students towards homosexuality. *East Asian Arch Psychiatry.* 2018 Jun; 28(2):59-63.
10. Taneja R. Homosexuality not a disorder, says Indian Psychiatric Society. *NDTV.com*. 2018 Jul 10 [Cited 2021 Nov 7]. Available from: https://www.ndtv.com/india-news/homosexuality-not-a-disorder-says-indian-psychiatric-society-1880806
11. Rao TS, Jacob KS. Homosexuality and India. *Indian J Psychiatry.* 2012 Jan-Mar; 54(1):1-3.
12. Rukmini S. Homosexuality in India: What data shows. *Mint.* 2018 Sep 14 [Cited 2021 Nov 7]. Available from: https://www.livemint.com/Politics/nLQiPpI5UICajLDXETU3EO/Homosexuality-in-India-What-data-shows.html
13. Culler J. Performative language. In: *Literary Theory: A Very Short Introduction*. 2nd ed. Chap 7. 2011 Jul 28.
14. Di Ceglie, Domenico. Autonomy and Decision Making in Children and Adolescents with Gender Dysphoria. In: *Justice for Children and Families - A Developmental Perspective* (145 - 153). Cambridge: Cambridge University Press; 2019 Mar.
15. Patel R. Being LGBT in India: Some home truths. *Mint.* 2016 Aug 27 [Cited 2021 Nov 7]. Available from: https://www.livemint.com/Sundayapp/sAYrieZdZKEybKzhP8FDbP/Being-LGBT-in-India-Some-home-truths.html
16. Ghosh S. Battle for right body: The reality of sex reassignment surgeries in India. *New Indian Express*. 2020 Feb 24 (2019) [Cited 2021 Nov 7]. Available from: https://www.newindianexpress.com/cities/delhi/2020/feb/24/battle-for-right-body-the-reality-of-sex-reassignment-surgeries-in-india-2107686.html
17. Moleiro C, Pinto N. Sexual orientation and gender identity: review of concepts, controversies and their relation to psychopathology classification systems. *Front Psychol*. 2015 Oct 1;6: 1511.
18. Veltman A, Chaimowitz G. Mental health care for people who identify as lesbian, gay, bisexual, transgender, and (or) queer. *Can J Psychiatry.* 2014 Nov; 59(11):1-7.
19. GLAAD Media Reference Guide. *Glossary of Terms: Transgender.* Available from: https://www.glaad.org/reference/trans-terms
20. Ladenheim A, Wormser GP. A New Gender-Neutral Honorific: 'RP'. *Am J Med.* 2019 Aug; 132(8):902 - 904.
21. American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. *Am Psychol.* 2015 Dec; 70(9): 832 – 864.
22. A Gender-Neutral Honorific - Mx: Words We're Watching. Merriam-Webster. 2017 Sep [Cited 2021 Nov 7]. Available from: https://www.merriam-webster.com/words-at-play/mx-gender-neutral-title
23. Grasso C, McDowell MJ, Goldhammer H, Keuroghlian AS. Planning and implementing sexual orientation and gender identity data collection in electronic health records. *J Am Med Inform Assoc.* 2019 Jan; 26(1): 66-70. https://doi.org/10.1093/jamia/ocy137
24. Klein DA, Paradise SL, Goodwin ET. Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know. *Am Fam Physician.* 2018 Dec 1; 98(11):645-653.
25. Wareham J. Should You Put Pronouns In Email Signatures And Social Media Bios? *Forbes.* Available from: https://www.forbes.com/sites/jamiewareham/2020/12/30/should-you-put-pronouns-in-email-signatures-and-social-media-bios/?sh=7b6dcd636320
26. Salkind J, Gishen F, Drage G, Kavanagh J, Potts H. LGBT+ Health Teaching within the Undergraduate Medical Curriculum. *Int J Environ Res Public Health.* 2019 Jun 28;16(13), 2305. https://doi.org/10.3390/ijerph16132305
27. Morris M, Cooper RL, Ramesh A, Tabatabai M, Arcury TA, Shinn M, Im W, Juarez P, Matthews-Juarez P. Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. *BMC Med Educ.* 2019 Aug 30;19(1): 325. https://doi.org/10.1186/s12909-019-1727-3

