is delivered at medical colleges and multi-speciality hospitals. Tamil Nadu also has a stated policy of establishing Medical Colleges in every district; with 24 existing Medical Colleges and an additional 11 planned for upgradation in the next year, Tamil Nadu has the highest number of Government Medical Colleges in the country.

Table 1: Tamil Nadu public sector health facilities

Type of Health Facility	Number
Primary health care	
Community health centers (CHCs)	400
Primary Health Centers (PHCs)	1885
Health sub-centers (HSCs)	8713
Secondary care	
Taluk and non-taluk hospitals	278
District hospitals	31
Tertiary care	
Medical colleges	24
Hospitals attached to medical colleges	50
Multi-speciality hospital	1
Dental college and hospital	1

Source: Tamil Nadu Policy Note of Health and Family Welfare 2019-2020.

2.4. Utilization of Healthcare

In Tamil Nadu, the public facilities are utilized more than private facilities both for outpatient care and inpatient care as compared to the national picture. The share of public facilities for outpatient care is 54%, which is a significant increase from 34.6 % (in 2014) in Tamil Nadu. There was a significant increase in both rural (20.9%) and urban (11.9%) areas[3].The share of public facilities for hospitalization has increased to 49.9% in 2017-18, from 34.6% in 2014. The share of public facilities in rural and urban areas increased from 40.4% to 56.9% and from 29.3% to 42.2%, respectively[3].

[3] NSSO 75th Rounds (2017-18), Ministry of Statistics and Program Implementation, GoI

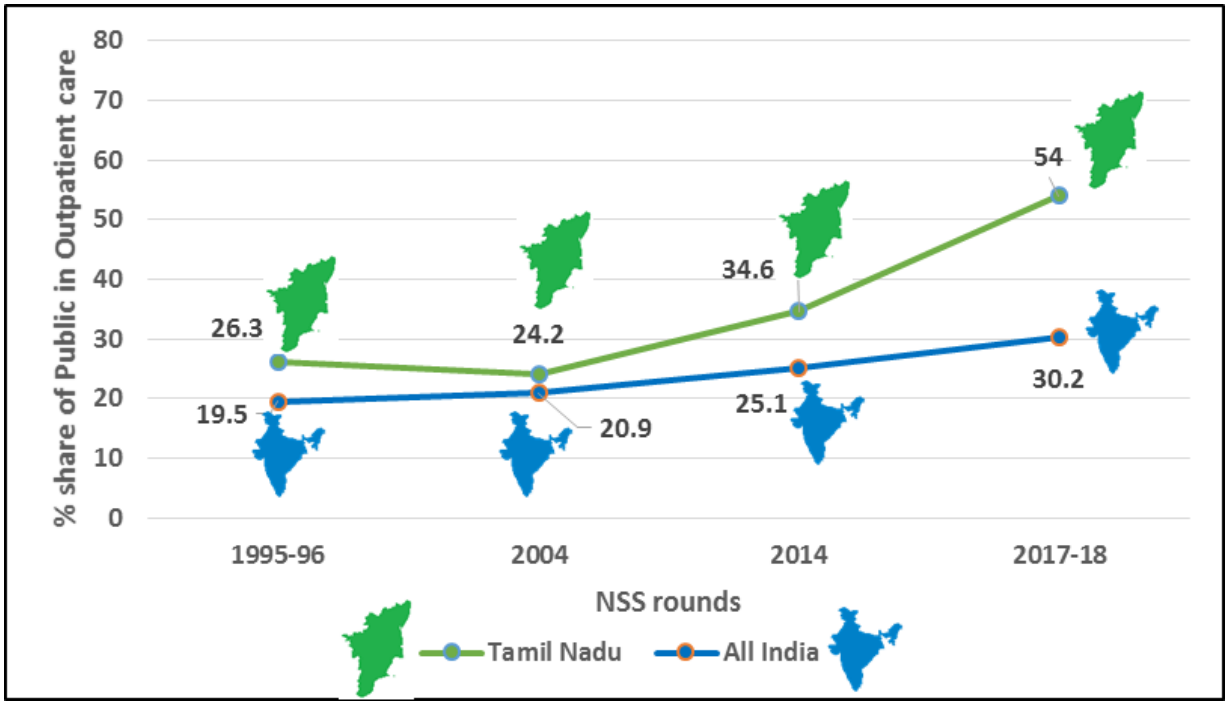


Figure 3: Share of public facilities for outpatient care in Tamil Nadu and all India[4]

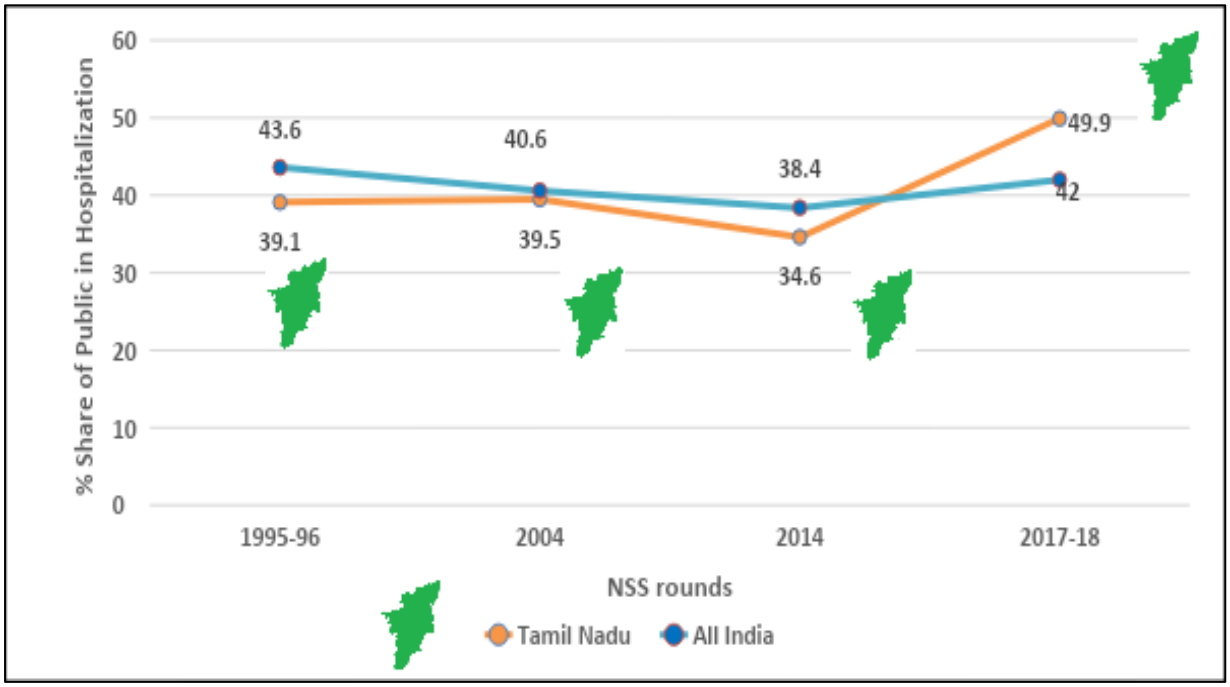


Figure 4: Share of public facilities for hospitalization in Tamil Nadu and all India[4]

[4]Centre for Technology and Policy, Indian Institute of Technology, Madras, February 2020

State Health Programs and Interventions

An efficient public health system in the state helped the state to eliminate or eradicate many infectious diseases several years before the country achieved it. Small pox was eradicated in 1977, Polio in 2004, Maternal and Neonatal tetanus eliminated in 2006, Guinea worm disease not reported since 1983 and declared eradicated in 1995, Yaws cases not reported since 2006 and eradicated in 2015 and leprosy elimination goal achieved in 2005.

Significant gains in maternal mortality and maternal health have been made and currently, the state has near universal institutional skilled deliveries. Much of this success can be attributed to Tamil Nadu's establishment and scale-up of Comprehensive Emergency Obstetric and Newborn Care centres across the state. Tamil Nadu is the only state in India giving Rs 18,000 as financial assistance per pregnant mother for compensating for the loss of wages during pregnancy and to meet the expenses on nutritious diet under the Dr.Muthulakshmi Reddy Maternal Benefit scheme.[5]

Tamil Nadu is currently pursuing opportunistic screening at all health facilities in the state but to close the gaps in the current program and strengthen the community linkages, the Government introduced the Population Based Screening (PBS) to improve NCD detection, referral and follow-up by enumerating all the population in the community through House-to-House visits. The program of PBS was conceptualized with the main objective of improving the screening rate and follow-up rate, as well as control rate, by involving a dedicated Women Health Volunteer, who is from the Tamil Nadu Corporation for Development of Women (TNCDW).

The Institute of Mental Health (IMH), Chennai is the State Nodal Centre for implementing the District Mental Health Programme (DMHP). The state has also constituted a State Mental Health Authority (SMHA) to enhance the monitoring of mental health institutions.

[5] This is in memory of Dr. Muthulakshmi Reddy, who was also the first and only woman candidate to join the Madras Medical College in 1907 and later became the first woman surgeon in the country. She also holds the unique distinction of being the first Indian woman legislator, a campaigner of women's rights; and the driving force behind one of the biggest cancer institute in India.

Special initiatives by Government of Tamil Nadu in Mental Health:

- Institutional Screening for mental health disorders is being done by utilizing the services of trained NCD Staff Nurses in all the health care facilities in the state.
- Community Based Screening for mental health disorders have been incorporated into the Population Based Screening Program for NCDs by Women Health Volunteers / Accredited Social Health Activist (ASHAs) through an incentive model.
- Follow up of all suicide attempted victims with mental health counselling at least with one visit in the nearby PHC by the Satellite Clinic
- Ensuring free drug availability up to PHC level
- Utilization of services of Rashtriya Bal Swasthya Karyakram (RBSK) Medical Officers for early identification of mental health disorders among school children.
- Provision of counselling services for suicide attempted victims by a trained Psychologist from Institute of Mental Health, Chennai.
- De-addiction centres have been established in Cuddalore, Kancheepuram and Tiruppur.
- Self-harm cases reported through Tamil Nadu Accident and Emergency Care Initiative (TAEI) Centres will be counselled for a period of 18 months with the consent of the patient.
- Establishment of Emergency Care and Recovery Centres with 50 beds cater to the needs of wandering mentally-ill.
- Mentally ill patients are shifted through Retrieval Vehicles for mentally-ill (1 per district).
- Linkage of DMHP with Non – Governmental Organization (NGOs) in 10 districts for performing door-to-door survey to screen mentally ill patients & to create awareness about mental illness in the community.

