

Letter from Chennai

KEEP IT SIMPLE

The rural programme of the Kidney Help Trust was a great success, earning an award from the International Society of Nephrology, mainly because of its effectiveness and simplicity. I have written about it often in these Letters, and will just summarize it for you. A group of villages was selected and a survey was carried out. Our workers (women who could write and maintain the records) went from house to house, checking every individual with a simple questionnaire covering symptoms suggestive of diabetes or renal disease, recording the blood pressure and performing a urine examination for albumin and sugar. All positives were confirmed by a doctor and underwent blood tests for glucose and creatinine, and were then put on treatment with simple drugs for diabetes and hypertension. We delivered the drugs to the patients at their homes and followed them up also on a domiciliary basis. Hypertension control (to 140/90 mmHg or less) was established by checking the blood pressure once a week and adjusting the dosage of drugs, and diabetic control (to glycated haemoglobin of 7% or less) by urine sugar once a week and glycated haemoglobin once in three months. We achieved the desired blood pressure in 96% of the population, and glycated haemoglobin in 52%. A further 25% achieved a reduction of 10% or more in the original HbA1C level though not to normal. Renal failure (eGFR below 80 ml per minute) was reduced from 2.8% of the population to 1.1% of the population, 'heart attacks' from 0.91% to 0.28% and strokes from 1% to 0.18%. The cost of the project, including salaries, transport, test materials and medicines, was ₹31.26 per capita per year, and we were able to sustain this project for 26 years with unsolicited donations from generous citizens. We had to give it up only because of advancing age of the main workers.

Our population was just around 43 000. I made great efforts to induce the government of the state and the Centre to adopt this project at least for a limited area of a block or a district, but finally had to give it up as all I obtained was verbal approval from some health ministers and secretaries, but no action at all.

I was therefore delighted when the Government of Tamil Nadu announced that they were introducing a scheme, 'Makkalai Thedi Maruttuvam' (literally medical care-seeking people) where they would check for non-communicable diseases at the patients' homes and treat them there. I am afraid my delight turned to dismay when I found that the government intended to cover all non-communicable diseases.

I thought over this problem decades ago when the doctor in charge of our project wanted to add hyperlipidaemia to the list of conditions to be sought for and treated. When is a prevention programme on a community-wide basis worthwhile? We need to ask ourselves a few questions. Is the disease widely prevalent in the community? Are the effects sufficiently serious to warrant efforts at detection and prevention or early treatment? Is the diagnosis easy and affordable? Is treatment in the community easy and affordable? All these questions should be answered in the affirmative, and only then would it be worthwhile to take up a massive programme of detection and prevention or early treatment. Among the non-communicable diseases, only

diabetes and hypertension would satisfy these criteria, and only if we keep the diagnostic methods and the treatment simple and cheap. Every additional disease covered would add to the difficulty and the cost of the project.

The scheme was inaugurated on 5 August 2021 by the Chief Minister. Initially, seven districts were chosen, and the scheme was limited to those above the age of 45 years and younger people with disabilities. I believe this is a waste of effort. If health workers are going to every house, they might as well test every individual in the house with simple tests as that would not add much to the time they spend or to the cost, and the benefit of any preventive measure would be so much greater if younger patients were detected and treated.

The scheme was also intended to treat end-stage renal disease at home with peritoneal dialysis. Bags of dialysis fluid and other supplies are delivered at home. A government official (whom I should not name lest he get into trouble) said this was very expensive, but the government could manage it because the Central Government gave considerable funds under the Pradhan Mantri National Dialysis Programme. This is not mentioned in any of the state government's reports, and the impression conveyed is that the entire expenditure is borne by the state. Clearly it would be politically disadvantageous to inform the public of the massive help from the Central Government.

A journalist, quoting unnamed health department sources, reported in *The Hindu* of 4 August 2022, that the scheme was not working as well as claimed. The health workers hired for the project were taken on a temporary basis on a meagre remuneration of ₹4500 a month, which was not disbursed on time. They did not do the regular house visits and screening, and the numbers actually screened were only half the 80 lakhs (8 million) claimed by the government. Incidentally, notifications on the web by the government advise people who are eligible for help to apply to the authorities to be enrolled in the scheme, which suggests that screening of the entire population has been abandoned. There also seems to be considerable delay in the applicants being registered for domiciliary help. The paper claimed that there was delay in the replacement of batteries for the electronic blood pressure instruments, and demand for data led to the staff falsifying entries.

The health minister (also cited in the paper), denied these allegations, and said the scheme was working well. The Kidney Help Trust also used to take temporary staff to do the periodic screening of the population, and I can confirm that it is very easy for a health worker to claim that she had screened everyone in the area allotted to her without actually doing all the tests, and therefore it was essential for us to do periodic visits to the villages to verify whether the tests had actually been done and correctly recorded. We could more easily dismiss a dishonest worker than the government could.