COMMENT

The "Dravidian model": egalitarianism and healthcare reform

KIRAN KUMBHAR

Abstract

Throughout the post-independence period, the state of Tamil Nadu has consistently performed better than most other states in several major healthcare indicators, including infant mortality rate and total fertility rate. At the same time, it has received praise for the deep penetration and robust functioning of its public health system. Tamil Nadu's achievements in healthcare have been analysed in a number of scholarly studies in the past, and a recent book by Kalaiyarasan A and Vijayabaskar M, titled "The Dravidian Model: Interpreting the Political Economy of Tamil Nadu," is the latest addition to this literature. The authors argue that the state's uniqueness in human and social development primarily originates in the egalitarian politics and radical social movements of the early twentieth century which constituted a "Dravidian common-sense" that has since "shaped the development trajectory of the state." Their arguments on the significance of egalitarian politics in improvements in health and wellbeing receive ample support from existing social sciences literature on health, equity, and justice.

Keywords: *Tamil Nadu, global health, equity, gender, caste*

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Praise for the public health system in Tamil Nadu (TN) has been an enduring theme in global health literature for several decades now (an honour the state shares with its neighbour Kerala). Experts have provided, and continue to provide, several useful insights into TN's achievements in healthcare. A recent book by Kalaiyarasan A and Vijayabaskar M (hereafter K-V), titled *The Dravidian Model: Interpreting the Political Economy of Tamil Nadu* [1], is among the most recent commentaries on TN's gains in public health and other domains. The book, however, differs from previous analyses in several, often radical, ways, and aims to equip readers with new and more fundamental insights into what the authors term the state's overarching "Dravidian model." [a]

In this essay, I intend to elaborate the central ideas which K-V articulate in their book, particularly by juxtaposing them with previous scholarship on public health in Tamil Nadu. Like many other scholars, I harbour an intense curiosity to understand the reasons behind the unique effectiveness of TN in healthcare in India, and it can be said that with *The Dravidian Model,* especially when read alongside earlier insightful scholarship, we have inched closer to a comprehensive answer.

Earlier explanations

As early as the 1990s, the state of Tamil Nadu was deemed exemplary in several aspects of public health services, including child nutrition and maternal health programmes [2, 3]. In 1997, the Swedish scholars Göran Djurfeldt and Staffan Lindberg wrote a vivid account of healthcare-related attitudes and services in some villages and towns of the state where they had formerly lived and worked (in 1969-70). They used the term "welfare state" to describe the drivers of many of the changes they saw in the 1990s: "Midday meals schemes for both school and pre-school children, nearly 100 per cent immunization, free hospital treatment [through primary health centres]…, access to at least part of the basic necessities of life through fair price shops, access to an improved water supply through hand pumps and *pucca* wells, access to subsidized housing, are but some of the 'welfarist' programmes operating with a reasonable level of efficiency…" [4:p 196].

Jean Drèze and Amartya Sen have noted the outlier nature of Tamil Nadu in several commentaries since the 1990s. In 2002, discussing the causes behind the "rapid demographic transition" of TN (eg, the state achieving a Total Fertility Rate of 2.0), they mentioned "commonly-cited factors [like] a good infrastructure, a rich history of social reform movements, high literacy rates in the younger age groups, wide popular exposure to mass media, and strong 'political will'," as well as the "less widely discussed… relatively liberated status of women in contemporary Tamil society." [5:p 215] They also emphasised two crucial observations made by Leela Visaria: that TN's demographic transition had been facilitated by "widespread accessibility of reasonably good quality health care," and that the "social distance" between medical officers and patients is relatively small in Tamil Nadu: "A visit to the primary health centres in the state would convince anybody that many medical officers have non-Brahmanical backgrounds and are very similar to many rural patients in dress, mannerism, language, as well as overall values and attitudes." [6]. Scholars like Visaria, Drèze, and Sen credited caste-based reservations in medical admissions and in the recruitment of medical officers, for helping diminish the exclusive dominance of "upper castes and classes" in the medical profession in TN.