The Government of Tamil Nadu has recognized the alarmingly rising morbidity and mortality due to emergency conditions and has been implementing the Tamil Nadu Accident and Emergency Care Initiative (TAEI), since June 2017, following a 'Systems Approach' as the way forward and has been collaborating with

stakeholders from transport, education, highways and police departments for achieving the Sustainable Development Goal 3.6.

TAEI focuses on strengthening post-crash interventions that falls on 3 major components namely prehospital, in-hospital and rehabilitation care, such that the right person is treated by the right person at the right place within the golden hour. The state has extended its role in setting up exclusive Emergency Departments with trained Human Resources (HR) in 80 designated TAEI centres that are geographically mapped as Level 1, 2 and 3 Trauma care centres and the policy underlines the fact that emergency care is an organizational concept and not just an infrastructural one in Tamil Nadu's context.

With a plethora of cross-cutting programmes and special initiatives such as the National Health Mission, AIDS Control Society, State TB Cell, Maternal and Child health initiatives, Indian Medicine, and TAEI the department is fully involved in both prevention and treatment to ensure that the health needs of the citizens are met in the state.

Another major reform in the health sector of Tamil Nadu was the formation of Tamil Nadu Medical Services Corporation (TNMSC) in 1995, an autonomous body regulating the drug procurement and distribution alongside promoting the rational use of generic drugs at an affordable cost. This has ensured the reliable supply of good-quality drugs at a low price to all Government health facilities which in turn led to increased patient satisfaction and greater utilization of public health facilities and lowest out-of-pocket expenditure for drugs and diagnostics in the country.

Tamil Nadu has been adjudged as the best state in the country in terms of deceased organ transplantation and also has the distinction of receiving four consecutive Best State Awards for the years from 2015 to 2018. Recently, the state also became the first in the country to do bilateral hand transplant in a government facility.

A detailed **Annexure (I)** depicts the health & healthcare landscape of Tamil Nadu (attached at the end of the document)

3. Gaps and challenges

Even though the state is on track in its pursuit to achieve SDG 3 targets, there are many issues and challenges ahead, which the state needs to address in its journey in achieving universal healthcare for its entire people.

The major issues and challenges ahead of the state in its pursuit to achieve UHC is mentioned as below:

3.1. Epidemiologic and demographic transition happening in the state (NCDs, Trauma and Injuries, Mental Health Issues): The Global Burden of Diseases (GBD) report was an eye-opener to the state, has clearly shown the epidemiologic transition happening in the state. The report reveals that Non-Communicable Diseases (NCD) constitute 69.2 per cent of the mortality from various diseases in Tamil Nadu with cardiovascular diseases alone constituting 36.1 per cent of the mortality. The mortality due to injuries also accounts for 13.5 percent. With regard to the Disability Adjusted Life Years (DALYs), 65.3 percent is due to NCDs of which major contribution is borne by cardio vascular diseases.

In spite of great progress under TAEI, challenges remain. Interfacility transfers (IFTs) as a proportion to total calls to 108 remains high at 41%, triaging at pre-hospital and in-hospital doesn't fully follow standard practices and the absence of a trauma registry are a few areas that need improvement.

According to the report on Mental Health Survey, 2016 by National institute of Mental Health and Neurosciences (NIMHANS), mental illness including self-harm is the 3rd leading cause of DALYs lost and depressive disorders as the 13th leading cause of DALYs lost in the state of Tamil Nadu.

Tamil Nadu also has the second highest suicide rate in the country (23.4 suicides per 100,000 population) (National Mental Health Survey, 2015). The policy insists on bringing more focus to this domain of mental health through a holistic approach.

Ischaemic heart diseases, diabetes, sense organ disorders, road injuries, self-harm, suicide, falls, low back and neck pain ailments, migraine, chronic kidney related diseases and depressive/anxiety disorders witnessed a larger loss of healthy years or DALYs in Tamil Nadu than the national mean of these ailments. Mental health issues (other than diseases) are also posing a huge challenge to the Tamil Nadu health systems.

Adding to this there is also a huge demographic transition happening in the state, and with low fertility and an aging population, NCDs will continue to escalate. The ageing population also poses a great challenge to the provision of comprehensive palliative care and geriatric care.

3.2. Unfinished Reproductive Maternal Newborn Child Health and Adolescent Health (RMNCH+A) agenda: Reduction in maternal, infant and under 5 mortality over the years has shown a substantial improvement. However, age-appropriate vaccinations, anaemia among pregnant mothers and adolescents, malnutrition, family planning service utilization in some parts of the state and high C-section rates in both public and private facilities remain concerning. These issues are indicative of quality of care and equity gaps.

3.3. Emerging and re-emerging Infectious Diseases: Even though Tamil Nadu is the front-runner in prevention, control and treatment of communicable diseases, the emerging infectious diseases is posing a huge challenge to Tamil Nadu due to high migratory rate (in-migration as well as out migration). The major emerging infectious diseases includes Nipah, SARS, Corona, Avian Influenza etc. and re-emerging infectious diseases includes Ebola, Chikungunya, Japanese encephalitis etc.

3.4. Quality of Care: While Tamil Nadu has made substantial strides in increasing health service utilization, it continues to face challenges in quality of health services. Quality of care challenges also underlie many of the remaining challenges in RMNCH+A and explains why patient outcomes are not as expected given the service coverage.

3.5. Health Financing and Out-of-Pocket Expenditure (OOPE): A new study estimates that implementing SDGs in India alone by 2030 will cost around US$14.4 billion[6]. The states have to play a pre-eminent role in mobilizing these resources for improving the healthcare of their people, given that health is a state subject. Even though the OOPE in public facilities in Tamil Nadu is one among the lowest in the country, the OOPE at private facilities is one among the highest.

Table 2: Mean OOPE for Hospitalization Episodes (in INR) in Tamil Nadu: 75th NSSO round

	Covered Public Funded Health Insurance		Not Covered	
	Public (Rs.)	Private (Rs.)	Public (Rs.)	Private (Rs.)
NSS 75th round (2017-18)*	1026	24244	1116	34629

*including childbirth

3.6. Community engagement and ownership for health program: One of the weakest linkages in Tamil Nadu's healthcare delivery mechanism is the weak community engagement and ownership. While the state has achieved a great deal to improve the interaction between policymakers and providers (systems of reviews and supportive monitoring) and between people and providers (village committees, hospital societies, patient satisfaction surveys etc.), the direct linkage between people and policymakers seems to have received the least attention and remains a gap which needs to be addressed. The weak linkage between Panchayat Raj system and health department is also an area of concern.

3.7. Addressing wider social determinants of health: There is a consistent relationship between health and inequities in social determinants of health including poverty, education, water, hygiene and sanitation, unemployment, food security, gender and caste based discrimination and violence etc. The addressing of these determinants is quite complex and is beyond the scope and ambit of the health department.

[6] Technology and Action for Rural Advancement (2015)

3.8. Issues of monitoring, evaluation & accountability: Tamil Nadu has been a frontrunner in establishing a Health Management Information System (HMIS). However, substantial challenges remain. The fragmented data system, non-availability of certain data, periodicity issues and incomplete and poor-quality data are important challenges the state currently experiences. The past record also indicates that the state has not adequately measured patient outcomes. There is no primary validation of the data collected at the field level and no robust accountability systems in place. Measurement has often also focused on inputs than on results. The state believes in data driven decision-making, and to enable this, the Health Management Information System (HMIS) is currently being revamped.

3.9. Gaps in Intra-departmental coordination creating fragmented health systems: With the many directorates and societies implementing the policies and programs as well as service delivery at the front lines, integration of service delivery, programming, financing and measurement/monitoring is challenging. Intra-departmental fragmentation contributes to these inefficiencies which need to be tackled by the health department.

3.10. Inter-departmental and intersectoral coordination: For any state to prosper in its health outcomes, intersectoral and inter-departmental coordination is utmost important. Since most of the health goals and targets (under SDG, NITI Aayog, MoHFW) are interlinked, support and coordination with other departments and sectors including education, food safety, road safety etc. is highly warranted yet currently lacking.

3.11. Antimicrobial resistance (AMR) – a growing burden: Antimicrobial resistance (AMR) is a major public health problem across the globe and in the country and the state. In Tamil Nadu, the studies for Healthcare Associated Infections (HAI) in Tertiary level hospitals attached Medical Colleges have observed higher degree of antimicrobial resistance among the strains identified and cultures.

4. Vision and Objectives

Vision

Accelerating improvements in health status of the people of Tamil Nadu with a special focus on the most vulnerable and marginalized in the society, towards building a healthy and equitable society, improving quality of life through a comprehensive, robust and sustainable health systems approach which is accessible, affordable and quality driven.

Objectives

1. To strengthen the health system to provide quality driven and people-centric care and delivery of preventive, promotive, curative, rehabilitative and palliative health care services to all the people.

2. To ensure universality of access and inclusiveness in providing healthcare with concentrated policy directives to address social, economic and environmental determinants of health.

3. To strengthen quality of care with a greater focus on the clinical processes, competent care, patient experience through continuous quality improvement of health facilities, services, programmes, schemes, medical logistics and supplies, medical education and continuing professional development.

4. To strengthen the system readiness to address the existing epidemiologic burden and emerging health issues, challenges, and create innovative and appropriate models of health care delivery.

5. To strengthen advocacy and health education of the public, to create awareness of health issues and promote preventive health behaviours.

6. To promote citizen engagement to improve accountability and citizen empowerment through more community centric initiatives in the health sector with multi-stakeholder collaboration.

5. Guiding principles

5.1. Achieving SDG for Health: The policy document maintains consonance with SDG3, which ensures universal access to high quality, effective and affordable healthcare to all and minimizing incidence and mortality from communicable, non-communicable and lifestyle diseases by 2030.

5.2. Progressive achievement of Universal Health Coverage (UHC): UHC is central to the SDG agenda. The UHC piloting in Tamil Nadu also has proven that provision of comprehensive primary health care services near to the community yielded improved patient outcomes with respect to access, affordable care and from equity point of view. The state which is currently going through the epidemiologic transition has conceptualized expanded service delivery with focus on NCD services without compromising Maternal and Child Health(MCH) services & communicable disease management under the ambit of UHC throughout the life course. The services provided shall be responsive to local needs or contexts and should have intact linkages – forward, backward and lateral.

The policy envisages that no person in the state shall be pushed back to impoverishment due to healthcare spending. The policy advocates public systems strengthening as the important tool for this objective and cost containment in private sectors through a basket of modalities including insurance with clear checks and balances.

The central epithet of UHC is equity and the policy emphasizes that care must be taken to prevent exclusions on basis of gender, social, cultural, ethnic or economic grounds. Health Policy should make sure about the inclusiveness of all people by promoting their rights to health and healthcare.