From my enquiries, I gather that case detection now is made from visits of patients to the primary health centres (PHCs), and those patients are provided with medicines at home. There is no periodic domiciliary testing to ensure adequate control. Only those patients who go to the PHC for tests have satisfactory treatment. I would point out that an asymptomatic person on daily wages would not sacrifice a day's wage to travel all the way

to the PHC, wait in a queue, and have tests done to adjust his medicine dosage and receive a week's or even a month's supply of medicine. I appeal again to the health minister to drop this massive scheme, simplify the exercise to just diabetes and hypertension, and add it to the duties of the PHCs. A few extra health workers could easily tackle the work involved, but there should be some supervision by the doctors at the PHC. The original plan of having PHCs was to look after health, and medical care was only a secondary approach. We have converted PHCs into primary care medical centres.

I am unable to reconcile the conflicting claims of the health minister and his officials reported by the newspaper, but I feel quite sure that the scheme as originally planned is not feasible and is not working. I would again appeal to the health minister to take up the protocol of the Kidney Help Trust all over the state. Once it is working well, other diseases could be added and the programme could be expanded.

I commend one initiative that has been taken up in many teaching hospitals. A counter has been set up where visitors and attendants of both outpatients and inpatients can have their blood pressure and blood sugar checked without charge, and when disease is detected they are advised to see a doctor for treatment. While this is not as effective as community-wide screening, any patient diagnosed to have diabetes or hypertension and maintained on effective treatment is one less candidate for the vascular complications of these diseases, particularly end-stage renal disease.

My enquiries show that both the state and the Central Government are spending considerable sums on the provision of dialysis. Tamil Nadu has dialysis facilities and a nephrologist at every district headquarters hospital, and dialysis facilities have also been set up at many other important government hospitals. Some private hospitals (which accept the scale of reimbursement provided by the insurance scheme) have also been empanelled. Costs could always be substantially reduced by dialysing for an hour or two less than the planned period, with corresponding savings in dialysis fluid and heparin, both expensive components of the dialysis. Obviously a patient who receives inadequate hours of dialysis would not do as well as a fully dialysed person. A detailed analysis of the success of long-term dialysis in the old composite Andhra Pradesh under the Rajeev Arogyashri scheme¹ showed disappointing long-term results with 17% of patients dying and 63.5% dropping out, but one hopes that lessons have been learned and current results are better.

It is clear that patients with end-stage renal disease are much better off today than they were a decade or so ago, but the system seems enormously complicated, and certainly nephrologists in government service have a hard time. Ultimately, all the money comes from the government. Why not just run the hospitals and provide the services as was done in the old days when I was an employee of the Tamil Nadu Government Medical Services? There was a budget for each hospital, an allocation for each department, and the Dean or the Medical Superintendent had some flexibility if some alterations had to be done within these limits. Today the government gives a fixed sum as premium to three insurance companies in the private sector, each of which covers a part of the state. If the claims are less than the premium, the company makes a profit. Why should

government funds go to a private sector company? The claims will never be allowed to exceed the premium. These are recurring expenses, and the private sector company is not a charitable organization. It will not pay more than the premium it receives. If it does lose money one year, it will certainly make it up the next year by denying some claims.

Now consider the plight of the staff. As the old dialysis technicians retire, they are no longer replaced by employees of the service. They are now appointed by a Medical Recruitment Board (MRB) and are on an annual contract, which is renewed every year. There is always a delay in this renewal, and there is an uncomfortable interval in which the technician works without a salary in the hope that his contract will be renewed. One of the great advantages of work in the government sector was the pension. The old pension scheme has been abolished. Now the staff contribute to their pension. They do get a matching contribution from the government, but with inflation as it is, I do not know what that pension will be worth when they retire.

By and large, nephrologists are happy that more patients are being dialysed, and no-one needs to be turned away for lack of facilities. As the units fill up, patients are referred to other hospitals in their vicinity where dialysis facilities are available. However, the red tape is considerable. There is a package for insertion of a jugular catheter for dialysis. To claim this, a photograph of the patient with the catheter *in situ* has to be uploaded to a website. Reimbursement for dialysis comes after every 10 dialyses; a treatment summary has to be submitted to the insurance company with a letter from the patient that he is satisfied with the treatment he received. When the money is received, 17% goes to the Dean's (or Superintendent's) Fund for various expenses, and 28% goes to the Tamil Nadu Health Systems Fund. The rest goes to run the unit.

There seems little doubt that patients are better treated in Tamil Nadu than in most other states in the country. Funds have been sanctioned from various international agencies, including the World Bank, the Japan International Cooperation Agency, and the Gates Foundation. I am delighted to know about all this, but I still cannot understand the rationale of routing payment through an insurance company and adding to the administrative complexity of the entire health system. I have asked some senior government administrators, some doctors, and some accountants about any possible advantages of this scheme. Not one of them could explain how it might be beneficial to the patients or to the government to route payment through an insurance company instead of just running the hospitals. The company would benefit if the claims cost less than the premium it received, which might have been the case in the early years of the scheme. The number of patients receiving help has increased enormously, and the company is now dragging its feet and delaying reimbursement. Any day now, it will either deny claims or demand an increased premium. Maybe that will convince the government to take back the running of the hospitals.

REFERENCE

- 1 Shaikh M, Woodward M, John O, Bassi A, Jan S, Sahay M, *et al.* Utilisation, costs, and outcomes for patients receiving publicly funded hemodialysis in India. *Kidney Int* 2018;94:440-5.

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