There were at least two other influential commentaries in later years. In 2009, Monica Das Gupta et al wrote a paper for the World Bank, titled "How to Improve Public Health Systems: Lessons From Tamil Nadu." Their primary emphasis was on how TN had built a "strong integrated public health system" by investing in a dedicated and professionalised public health workforce which, among other things, ensured continuity in policy over longer stretches of time and helped the state conduct "long-term planning." [7]. In 2011, VR Muraleedharan et al presented TN as a "success story" in terms of providing "good health at low cost." They discussed, among other things, the state's commitment to primary care and its public health management cadre, village health nurses' network, encouragement to indigenous medical systems, innovative drug purchase and distribution system for the public sector, gender equality, and economic growth [8].

Interestingly, the emphasis on radical politics and egalitarianism seen in the analyses of Visaria, Sen, Drèze and others, did not find place in these later analyses. Supposing that the states of Uttar Pradesh, Gujarat, or West Bengal were to institute a dedicated public health cadre and establish a specialised corporation to streamline drug purchase and distribution — but all in the absence of egalitarian politics and radical social thought — would those interventions still lead to strong, sustained achievements in major health indicators across the socioeconomic spectrum? That is, can other states "replicate" the success of the TN "model" by picking out individual elements of it and implementing those in their own regional contexts?

The "Dravidian common-sense"

The Dravidian Model provides crucial clues to answer these questions. Kalaiyarasan and Vijayabaskar's (K-V) intervention in the abundant literature on healthcare in Tamil Nadu is their argument that most of the state's long-standing development policies (including health-related policies) have their genesis in its foundational "Dravidian" philosophy, which they elaborate in the book's second chapter titled "Conceptualising Power in Caste Society." The origins of modern Tamil Nadu's uniqueness, they say, go back to the pre-independence period and the work of radical Tamil thinkers and activists who were vehement advocates of social justice and egalitarian politics. EV Ramasamy, popularly known as Periyar, has been the most influential of these thinkers, and the chapter shows that his ideas permeated deep into Tamil society and powered the political discourse there:

> *Periyar held that the most important dimension of being human, and which distinguishes them from other animals, is the sense of dignity (**maanam**) that can come only through self-respect (**suyamariyadhai**)... Taking issue with Tilak's 'Swaraj is my birth right' slogan, he argues that this addressed only the political and the material domain, but does not speak about the dignity of individuals and their social being… He also emphasises experiential equality as fundamental to the idea of equality. Only when people share a similar experience can they develop a*

> *sense of fraternity and belonging… He therefore articulated a demand for 'equal rights' that can be claimed by all.* [1:p 35]

To Periyar, "redistribution of property [and other material entities] without abolition of caste-based privileges was unlikely to lead to an egalitarian system because of the entrenched power of caste elites." [1:p 39] Hence, helping to erode the centuries-long rooted dominance and hegemony of privileged caste groups, and thereby making "way for the… realisation of self-respect," was among the foundational ideas of the emerging Dravidian politics. The authors argue that these powerful demands for self-respect and social justice have "shaped the development trajectory of the state." These early political interventions "made visible the contours of caste-based social injustice, constituting in turn what we refer to as 'Dravidian common-sense' that comprised of securing justice through *caste-based reservation, faith in a productivist ethos, need for greater state autonomy and forging an inclusive modernity*." [emphasis original][1:p 27]