The state realizes that the tail end facilities (HSCs) have been the weakest link in the entire edifice of public healthcare delivery system. From an equity perspective, it is logical to first strengthen these facilities providing comprehensive primary care

services. Differential healthcare services shall be provided at different levels of care as per patient's convenience to bring in more patient satisfaction. It would also require the participation of communities, families and individuals and there shall be a provision for feedback mechanism from the patient side, in order to measure the quality of service they had received and also to know about provider client relationship.

The policy recognizes that the healthcare services should be served by maintaining the highest quality, which is safe to the people as well as to the environment, timely, equitable, effective, and conveniently accessed by all and also to provide with dignity and confidentiality in all facilities across all sectors being assessed by the community. The term 'quality' in this document doesn't delimit with few outcome indicators based on quality assurance programs but also emphasizes upon the processes and larger impacts it makes on the health systems.

5.3. Efficiency: Healthcare efficiency is very critical in health sector and the policy document envisions efficiency from a broader perspective (other than the ratio of output to the input). The policy advocates for better allocation and judicious use of health resources for the betterment of society and avoid unnecessary leakages in the system.

5.4. Evidence-based service delivery and a culture of continuous learning: The health system should deliver its services based on scientific evidence and constantly look for an improvement based on the knowledge and evidence, obtained from the analysis of data and learnings of national and international knowledge partners. Evidence-based service delivery also takes into account the local context to appropriately translate evidence into practice.

5.5. Medical Pluralism: Health system should be designed in a way that, alternate systems of medicine are encouraged to do their evidence-based practices that should benefit the patients, ultimately helping in achieving overall health goals and objectives. The policy gives emphasis on medical pluralism.

5.6. Strengthening community linkages: It is essential for the Government to establish a system to engage with the public, enabling people from the community

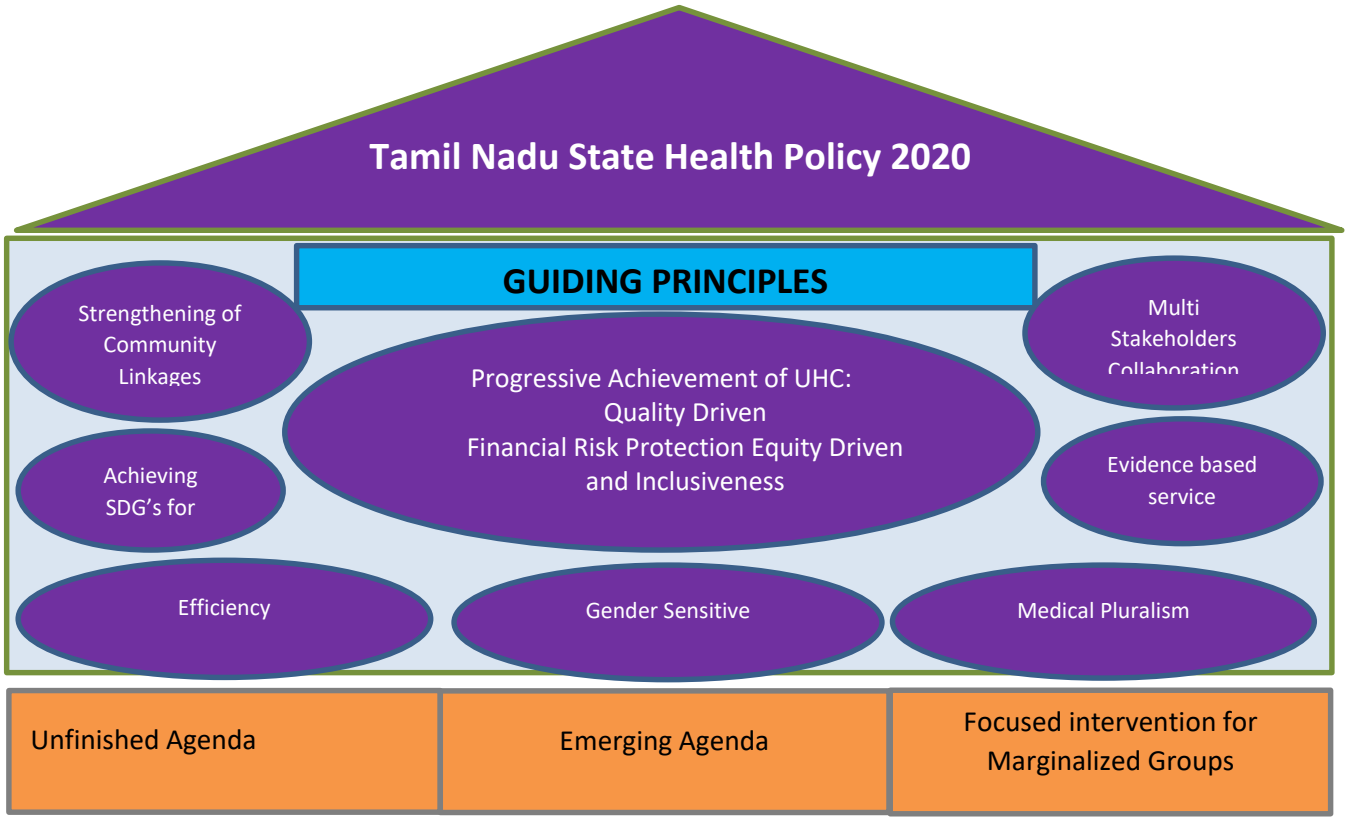
themselves to be responsible to take care of their individual health and also to promote and sustain the health of the community as a whole. The National Health Mission has created some spaces for community participation in the form of Hospital Development Societies / Patient Welfare Societies and Village Health Sanitation and Nutrition Committees (VHSNC) -but has more scope for further strengthening. The policy envisions that health system should build community linkages and ownership and also to reinvent the role of community as active co producers rather than mere consumers of healthcare. The state believes that this will lead to shifts in mind-sets of providers and citizens, and a more balanced perspective reflected in consensus-based resolutions for better health outcome of the state.

5.7. Multi-stakeholder Collaboration: The policy drives for engagement of health sector systemically across government sectors and also with other stakeholders and partners for improved health outcomes. The policy demands for widest level of partnerships with academic institutions and other knowledge partners including national/international universities for knowledge transfer and cross-country learning.

5.8. Gender sensitive and strong emphasis on women's health: The TNSHP echoes the same reflections as of the National Health Policy (NHP) 2017 with regard to women's health and gender main streaming. In addition to that, the policy wants to highlight that Women's health issues and concerns go far beyond maternal health and the health systems should be strengthened further to seriously address these issues through a gender sensitive approach. The health policy also advocates for the empowerment of women as a key determinant to improve the overall health status of the state. The policy reiterates that gender-based violence at any place or due to any circumstances shall be dealt with very seriously and demands that survivors of those events should be treated with utmost dignity both in public and private health facilities. The policy advocates bringing in men also as a part of all gender equity campaigns and activities.

6. Key Policy Priorities

Figure 5: TNSHP Framework



6.1. Sustainable Agendas

6.1.1. Reduce equity gaps & improve quality in RMNCH+A:

Improving the maternal and child health and their survival are central to any State's social development. The policy proposes that RMNCH+A strategy be built upon the concept of continuum of care, holistic in design, encompassing all interventions aimed at improving reproductive, maternal, new-born child, and adolescent health under a broad umbrella, and focusing on strategic lifecycle approach. The policy also focuses on linking MCH services to other components like family planning, HIV, gender, preconception and prenatal diagnostic techniques and linking home and community-based services to facility-based services. The strategies also should ensure linkages, referrals and cross -referrals between and among various levels of health care system and with multi stakeholder involvement to create a continuous care pathway, and to bring synergistic effect in terms of overall outcomes and impact. The policy elicits need for a focused and coordinated effort during the last week of pregnancy and in first week after childbirth for achieving the last mile.

Tamil Nadu is considered as a pioneer in the implementation of the Family Welfare Programme in the country. Family welfare services are provided through the government and private health facilities to the eligible couples. Decrease in birth rate was achieved due to paradigm of shift from "Target based approach" to "Community Needs Assessment Approach" where importance is given to meet the unmet needs for family planning services and improving the Maternal and Child Health services. There is more scope to increase the awareness among the population to choose and adopt their convenient contraception methods especially spacing methods (e.g. IUCD, OCPs, condoms etc.). The policy thrusts to focus the family welfare program on birth spacing and adapting permanent methods for high order birth.

Tamil Nadu state has shown improvement in sex ratio between two census 2001 to 2011 from 987 to 996, but the focus should be to reduce the inter-district variability and improve sex ratio at birth. To reduce the equity gap in sex ratio, regulatory approach such as Pre-Conception and Pre-Natal

Diagnostic Techniques Act, 1994 and other developmental approaches such as Cradle Baby Scheme, Chief Minister's Girl Child Protection Scheme, Beti Bachao Beti Padhao Scheme should be prioritized. The policy advocates for extensive community-based IEC strategies.

6.1.2. Interventions to Address Malnutrition and Micronutrient Deficiencies:

The present efforts such as Iron Folic Acid (IFA) supplementation, calcium supplementation during pregnancy, iodized salt, Zinc and Oral Rehydration Salts/Solution (ORS), Schemes such as POSHAN Abhiyaan under Integrated Child Development Services (ICDS), Vitamin A supplementation and other initiatives from Food Safety and Standards Authority of India (FSSAI) needs to be further strengthened.

The policy also thrusts to strengthen the facility based and community-based management of Severe Acute Malnourished Children (SAM). Interventions such as promotion of traditional food practices in the community, home based nutrition care and cost-effective measures such as kitchen garden and community gardens should be promoted in this regard. The policy pushes for strengthening the health system and community linkages to identify, refer, manage and regularly monitor the under nourished children to reduce the incidence and prevalence of malnutrition.

6.1.3. Fill the gaps in addressing communicable diseases:

Tamil Nadu is the front-runner in prevention, control and treatment of communicable diseases. Vaccines for Vaccine Preventable Diseases (VPDs) namely Diphtheria, Pertussis, Tetanus, Poliomyelitis, Tuberculosis, Hepatitis B, Haemophilus Influenza B, Measles, Rubella and Japanese encephalitis and Rota viral diarrhoea are provided under the Universal Immunization Programme in Tamil Nadu. The policy advocates to ensure cent percent immunization against VPDs for all children with universal coverage with special focus on the marginalized groups.

Universal Immunization: The priority would be to improve immunization coverage with quality, safety and vaccine security as per National Vaccine Policy 2011. The introduction of newer vaccines based on epidemiological considerations is essential, and also to have better system to test the efficacy of the vaccines. The focus will be to build upon the success of Mission Indradhanush and strengthen it. The policy also recognizes emerging challenges such as vaccine hesitancy.

