Letter from Chennai

HALF MEASURES

Ever since the International Society of Nephrology declared the rural prevention programme of Chennai's Kidney Help Trust to be the best low-cost method of preventing the ravages of non-communicable diseases (NCDs), I have repeatedly tried to have it adopted by the Government of Tamil Nadu or by the Government of India, at least in a limited area. One Central Health Secretary showed some interest in this protocol, but he was transferred to another post soon after, for reasons other than his preference for prevention.

I am firmly convinced that any prevention programme will work only if we actively seek patients with diabetes and hypertension and provide them treatment at home. Most of them are on daily wages, and cannot afford to lose a day's wage in travelling to a primary health centre (PHC) to pick up a week's or even a month's supply of medicines. I believe the PHC should strive to maintain health rather than be a medical centre to treat disease after it sets in.

Our Chief Minister gave an electronic blood pressure (BP) instrument and a glucometer to each of seven non-governmental organizations (NGOs) working in rural areas. They are to be used in going door-to-door and finding people with diabetes and hypertension at home. We are not told what will be done with them once they are detected, but case finding is a good first step. This is said to be part of the 'prevention, containment and treatment policy' of the state government to control NCDs, and I presume the newly diagnosed patients will be told to go to a PHC or to their doctor. How many patients will seven BP instruments and seven glucometers pick up? All electronic instruments are suspect if they are not calibrated regularly. Most lay people (and some doctors) who use these instruments regard them as infallible. I hope we will not get a flood of people wrongly labelled with hypertension, or a number of people with hypertension certified to be normal.

Mr C.E. Karunakaran is an engineer who thought of spending his retirement in public service. He joined the National Network for Organ Sharing (NNOS), a not-for-profit organization that tried to promote organ donation and sharing of organs between hospitals in Tamil Nadu. Before long he realized that laudable and essential though transplantation may be for India, only a fraction of those who need transplantation will receive it in the foreseeable future because there is not enough money to provide treatment to all who need it. The Government of Tamil Nadu established the Transplant Authority of Tamil Nadu (TRANSTAN) as a registered society in 2014. The NNOS continues to provide staff for the office functions of TRANSTAN. The government is expected to reimburse the NNOS for their salaries, but they are not recognized as government employees, and like all government disbursements, payment is often tardy.

The NNOS morphed into the NNOS Foundation (NNOSF) and has been trying to detect NCD in the community and to provide treatment in some public–private partnership with the government. Another tireless worker in the NNOSF is Dr R. Swaminathan, a retired IAS officer. I have been privileged to have many conversations with them. I admire their efforts. Initially, they reached a Memorandum of Understanding with the Tamil Nadu Health Systems Project run by the state government with funds from the WHO. The plan was for the NNOSF to detect patients in the community by door-to-door screening. The patients so detected would be seen by the PHC doctors either at the PHC or during visits to the different areas in their mobile medical units (MMUs), and the government would provide the necessary medicines. Alternatively, the NNOSF would collect medicines from the PHCs and distribute them to the patients at their homes.

'The best laid schemes o' mice an' men gang aft a-gley' (Robert Burns). It proved difficult to get the detected patients and the MMU staff together because the MMU often failed to stick to its schedule. The van might be in need of repairs, or the driver or the doctor might not be available. Patients waited in vain at the designated place and time; at times, the MMU made an unscheduled visit and found it had very little to do. Patients lost confidence in the MMU, and finally it became necessary for them to go to the PHC to collect their medicines. There were problems in that too. The PHC doctors said they could take only 10 to 15 NNOSF patients each day. Sometimes there was no stock of medicines, and the patients would be asked to come the following day. They were sometimes given medicines only for two weeks instead of a month's supply, and only around a third of patients received government medicines, and even that not fully.

Diabetes is a tougher problem. The PHC wanted fasting and post-prandial blood glucose levels, and the logistics of this proved insuperable. Finally, they settled for random blood glucose readings. There has not so far been an analysis of the results achieved by this protocol. Meanwhile, the NNOSF is running out of funds for its part of the work, and is now thinking of a different system, with patients being provided domiciliary care and having tests of glucose and BP, but making payment for the service.