Malaria, filaria, dengue, Chikungunya and Japanese encephalitis are the major communicable diseases under the National Vector Borne Disease Control Programme (NVBDCP) and the policy advocates for a robust integrated approach to vector borne diseases control by strengthening daily surveillance, entomological surveillance, Water Sanitation and Hygiene (WASH), extensive IEC and convergence with other departments & sectors (local body, municipal administration, education, Panchayat Raj, rural development etc.).

Daily monitoring of infectious diseases through VBDCP Division, Integrated Disease Surveillance Programme (IDSP) Division, 24x7 control room, immunization division, Epidemic division and media surveillance are in place but fragmented. The policy thrusts to converge the daily surveillance systems working under these various divisions and enhance the surveillance from hospital-based information systems to elicit rapid field response.

Epidemic Control Activities at the State and District Level: The state level Epidemic Monitoring Committee and the Public health disease surveillance unit, coordinates with all departments and stakeholders for effective monitoring and control of the communicable diseases. At the district level, the committee functions under District Collectors. This will ensure regular cleaning of water tanks, testing of samples, preventing sewage contamination, anti-larval measures, effective solid waste management practices, and to keep check for an outbreak. The policy thrusts for strengthening cross boarder exchange of information on infectious diseases.

TB-Free Tamil Nadu by 2025: The state has already drafted the Strategic Document for TB-Free Tamil Nadu by 2025, which clearly spells out key strategies to achieve "TB-Free Tamil Nadu by 2025." The strategies are aimed at achieving the notification rates for each year from 2019 based on the projections, to move towards TB elimination levels by 2025. It was developed based on the four principles of the National Strategic Plan (NSP) 2017-2025 namely, 'Detect-Treat-Prevent-Build'. Tamil Nadu, by implementing the key strategies as per Strategic Document will be able to achieve the goal 'TB-free Tamil Nadu by 2025'. The policy document emphasizes on implementation of the strategies laid down in TB-Free Tamil Nadu by 2025.

HIV/AIDS: Tamil Nadu was the first state in the country to set up an AIDS Control Society in 1994 and set an example for other states to follow. The state works towards ending AIDS as a public health threat by 2030. The Government of Tamil Nadu is committed to eliminate HIV and Syphilis amongst newborns through universal screening of pregnant women for HIV and Syphilis as an essential component of the Antenatal Care (ANC) services package. The Elimination of Mother to Child Transmission (EMTCT) services are being implemented in close collaboration with Maternal and Child Health (MCH) programme of the National Health Mission (NHM) to scale up prevention and care interventions amongst the ante-natal mothers through primary prevention, family planning, voluntary counselling, confidential testing, lifelong Anti- Retroviral Therapy (ART) and counselling on infant feeding practices. The state's achievements in HIV control owe a lot to both its emphasis on prevention, its partnership with active and vibrant communities and civil society and evidence based programming. The policy further recommends focused interventions on the high-risk groups (men who have sex with men, transgender, female sex workers, injectable drug users etc.) and prioritized geographies. The policy also assures access to blood and blood safety across the state.

6.2. Emerging agendas:

6.2.1. Addressing the Emerging infectious diseases through a robust surveillance system:

Even though the state is having a robust surveillance system, the emerging and re-emerging diseases (SARS, Corona, Nipah etc.) strain the health systems response which mandates the community participation as an inevitable intervention. Tamil Nadu shall adopt the “One Health Initiative”, where the human, animal and environmental health are discussed under one umbrella with a view to share disease intelligence especially on Zoonotic and Vector Borne issues. The policy thrusts to bring it in complete action to set up a monitoring mechanism for disease dynamics.

The policy thrusts on establishing strong linkages between Medical Colleges and District Headquarters Hospital with the public health department for managing epidemics and outbreaks. The policy also pitches for establishing well-equipped regional apex labs with biochemistry, pathology and microbiology departments with linkages with tertiary hospitals.

International Health Regulations (2005): The IHR (2005) has a set of rules to prevent, protect against, control and respond to the international spread of disease under public health emergency. It has a global alert outbreak response system with national surveillance to ensure global public health security. Vaccination against certain diseases like yellow fever and airport and seaport screening for international travellers are regularly being done to monitor the spread of diseases notified by WHO as Public Health Emergency of International concern.

6.2.2. Improve prevention and management of NCDs and mental health:

This policy lays emphasis on addressing NCDs and mental health, guided by the NCD Strategy 2020-2025 (including mental health) and the “State Mental Healthcare Policy and Implementation Framework 2019. The NCD Strategy

2020-2025 envisions that Tamil Nadu becomes “a State where everyone is free from preventable morbidity and mortality due to NCDs”.

The NCD Strategy emphasizes the following areas on NCD prevention and management: (a) health promotion and prevention of risk factors; (b) early detection and treatment of NCDs (c) Regular follow-up and improving control rate (d) secondary prevention and management of NCD related complications (f) Comprehensive rehabilitative care including Palliative and Geriatric care (e) strengthening community mechanisms for NCD control (Population based NCD Screening, Patient Support Group formation, community focused IEC interventions etc.).

The interventions in NCD Strategy have been selected based on the challenges identified in the situation analysis combined with global evidence on what works to address NCDs. These interventions are consistent with WHOs guidance on “best buys” and other recommended interventions to prevent and control NCDs.[7] The interventions will help to strengthen service delivery at all levels of care, ensure multi sectoral collaboration to combat NCDs and create an enabling environment for the public to adopt lifestyle modifications as a routine practice.

Even though the State leads in Organ Transplantation, the policy identifies the critical need and demand for tissue and organ transplant and encourages widespread public awareness to promote voluntary donations.

Tamil Nadu State Mental Healthcare Policy and Implementation Framework: The Tamil Nadu Government has adopted the “State Mental Healthcare Policy and Implementation Framework” in 2019 with the following vision:

> *“*To promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by

[7]WHO NCD Best Buys; WHO PEN. Additional resources can be found on the WHO NCDs Tools webpage

providing accessible, affordable and quality health and social care to all persons through their lifespan, within a rights-based framework”

This policy and the NCD Strategy reaffirm the commitment of the State to address mental health issues under the “State Mental Healthcare Policy and Implementation Framework”

6.2.3. Comprehensive Trauma and Emergency Care:

The key organizational process and paradigm shifts in emergency care that has been introduced under Tamil Nadu Accident and Emergency Care Initiative (TAEI) are namely in-hospital triage (red, yellow, green and black), pre-arrival intimation (PAI), inter facility transfer protocols, trauma registry, clearly defined stages and steps with fixed time norms, easy to implement protocols and guidelines, check lists and standardization of registers. The policy thrusts to bring capacity building among all health staff including primary care level for emergency management. The policy also advocates creating a Trauma and Emergency care Registry at the state.

The policy thrust is to strengthen the post-crash interventions and Emergency Stabilization Centres (ESC) established along highways where the distance to definitive care is long. These centres stabilize critically ill trauma and medical emergency patients within the golden hour, thereby providing a longer window of survival.

As the domain of emergency care still remains in infancy in the country, the state of Tamil Nadu has been pioneering in this field with excellent results. The state envisages to have a model for the entire nation and Lower and Middle Income Countries (LMIC). For which the following policy thrusts are required.

- To establish regional & inclusive trauma & emergency care systems in Tamil Nadu through Hub and Spoke Model for decentralized service delivery and establishing state-of-the-art emergency care services.

- To focus more on post-crash care by developing mechanisms/strategies in line with the maternal mortality ratio for maternal deaths.
- To ensure optimum utilization of Inter-facility transfer of critically ill patient services based on standard protocols and guidelines.
- Special attention for trauma &emergencies among children & elderly population who require long term treatment support.
- To ensure rehabilitation services to be appropriately linked with emergency care and palliative care and follow up of injured patients for better outcome.
- To equip PHCs to provide basic first aid and emergency care services thereby avoiding strain at the tertiary care centres.

Objectives of TAEI (Under the Trauma Care Policy)

- To reduce the trauma morbidity & mortality and paediatric emergency related morbidity and mortality in the state by half by the year 2023.
- To reduce the myocardial infarction related morbidity & mortality, burn injury related morbidity & mortality and cerebrovascular accidents morbidity and mortality by 1/3 by the year 2023.
- To reduce the self-harm and poison related morbidity and mortality by half by the year 2023.

6.3. Focused Interventions for the Marginalized & Disadvantaged Groups

6.3.1. Tribal health:

The Government of Tamil Nadu is paying special attention for the development of tribal people with focused schemes. The policy highlights the further need for strengthening the tribal health schemes and recommends that their health rights are prioritized.

6.3.2. Children with 4D's (Defect, Deficiency, Developmental Delay & Disease):

School Health programme aims at early detection and management of a set of 30 health conditions prevalent in children less than 18 years of age. Children who require surgical intervention like corrective surgeries for Congenital Heart Diseases, Cleft Lip, Cleft Palate, Club Foot, Congenital Cataract, Cochlear implantation for congenital deafness and treatment for Autistic disorders are covered under the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS). The policy pitches for bridging the existing gaps in the RBSK and Rashtriya Kishor Swasthya Karyakram (RKSK) program and recommends that the non-school going children must also be covered and assured treatment. The policy further highlights to strengthen the Block Early Intervention Centres (BEIC) in addition to the District Early Intervention Centre (DEIC) to decentralize the service delivery and collaboration with the School Health Department. Since children are the most valuable asset to any Country/State, the policy ensures affirmative action in addressing the varying healthcare needs of the children by strengthening the school health program.

6.3.3. Occupational Health Services for Unorganized sector workers in rural and urban areas:

In Tamil Nadu, the unorganized sector workforce constitutes 93% of the total workforce (Census 2011). They suffer from various occupation-induced diseases like Silicosis, Asbestosis, Deafness, Irritant Dermatitis, Spondylosis etc. apart from several work-related illnesses. The policy highlights that they are one among the disadvantaged group in terms of seeking healthcare as they cannot afford to sacrifice a day's wage.

Currently, the state has implemented occupational health services for unorganized sector workers in all 385 blocks through respective Mobile Medical Units (MMU) on specific days. The policy thrusts for further up-scaling and strengthening the program to ensure universal coverage and also pitches for collaboration with Department of Labour and Employment.

The policy also advocates to bring attention by placing suitable measures to address the healthcare needs of the organized sector.

6.3.4. Urban Healthcare:

The National Urban Health Mission was established to “improve the health status of the urban population in general, particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality healthcare through a revamped public health system, partnerships and community-based mechanism with the active involvement of the urban local bodies”. The policy wants to highlight that there exist many gaps in implementation of the urban (including peri-urban) health program as compared to rural.

The policy prioritizes addressing the varying primary health care needs through strategies formulated for the urban population with special focus on poor populations living in slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. The policy also pushes for addressing the wider social determinants of health specific to urban areas (air pollution, solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress) with multi sectoral collaboration. The policy also demands for strengthening special services namely, Special Outreach Camp (SOC), Urban Health Nutrition Days (UHNDs), Urban RBSK, Urban Polyclinics, Urban Mobile Medical Units (MMU) and establishment of Maghila Arokya Samitis (MAS).

6.3.5. Elderly Geriatric care:

The percentage of senior citizens in Tamil Nadu, over the age of 60, is projected to increase 22.6 per cent by 2041 from 10.4 per cent in 2011, second only to Kerala that is set to see a 23.9 per cent increase. Government of Tamil Nadu through National Health Mission, established elderly-friendly healthcare facilities at various levels of care under National Program for Health Care of Elderly (NPHCE). The policy pitches for provision of comprehensive geriatric care services at the convenience of elderly people at all levels of care understanding the science & sociology of ageing.

6.3.6. Chronically /Terminally ill people:

National Programme for Palliative Care has been implemented in all districts of Tamil Nadu with provision of institution and community-based services. The State policy directs the implementation of strategies as per the State Palliative Care policy with more focus on community based palliative care services. The policy also highlights that the concept of ‘social care’ is the cornerstone of palliative care in Tamil Nadu’s context.

6.3.7. Lesbian, Gay, Bisexual, Transgender and Queer(LGBTQ):

Tamil Nadu was the first state in India to introduce a transgender welfare policy, wherein transgender individuals can access free sex reassignment surgery in government hospitals. Currently, there are two Transgender clinics in Medical College Hospitals. One of the unique initiatives of TANSACS is Transgender Welfare Society with the help of the Social Welfare Department. The policy also advocates for main streaming transgender into the regular healthcare delivery systems eventually and till then establishing gender guidance clinics to support their special needs in all medical colleges.

7. Cross-cutting strategies to address policy priorities

7.1. Strengthening Human Resources for Health (HRH):

The TNSHP 2030 also resonates the NHP 2017 on HRH and emphasizes the notion to build a strong and dedicated healthcare delivery team at all levels of care.

Medical Services Recruitment Board (MRB) plays a crucial role in contributing human resources required for achieving the objectives of Health and Family Welfare department. With more than 10 directorates under the control of Health and Family Welfare Department, MRB undertakes recruitment for over 200 categories of posts existing in various Government medical institutions throughout the state.

The policy advocates to fill in all the gaps in human resource for health and create, clear job roles and responsibilities for the health work force for providing comprehensive primary healthcare services. The policy also demands to create innovative strategies in pooling of human resources and strategically placing them in health service delivery to address the existing gaps. The policy advocates that available and appropriate work force with primary care skills and motivation to work in remote and rural centers shall be the primary criteria of placing the human resource at the Health and Wellness Centres (HWCs). The policy also pitches to create a pool of community caregivers (ASHA, AWW, WHV) since its pre-requisite in the State's journey towards achieving UHC. The key aspect of the capacity building of the work force should be that it has to be a continuous process and focus on improving hands-on-skills.

Continuous Professional Development and Capacity Building

Provision of quality medical care to the public and the provision of qualified human resources are the twin functions of the Directorate of Medical Education. The Department of Medical Education plays a pivotal role in developing medical and para-medical personnel to cater to the health needs of the state. The department also has a role to play in establishment and maintenance of well-equipped teaching institutions, which are the premier referral centres with state-of-the-art equipment and technology.

Medical and paramedical courses are affiliated and follow the standards laid down by The Tamil Nadu Dr. M.G.R Medical University. The University has been awarded ISO certification in ensuring quality of medical and paramedical education in the state.

Continuing Medical Education (CME) of providers needs to be reformed to ensure that it is in fact continuous and responsive to the changing health needs of the population. The policy also advocates for modernization of preservice medical education to achieve competence through active, problem-based learning, early clinical exposure as well as familiarity with quality improvement methods.

The policy also thrusts for engaging in Continuing Professional Development (CPD) to ensure that health workforce continually ‘up skill’ or ‘re-skill’ themselves, regardless of occupation, age or educational level. CPD combines different methodologies of learning, such as training workshops, conferences and events, e-learning programs, best practice techniques and ideas sharing, all focused for an individual to improve and have effective professional development. The state has drafted the Tamil Nadu Quality Enhancing Structured Training (TAN-QuEST) program for the same.

The policy pitches for an accelerated push towards using education to address existing inequities in the society including health inequity and substantial reforms in medical education responsive to current healthcare needs.

The policy states that technical institutes of education generating a wide range of allied healthcare professionals should be closely linked to public hospitals and select

not for profit hospitals, private healthcare providers, and different field training sites within district health systems to provide the wide range of practical training that the allied healthcare professionals' needs. Such hospitals and field training sites should have adequate facilities, adequate staff and student-patient ratios as required for practical training and mentoring.

The policy also advocates that the health system should respect the dignity and confidentiality of the patients. Laws and regulations should be strengthened to promote equity and justice. Health care professionals shall perform their work with the highest level of professionalism, integrity and trust and be supported by systems and a regulatory monitoring mechanism by utilizing appropriate technology that enables better service delivery.

HR reforms aim at ensuring fair terms for health professionals, competence-based career developments, occupational health and safety and creating a positive work environment.

7.2. Improving and ensuring Quality of care (QoC) and Continuous quality improvement (CQI):

Tamil Nadu has prioritized quality of care as the next frontier to further improve health outcomes for its people. With this motivation, the Government of Tamil Nadu (GoTN) is highly committed to improving quality of care and has worked with a coalition of stakeholders in a consultative manner to develop a comprehensive Quality of Care Strategy (QoCS). The Tamil Nadu Quality of Care Strategy is the first of its kind in India to systematically improve quality of care using a comprehensive framework.

TN QoCS seeks to accelerate the transformation to a high-quality health system in Tamil Nadu. The framework by the Lancet Global Health Commission (2018) for Quality Health Systems has been fine- tuned to develop the TN QoCS.

Tamil Nadu defines quality of care as "people-centred, safe, timely, and integrated health services in line with established quality standards".

The policy pitches for implementing the TN QoCS with renewed vigor by building an ecosystem for quality in which all stakeholders at all levels have a role to play. At the heart of this ecosystem are patients, their families and communities who are empowered to proactively take care of their health, demand and seek quality care from the system and hold the system accountable for quality.

7.3. Drugs and Diagnostics:

A robust drug and diagnostics system is a prerequisite from the financial point of view since the maximum out of pocket expenditure for any individual accessing a health facility is towards drugs and diagnostics. The Government of Tamil Nadu is already providing free drugs at all levels through TNMSC. To reduce the OOPE for the poor, it is not only necessary to ensure availability of free drugs but also ensure free diagnostic services to them. The policy thrusts to establish the 'Essential Diagnostics Services System' (EDSS) across the state with a sole aim to provide quick, prompt and hassle-free laboratory services. The policy proposes for strengthening all the laboratories across the state by ensuring the availability of an appropriate 'Assured Diagnostic Test Menu' at each level of health care delivery through a Hub & Spoke Model along with a well-equipped Laboratory Information and Management System (LIMS).

7.4. Provision of Adequate and appropriate Health Financing:

The Government of Tamil Nadu's health budget has witnessed a consistent raise in allocation every year (> 10% as compared to the preceding year). The current policy proposes for further raise in the budgetary allocation for health sector to achieve UHC in a time bound manner. The policy also aims to reduce waste and ensure that the resources are spent efficiently. Performance based incentives will be developed linked with state priority indicators and SDG targets. General taxation will remain the predominant means for financing care and the state will try to pool in funds under Corporate Social Responsibility, Mines funds, Collector's discretionary funds, Tamil Nadu Innovation Initiatives (TANII) etc.

Given the two-way linkage between economic growth and health outcomes, this Tamil Nadu State Health Policy is a declaration of the determination of the

Government to leverage economic growth to achieve health outcomes since it believes that better health contributes immensely to improved productivity as well as to equity.

Tamil Nadu views a publicly funded and owned healthcare delivery model as critical for the sustainability of the health system. Hence, the policy emphasizes creation of own in-house models. Public systems strengthening along with the requisite strategic purchasing and enforced regulation will also help to align private sector with public health goals. The policy also advocates to ensure an adequate Public Health Workforce- in numbers, skills and motivation. The policy emphasizes that the presence of a strong and robust public sector with adequate quality mechanisms can only lead the State in its journey to achieve UHC.

7.5. Strengthening and Integration of Health Management Information Systems:

Pregnancy and Infant Cohort Monitoring and Evaluation (PICME) for capturing mother and child related information and Health Management Information System (HMIS) consisting Hospital management system (HMS), Management Information System (MIS), College Management System (CMS) and University Automation System (UAS). The HMS and MIS are two major applications in the health department where data flows from community till tertiary care centres and vis-à-vis. Around 120 software applications are being used by health staff at various settings like community, hospitals, labs and administrative offices.

Health applications in the state are in silos having patient medical history and fragmented IT systems, which limits the health provider to access the available patient information. Unique Health Identifier across the health applications and common master list of facilities, addresses, family folders and variables are gaps in the existing HMIS.

The state has conceptualized that a state-owned comprehensive IT platform with entire population as denominator is essential to establish a continuum of care from community to referral units. The policy also thrusts that all the developments and

guidelines should be owned by the public systems (source codes, datasets, copyrights, intellectual property rights).

The policy pitches for a user-centric unified data exchange platform through an IT system approach for creating a Master Registry for establishing a digital cohort. The policy advocates that communication systems and advance technology has to be established to support HR for Health (move one level above in the value chain).

7.6. Strengthening Indian Systems of Medicine: Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH):

On par with NHP 2017, the policy recognizes the need to standardize and validate Indian Systems of Medicine and Homeopathy, establish a robust and effective quality control mechanism for AYUSH drugs. The policy advocates to that ensure that AYUSH services are also accessible to those people who make this choice and also to increase the basket of services provided by the AYUSH provider by including NCD and other services for chronic care. The policy also wants to promote wellness as a movement for preventive and promotive healthcare in the community.

7.7. Health Research:

The TNSHP 2030 also envisions the same objective set by the NHP 2017 with regard to Health Technology Assessment and adoption, strengthening Health Research in public and private medical colleges, strengthening the Government Research Institutes in the state and collaborating with other technical partners especially from the Government sector. The policy underlines that the state believes in knowledge sharing and pitches for an open platform for sharing health researches happening in the state. The state has also come up with Operational Research Programme guidelines for using research to strengthen health systems.

7.8. Climate Change:

The crisis of climate change, which is part of the larger human induced environmental change, is affecting health through direct and indirect manifestations. The policy advocates to take necessary steps to create systems to mitigate its effects. The strategy against health impacts due to climate change needs to focus

more on environmental health rather than on disease management that is patient-centered and largely curative.