Meanwhile, governments at the Centre and of the southern states continue to provide funds for dialysis and transplantation, and claim that they are saving patients with end-stage renal failure. We need the whole programme to be properly audited. How many people have received transplants under these schemes, and how long have they and their grafts survived? How many people have survived on long-term dialysis and for how long? How many have been restored to productive lives? How much money have the various governments spent on these schemes? The Finance Ministry estimated that 2.2 lakh people enter end-stage renal disease every year in the country. Hardly 10 000 receive transplants or go on dialysis each year. The rest die quietly, and do not bother the government thereafter. No account has been rendered to the people. Are we providing the greatest good for the greatest number at the least expense? Is it correct to spend so much on saving fewer than 10% of the patients, and how do we decide who should live and who should die? Would the money not be better spent on detecting all people with diabetes and hypertension soon after they develop the disease, and making sure they receive medicines in adequate doses and without a break, so that they do not develop renal failure in the first place? This would cost a small fraction of our health budget, and can be easily done, if only governments had the will to do it. There is also the added bonus of preventing much coronary and cerebrovascular disease.

OTHER METHODS OF RESTRICTING OUR POPULATION

Against the wishes of the Supreme Court and of People for the Ethical Treatment of Animals (PETA), the state government and we the people of Tamil Nadu have had our way in performing

jallikattu or the ancient sport of bull baiting. The argument is that this tradition must be kept alive to sustain Tamil pride, and also the particular breed of bulls that is used in the 'sport' will die out if we do not use them for this purpose. This breed has been developed by our Tamil ancestors specifically for *jallikattu* and we would not be true to our heritage if we allowed it to become extinct. The solemn undertaking made by the state government is that all precautions would be taken for the safety of both spectators and competitors, and under no circumstances would the bulls be given intoxicants or irritants, nor will they be maddened by having their mucosae rubbed with chilli powder. I have been keeping a record of all the *jallikattu* events reported in one newspaper, *The Hindu*, since 1 January 2018. Till 31 March 2018, 12 spectators and three bull tamers had died, so it is certainly a hazardous sport to watch. Four bulls died, two who ran across a railway line while they were being chased and were hit by trains, and one died of injuries when he was roughly thrown to the ground by a band of bull tamers. The fourth ran into a tree with such force that he fractured his skull and died on the spot.

Can you imagine any sane bull that has not been fed intoxicants, or maddened by irritants, running into a tree with sufficient force to commit suicide? What further proof does the Court require to establish that the government has been unable to prevent the torture of these noble animals, or is actively encouraging it? And how will we preserve a valuable breed by killing some of the best specimens?

Lest you feel that the number of humans killed has been quite small, I hasten to assure you that this poor yield is not for lack of trying. *The Hindu* reported that nearly 1298 spectators had been injured and taken to hospital. As for preserving the bulls, 142 of them had been injured. A strange way of ensuring the survival of the breed!

INCENTIVES TO STAY IN TAMIL NADU MEDICAL SERVICE

On 28 March 2018, the Additional Director of Medical Education released a revised schedule of incentives to service candidates (people working in the Tamil Nadu Medical Services [TNMS]) for entrance to postgraduate medical courses. Doctors serving the government in hilly areas, in 'backward districts with difficult areas having low density of doctors, high vacancies and poor health indicators', and people working in all accident, emergency and intensive care units would receive 100% of the allowed incentive marks. People working in all medical colleges and in hospitals within corporation or municipality limits would not be eligible for incentive marks, and those in all other government medical institutions would receive 40% of the bonus marks. A detailed list of the institutions in each of these categories was also released.

The incentive marks would be 10% of the marks obtained in the NEET PG 2018 examination per completed year of service in the designated hospitals or dispensaries, subject to a maximum of 30% of the NEET marks. Candidates in the TNMS wanted the previous reservation of 50% of seats for service candidates to be continued. However, the Madras High Court struck down both the incentive scheme and the 50% reservation on the grounds that both discriminated against non-service aspirants, and allowed candidates who might not be the most deserving academically to enter postgraduate courses.

It is clear that persons serving the government and thereby the people by working in difficult areas should get some reward for their service. However, that reward should not be at the expense of reducing the quality of candidates being accepted for higher education, the very purpose for which NEET was introduced. The incentives offered could be financial or weightage for promotions in the service. Also, after candidates have worked some years with these hardships, they should have a choice of postings for which they are professionally qualified, for an equal period of time. The financial incentives should be large enough to attract people to enter government service. The system tried successfully in Karnataka, of publishing the list of vacant posts and allowing candidates to take their pick, would also help to keep people in the service.

M.K. MANI