7.9. Tackling Antimicrobial Resistance:

The Government of Tamil Nadu is already committed to take suitable action to address antimicrobial resistance in the State and will develop a State Action Plan on AMR, which will be in alignment with the National Action Plan on Antimicrobial Resistance (NAP-AMR) and the Global Action Plan on Antimicrobial Resistance (GAP-AMR).

8. Monitoring & Evaluation (M&E) Framework

Tamil Nadu state is already having an M & E framework under **Vision 2030 document** for SDG-3 which is reviewed by State Planning Commission on regular basis. The **Vision 2030 document** for SDG-3 focuses more on the service delivery parameters and has limited information on quality of care delivered. Hence, an M & E framework based on TN QoC document and NCD Strategy document has been derived. This is in addition to the existing Monitoring & Evaluation framework under **Vision 2030 document** for SDG-3

Table 3: Key Indicators for Monitoring & Evaluation of TNSHP

Indicator Name	Numerator	Denominator	Source of Data
Age-appropriate full vaccination	Children 0-23 months who received vaccinations as per the recommended schedule	Total children in the age group of 0-23 months	Surveys
Percentage of districts with functional Quality Assurance Committee (QAC)[Functional refers to conduct of QAC meeting every month in all the hospitals and issues addressed]	No: of districts with functional Quality assurance committee	Total Number of Districts in the state.	HMIS
Percentage of health facilities with NQAS/NABH accreditation	No: of health facilities with NQAS/NABH accreditation	Total no: of health facilities in the state.	HMIS

Indicator Name	Numerator	Denominator	Source of Data
Percentage of facility in charges who have completed management and administrative training under TAN-QuEST	No: of facility in charges who have completed management and administrative training	Total no: of health facilities in the state.	DPH, DMS& DME
Percentage of labs implementing EQAS	No: of health facilities, whose labs are EQAS certified	No: of health facilities with labs	DMS/DME
Average score on patient satisfaction Survey	Score on all Patient satisfaction survey conducted	Total patients surveyed	Patient satisfaction survey
Control rates of Hypertension	The number hypertensive patients with a BP < 140/90 mm/Hg	Total number of Hypertensive patients	State NCD Cell, NHM-TN
Control rates of Diabetes	The number of Diabetes patients with an RBS < 140 mg/dl	Total number of Diabetes patients	State NCD Cell, NHM-TN
Physical inactivity	Number of individuals aged 18 and above not meeting the criteria for physical activity	Number of individuals aged 18 and above	STEPS survey
Over weight	Number of survey individuals aged 18 and above who are overweight	Number of individuals aged 18 and above	STEPS survey
Obesity	Number of individuals aged 18 and above who are obese	Number of individuals aged 18 and above	STEPS survey
Cervical cancer	Number of women aged 30 and above screened for Cervical Cancer	Total number of women above 30 years	Monthly Reports / HMIS
Percentage of women with positive VIA undergoing follow-up Colposcopy	No: of women who had undergone follow-up Colposcopy within 6 weeks of positive VIA test	No: of women found positive by VIA	Monthly Reports / HMIS
Breast cancer:	Number of women aged 30 and above screened for Breast Cancer	Total number of women above 30 years	Monthly Reports / HMIS

Indicator Name	Numerator	Denominator	Source of Data
Percentage of women who tested positive with Clinical Breast Examination (CBE) underwent USG/Mammogram	No: of Women who tested positive with CBE underwent USG mammogram within 6 weeks	No: of women found positive by CBE	Monthly Reports/ HMIS
5 Yr Survival Rate Cervical Cancer	No. of women with cervical cancer who have survived for 5 years after diagnosis	No. of women diagnosed with cervical cancer	Cancer Registry
5 Yr Survival Rate Breast Cancer	No. of women with breast cancer who have survived for 5 yrs after diagnosis	No. of women diagnosed with breast cancer	Cancer Registry
Drug therapy to prevent heart attacks and stroke: Proportion of HT/DM/Both receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	Number of individuals above 18+ years confirmed with Hypertension/Diabetes Mellitus/Both who are receiving drug therapy and counselling	Number of individuals above 18+ years with Hypertension/Diabetes Mellitus/Both	Monthly Reports / HMIS
Drug Stock Out in Essential NCD Medications: Percentage of drug stock out against essential drugs for NCDs	No of essential drugs for NCDs not available	Total number of essential drugs for NCDs	Monthly Reports / HMIS

9. Way forward

A progressive step towards Right to Health

Tamil Nadu State Health Policy 2030 provides broad contours towards building a healthy society for improved quality of life and the first progressive steps towards Right to Health. The policy aims for continuing the ongoing initiatives and interventions and their scaling up as deemed necessary as well as new initiatives identified by mapping of the emerging health needs to advance to the next higher level of development.

Annexure 1:

SITUATION ANALYSIS; FIGURES AND TABLES

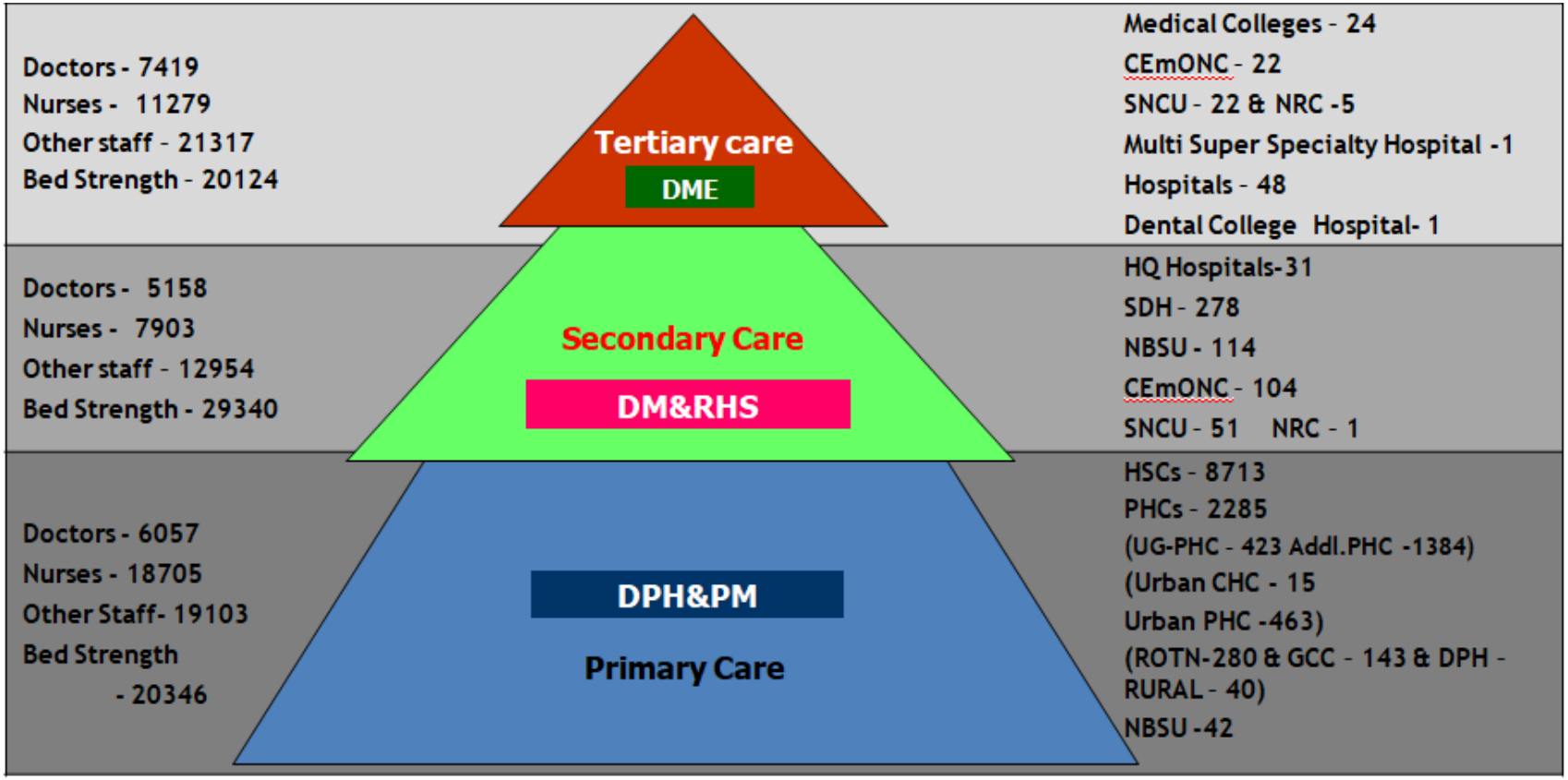


Figure1: Public Health Service Delivery Mechanism in Tamil Nadu

Table 1: Vital Indicators

Vital Indicators		Tamil Nadu	India
Population 2011 Census (in Crores)		7.21	121.02
Decennial Growth Rate (2001-2011) (%)		15.6	17.7
Sex Ratio (females per 1000 males) (2011 census)		996	943
Life expectancy at birth (SRS 2013-17)		71.7	69
Crude Birth Rate (SRS 2017)		14.9	20.2
Crude Death Rate (SRS 2017)		6.7	6.3
Infant Mortality Rate (SRS 2017)		16	33
Maternal Mortality Ratio (SRS 2015-17)		63	122
Total Fertility Rate (SRS 2017)		1.6	2.2
Literacy Rate (2011 census)	Male	86.8	80.9
	Female	73.4	64.6
Neonatal Mortality Rate (SRS 2017)		11	23
Early Neonatal Mortality Rate (SRS 2017)		8	18
Late Neonatal Mortality Rate (SRS 2017)		3	5
Post Neonatal Mortality Rate (SRS 2017)		6	10
Perinatal Mortality Rate (SRS 2017)		11	23
Stillbirth Rate (SRS 2017)		3	5
Under 5 Mortality Rate (SRS 2017)		19	37
Immunization coverage (NFHS 4)		69.7	62
At least 4 antenatal care visits (NFHS 4)		81.2	51.2

Table 2: Percent of Deaths in 2016 from disease categories in Tamil Nadu

	India	TN		India	TN		India	TN
Non-Communicable	**61.8%**	**69.2%**	**Communicable**	**27.5%**	**17.2%**	**Injuries**	**10.7%**	**13.5%**
Cardiovascular diseases	28.1	36.1	Diarrhoea, lower Respiratory, and Other common Infectious diseases	15.5	10.6	Unintentional injuries	4.9	6.0
Diabetes, urogenital, blood, and endocrine diseases	6.5	12.2	HIV/AIDS and tuberculosis	5.4	3.8	Self-harm and interpersonal violence	2.8	4.3
Neoplasms	8.3	7.5	Neonatal disorders	3.8	1.6	Transport injuries	2.9	3.2
Chronic respiratory diseases	10.9	6.5	Neglected tropical diseases and malaria	0.8	0.5			
Neurological disorders	2.1	2.3	Other communicable, maternal, neonatal, and nutritional diseases	0.9	0.4			
Digestive diseases	2.2	1.7	Nutritional deficiencies	0.5	0.2			
Cirrhosis and other chronic liver diseases	2.1	1.6	Maternal disorders	0.5	0.1			
Other non-communicable diseases	1.1	0.8						
Mental and substance use disorders	0.4	0.4						
Musculoskeletal disorders	0.1	0.1						

Table 3: Percent of DALYs in 2016 from disease categories in Tamil Nadu

	India	TN		India	TN		India	TN
Non-Communicable	**55.4%**	**65.3%**	**Communicable**	**32.7%**	**20.4%**	**Injuries**	**11.9%**	**14.2%**
Cardiovascular diseases	14.1	19.5	Diarrhoea, lower respiratory, and other common infectious diseases	12.7	7.2	Unintentional injuries	5.4	5.7
Diabetes, urogenital, blood, and endocrine diseases	5.6	9.5	Nutritional deficiencies	4.6	4.3	Self-harm and interpersonal violence	3.1	4.8
Other non-communicable diseases	7.4	7.8	Neonatal disorders	7.9	4.1	Transport injuries	3.3	3.7
Mental and substance use disorders	5.6	6.8	HIV/AIDS and tuberculosis	4.2	3.1			
Musculoskeletal disorders	4.6	5.6	Neglected tropical diseases and malaria	1.5	0.9			
Chronic respiratory diseases	6.4	4.9	Other communicable, maternal, neonatal, and nutritional diseases	1.1	0.6			
Neoplasms	5	4.7	Maternal disorders	0.6	0.2			
Neurological disorders	3.6	4						
Cirrhosis and other chronic liver diseases	1.6	1.3						
Digestive diseases	1.5	1.2						

Source Table 2 & 3: Global Burden of Diseases, ICMR, PHFI, and IHME (2017).

Table 4: SDG – Goal 3 Targets, Indicators and values to be achieved by 2030

Targets	Indicators	Values (2018-19)	Value to be achieved by 2025 (Tentative)	Value to be achieved by 2030 (Tentative)	Remarks; Data Source
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal Mortality Ratio	60	39	29	State HMIS/NHM
	3.1.2 Percentage of births attended by skilled health personnel (period 5 years)	99.9	100	100	State HMIS/NHM
	3.1.3 Percentage of births attended by skilled health personnel (period 1 years)	99.9	100	100	State HMIS/NHM
	3.1.4 Percentage of women aged 15 - 49 years who received antenatal care, four times or more (Period 5 years / 1 year)	86.1	90	95	State HMIS/NHM
3.2 By 2030, End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under 5 mortality rate	19	11	6	SRS
	3.2.2 Neonatal mortality rate	11	8	5	SRS
	3.2.3 Percentage of children aged 12-23 months fully immunized (BCG, Measles and three doses of Pentavalent	95	0	100	State HMIS/DPH
3.3 By 2030, End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.	3.3.1 Number of new HIV infections on per 1000 uninfected population, 2015 (per 1000 population)	0.05 (2017-18)	Yet to decided	Yet to decided	PALS - NACO-TANSACS
	3.3.2 Tuberculosis incidence On per 100,000 population	141	44	22	Nikshay Portal, RNTCP
	3.3.3 Malaria incidence on per 1,000 population	0.05	0	0	State VBDC Division, O/o DPH&PM, Chennai

Targets	Indicators	Values	Value to be achieved by 2025	Value to be achieved by 2030	Remarks; Data Source
		(2018-19)	(Tentative)	(Tentative)	
	3.3.4 Viral Hepatitis (including A & B) on incidence per 100,000 population				NO AVAILABLE DATA SOURCE
	3.3.5 Dengue: Case Fatality Ratio (CFR)	0.29	0	0	State VBDC Division, O/o DPH&PM, Chennai
	3.3.6 Number of Chikungunya cases	0.35	0	0	State VBDC Division, O/o DPH&PM, Chennai
	3.3.7 Number of new cases of Kala azar / V Leishmaniasis	0	0	0	State VBDC Division, O/o DPH&PM, Chennai
	3.3.8 Number of new cases of Lymphatic filariasis (LF)	0	0	0	State VBDC Division, O/o DPH&PM, Chennai
	3.3.9 The proportion of Grade-2 cases amongst new cases of Leprosy	3.03	0	0	O/o Additional Director (Leprosy), DM RHS, Chennai
	3.3.10 HIV Prevalence Rate (in percentage)	1.23	0	0	PALS - NACO-TANSACS
3.4 By 2030, reduce by one-third premature mortality from NCDs through prevention & treatment and promote mental health & well-being.	3.4.1 Number of deaths due to cancer	6241 (2017-18)	Yet to be finalized	Yet to be finalized	MCCD&CRS, O/o DPH&PM, Chennai
	3.4.2 Suicide mortality rate	18 (ADSI-18)	Yet to be finalized	Yet to be finalized	NCRB & SCRB

Targets	Indicators	Values (2018-19)	Value to be achieved by 2025 (Tentative)	Value to be achieved by 2030 (Tentative)	Remarks; Data Source
	3.4.3 Percentage distribution of leading cause groups of deaths (CMNND / NCD / Injuries)	6.8/88.4/ 4.8	Yet to be finalized	Yet to be finalized	MCCD&CRS, O/o DPH&PM, Chennai
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Percentage of adults (15+ years) who have had at least 60 ml or more of pure alcohol on at least one occasion weekly (approximately equivalent to standard alcoholic drinks)				Yet to be finalized
	3.5.2 Number of persons treated in De-addiction centres in 2015-16 (in number)				Yet to be finalized
	3.5.3 Percentage of population (men (15-54 years)) and women (15-49 years)) who consume alcohol.				Yet to be finalized
3.6 By 2020, half the number of global deaths and injuries from road traffic accidents	3.6 No. of deaths due to road traffic accident.	12216	0	0	RADMS
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Percentage of currently married women (15-49 years) who use any modern family planning methods.	68.9	70	70	State HMIS/DFW
	3.7.2 Percentage of women aged 15-19 years who were already mothers or pregnant.	0.93	0	0	State HMIS / DPH
	3.7.3 Percentage of Institutional Births (5 years / 1 year)	99.9	100	100	State HMIS/DPH

Targets	Indicators	Values (2018-19)	Value to be achieved by 2025 (Tentative)	Value to be achieved by 2030 (Tentative)	Remarks; Data Source
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Percentage of currently married women (15-49 years) who use any modern family planning methods.	68.9	70	70	State HMIS/DFW
	3.8.2 Percentage of TB cases successfully treated (cured plus treatment completed) among TB cases notified to the national health authorities during a specified period.	82		92%	NIKSHAY Portal, RNTCP
	3.8.3 Percentage of people living with HIV currently receiving ART among the detected number of adults and children living with HIV.	77	90	90	PALS - NACO-TANSACS
	3.8.4 Proportion of population in age group 15-49 years who are currently taking antihypertensive medication among age group 15- 49 with systolic blood pressure ≥ 140 mm Hg, or with diastolic blood pressure ≥ 90mmHg	2.5	3	4	State NCD Cell, NHM-TN
	3.8.5 Proportion of population in age group 15-49 years who are currently taking medication for diabetes (insulin or glycaemic control pills) among number of adults 15-49 years who are having random blood sugar level – high (>140 mg/dl)	0.9	1.75	2	State NCD Cell, NHM-TN

Targets	Indicators	Values (2018-19)	Value to be achieved by 2025 (Tentative)	Value to be achieved by 2030 (Tentative)	Remarks; Data Source
	3.8.6 Proportion of women aged 30-49 years who report they were ever screened for cervical cancer and the proportion of women aged 30-49 years who report they were screened for cervical cancer during the last 5 years.	42.7	50	55	State NCD Cell, NHM-TN
	3.8.7 Prevalence of current tobacco uses among men and women aged 15 -49 years.	Men – 31% Female- 9.3% (2015-16)	Yet to be decided	Yet to be decided	GATS Report
	3.8.8 Total physicians, nurses and midwives per 10000 population	1.7 ANM per 10000 4.03 SN per 10000 2.90 MO per 10000	Yet to be finalized	Yet to be finalized	State HMIS/NHM
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to unintentional poisoning				Yet to be finalized
	3.9.2 Proportion of men and women reporting Asthma 15-49 years.				Yet to be finalized
3.10 Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.	3.10.1 Prevalence of current tobacco uses among men and women aged 15 -49 years.	Men – 31% Female- 9.3% (2015-16)	Yet to be decided	Yet to be decided	GATS Report

Targets	Indicators	Values (2018-19)	Value to be achieved by 2025 (Tentative)	Value to be achieved by 2030 (Tentative)	Remarks; Data Source
3.11 Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.	3.11.1 Total net official development assistance to medical research and basic health sectors.				Yet to be finalized
3.12 Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	3.12.1 Total physicians, nurses and midwives per 10000 population.	1.7 ANM per 10000	0	Yet to be decided	State HMIS/NHM
		4.03 SN per 10000	0	Yet to be decided	State HMIS/NHM
		2.90 MO per 10000	0	Yet to be decided	State HMIS/NHM
	3.12.2 Percentage of public investment in health as proportion to GDP.				Yet to be finalized

Utilization of Healthcare

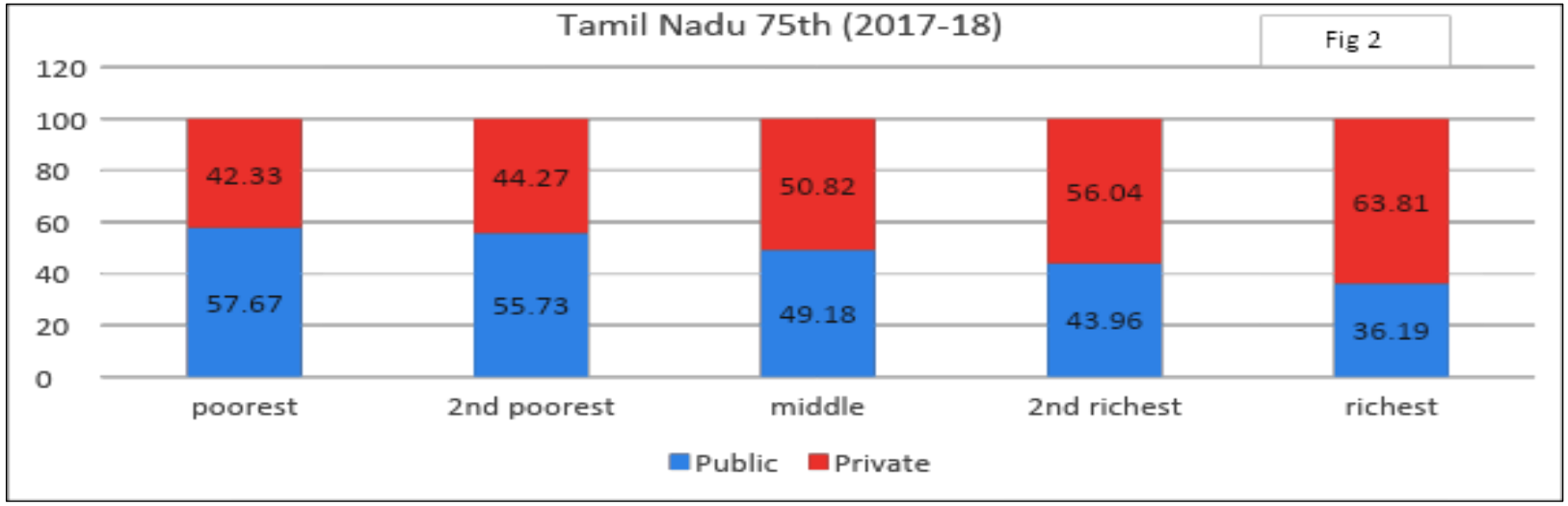
Table 5: Percentage distribution of outpatient episodes treated by levels of care across Rural and Urban regions in Tamil Nadu

	NSS 71st (2014)			NSS 75th (2017-18)		
	Rural	Urban	Total	Rural	Urban	Total
Public hospital (including HSC/PHC/CHC etc.)	42.4	28.6	34.6	63.31	40.55	54
charitable/trust/NGO-run hospital	-	-	-	0.11	1.51	0.7
private hospital	37.8	43.4	41	27.04	44.89	34.3
private doctor/ in private clinic	19.9	27.8	24.4	8.84	12.95	10.5
informal health care provider	-	-	-	0.7	0.09	0.4
All treated episodes	100	100	100	100	100	100

Table 6: Percentage distribution of all inpatient episodes by levels of care across Rural and Urban regions in Tamil Nadu

	NSS 71st (2014)			NSS 75th (2017-18)		
Level of care	Rural	Urban	Total	Rural	Urban	Total
Public hospital (including HSC/PHC/CHC etc.)	40.39	29.26	34.58	56.88	42.23	49.88
Charitable/Trust/NGO-run hospital	-	-	-	1.2	2.89	2.01
Private hospital	59.61	70.74	65.37	41.93	54.88	48.11

Share of public and private sectors in total In-patient episodes by socio-economic groups in Tamil Nadu



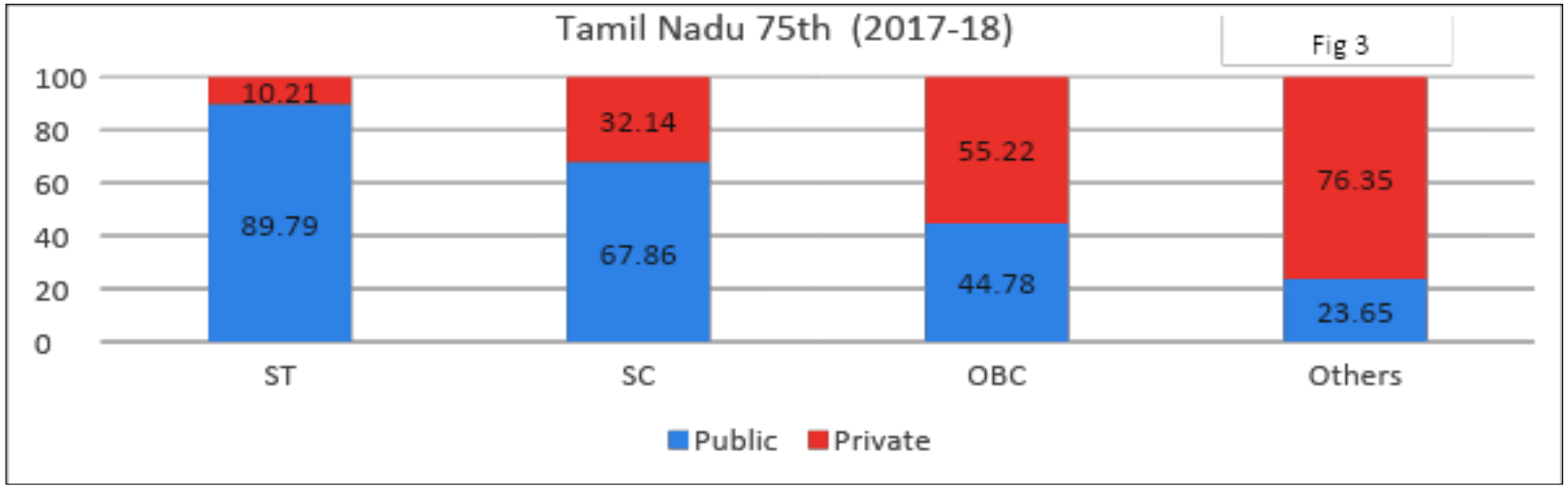


Fig 2 & 3: Categorization by Economic group & Social group

Table 7: Total OOPE in hospitalization and out-patient care as proportion of total GDP of India

	India's Population	India's GDP (at current prices)	OOPE in Hospitalization (in Rs)				OOPE in Out-patient care (in Rs)					Total OOPE (in Rs)		
			Public	Private	Trust/ NGO	Total	Public	Private	Trust/NGO	Informal	Total	Public	Private	Total
All India (All numbers in crore)														
NSS 71st Round, 2014	129.6	11233522	11820 (0.11)	73304 (0.65)	-	85124 (0.76)	35064 (0.31)	170711 (1.52)	-	-	205775 (1.83)	46,884 (0.41)	2,44,014 (2.17)	2,90,898 (2.59)
NSS, 75th Round2017-18	135.3	17095005	7745 (0.05)	63586 (0.37)	2442 (0.01)	73773 (0.43)	28308 (0.17)	132168 (0.77)	2153 (0.01)	4220 (0.02)	166850 (0.98)	36,053 (0.21)	2,04,569 (1.19)	2,40,622 (1.41)
Tamil Nadu (All numbers in lakh)														
NSS 71st Round2014	7.60 Crore	85423816	13912 (0.02)	724975 (0.85)	-	738887 (0.86)	92724 (0.11)	1366675 (1.60)	-	-	1459399 (1.71)	106636 (0.12)	2091650 (2.45)	2198286 (2.57)
NSS 75th Round 2017-18	7.98 Crore	142707394	12510 (0.01)	405639 (0.28)	5675 (0.00)	423823 (0.30)	75794 (0.05)	569594 (0.40)	1023 (0.00)	83948 (0.06)	730359 (0.51)	88304 (0.06)	1065879 (0.75)	1154183 (0.81)

Table 8: Expenditure on Institutional care and childbirth (in Rs)

		71st			75th		
		Rural	Urban	Rural + Urban	Rural	Urban	Rural + Urban
Public	Normal				2902.43	2979.01	2926.54
	C-section				4366	4769.46	4513.56
	All	2,214	2,776	2,454	3373.72	3647.56	3464.67
Private	Normal				23881.59	26963.02	26031.89
	C-section				43632.11	42196.47	42779.45
	All	31,811	32,448	32,182	35469.1	34174.78	34634.97

Source (Table 5-8): Health Status and Access to Healthcare in Tamil Nadu: a comparison of 75th Round (2017-18) with 71st Round (2014) National Sample Surveys" (report prepared by Centre for Technology and Policy, Indian Institute of Technology, Madras, February 2020)

Table 9: State Health Budget

Year	Amount (Rupees in Crore)	% of increase
2012-13	5569.28	23.61
2013-14	6511.76	16.92
2014-15	7176.28	10.20
2015-16	8245.41	14.89
2016-17	9072.72	10.03
2017-18	10157	11.95
2018-19	11326.3	11.52
2019-20	12563.82	10.93

Source: Finance Department, Go TN

List of Regulations Related to Health Sector Enforced in Tamil Nadu

The policy recognizes that the following regulations are enforced in Tamil Nadu:

- The Tamil Nadu Clinical Establishments (Regulation) Act, 1997.
- Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994.
- Transplantation of Human Organ Act, 1994.
- Deceased Organ Transplant Programme.
- Tamil Nadu Public Health Act, 1939.
- Civil Registration System and Birth and Deaths Registration Act 1969.
- Medical Certification of Cause of Death.
- Cigarettes and Other Tobacco Products Act (COTPA), 2003.
- Food Safety and Standards Act, 2006 Tamil Nadu Food Safety and Drug Administration Department was formed in 2011. Six Food Laboratories are functioning in the State for testing of food samples.
- The Drugs Control Administration is enforcing of the following enactments, all being Central Acts for regulating the manufacture, distribution and sale of drugs and cosmetics: Drugs and Cosmetics Act, 1940, Drugs and Cosmetics Rules, 1945 and Medical Devices Rules, 2017, Drugs Price Control Order, 2013, The Drugs and Magic Remedies (Objectionable Advertisement) Act,1954 and Rules, 1955. The Officers of this Department are also empowered to act under the Narcotic Drugs and Psychotropic Substances Act, 1985.
- State Drug Licensing Authority for Indian Medicine
- Statutory bodies – Councils for licensing for registration of Medical and paramedical professionals to practice- The following councils are established through various Acts to register the qualified medical, nursing and paramedical professionals to regulate their practice in Tamil Nadu:
    - Tamil Nadu Medical Council
    - Tamil Nadu Dental Council
    - Tamil Nadu Nurses and Midwives Council
    - Tamil Nadu Pharmacy Council
    - Tamil Nadu Siddha Medical Council (Siddha and Traditional Practitioners)
    - Board of Indian Medicine (Ayurveda, Unani and Yoga and Naturopathy)
    - Tamil Nadu Homoeopathy Council
    - Tamil Nadu Physiotherapists Council

TN - State Health Policy
Vision 2030

Strengthening the State Health Care Delivery System

- To provide quality driven and people-centric holistic care
- To ensure universality of access and inclusiveness of health care
- To advance medical education and continuing professional development
- To address existing and emerging health issues effectively
- To promote social and behavioural change in individuals and communities
- To encourage citizen engagement and multi stakeholder collaboration

Tamil Nadu Health System Reform Program
DMS Annex Building, DMS Complex, Anna Salai, Teynampet, Chennai - 600 006
Email: pdtnhsp@gmail.com, Contact: 04424345990