In the chapter titled "Democratising Care," K-V discuss the application of the "Dravidian common-sense" to healthcare policy, liberally citing the existing work of many social scientists who have over the years offered important perspectives on healthcare in Tamil Nadu. They emphasise, for example, TN's strong commitment to gender equality: the state's focus on women's literacy and education have led to, among other things, a higher average age at marriage and reductions in the fertility rate. At the same time, more than 72% of Primary Health Centres in TN have a woman doctor (the all-India figure for this is 27%). Tamil Nadu has consistently had better women to men doctor ratios than other states. Even in the 1960s, for example, the state (then known as Madras) had 24 women to 100 men doctors, the highest ratio in the country [9]. K-V further argue that with the state's historical commitment to caste-based reservations, "the generation of a pool of healthcare professionals drawn from socially diverse backgrounds ensured an incentive to cater better to socially marginalised groups," and that "changes in the social composition of the [public health] bureaucracy enabled better information dissemination." [1:p 84] Since disparities in people's access to expertise end up augmenting and sustaining social and economic hierarchies, "social networks between the members of a marginalised community and a service provider [from that community]" play a singular role in disseminating information and enhancing public access to services. [1:p 106]

The authors delve into how Tamil Nadu's historical political commitment to dismantling gender and caste-based inequalities holds the key to understanding the unique human development success of the state. This commitment to egalitarian politics stems from, as the authors put it, the state's "Dravidian common-sense." TN's politicians and people were able to achieve stellar success in multiple healthcare and wellbeing indicators, less through piecemeal "vertical" policies which aimed to reduce this metric or increase that statistic, and more through a robust commitment to reducing social inequalities and strengthening grassroots democracy and participation. This commitment to egalitarianism not only enabled but also sustained investment in such entities as primary healthcare, effectively managed mid-day meal schemes, and dedicated public health cadres. To quote from Partha Chatterjee's endorsement, this book argues that TN's development strategy has emphasised "status inequalities of caste and gender rather than income inequalities with remarkable success." Hence, if another state or region wishes to "replicate" the TN "model," picking out disjointed aspects of its policies will be far less helpful than instituting a sustained political and social commitment to eradicating structural socio-political obstacles to all-round human development. The most effective replicable aspect of Tamil Nadu's journey is, thus, the state's direct political assault on the entrenched social structures and behaviours which perpetuate experiential inequalities including, most importantly for India, those of caste and gender.

The only sustainable solution: egalitarian politics and policies

The Dravidian Model thus contributes important evidence to the existing literature and experience of how broad-based, sustainable advancements in public health and wellbeing are possible only through serious commitment to and action on egalitarianism. In a recent article showing how there are wide disparities in the life expectancies of Indians depending upon their caste and religion, Vyas et al argue that "extreme social stratification and exploitation in India may be contributing to global population health deficits and slower improvements in health worldwide." [10] The passionate activist-intellectual-doctor Paul Farmer devoted a lifetime of work to resisting inequalities and working towards social justice. In the book *Pathologies of Power*, he wrote that "equity is the central challenge for the future of medicine and public health," and underscored the "pathogenic role of inequity." [11:p 20] Analysing Maharashtra's Jamkhed healthcare delivery model, anthropologist Patricia Antoniello has written that it is based on a premise that identifies "everyday injustices as primary social determinants of health," and that its success has shown that "elimination of the embedded inequalities of caste and gender promote health and well-being." [12:p 2] In one of the most profound studies of the healthcare system and policy in India, social scientist Sheila Zurbrigg perceptively wrote, in the 1980s, that "issues of health and socio-economic justice are concretely inseparable." [13:p 15]

In recent years, policy, including health policy, has been overtaken by what historian Jerry Muller has called the tyranny of metrics. While metrics have their place in policy, Muller says that our obsessive "fixation" with numbers and data "leads to a diversion of resources away from frontline producers toward managers, administrators, and those who gather and manipulate data." [14:p 8]. The trajectory of Tamil Nadu, which had already achieved stellar results in health

and wellbeing before the fixation with data gathering (and with digital IDs and apps) intensified in India over the past decade, seems to indicate that what the country needs to do is not to fixate over and submit to the tyranny of metrics, but fix the obstinate tyrannies of inequality and injustice [15].

However, as K-V write in their final chapter ("Fissures, Limits, and Possible Futures"), equity and egalitarianism in TN are still a work in progress, even if the state shines when compared with most other states. Besides, as Ajantha Subramanian's research on caste-based privilege in IIT Madras shows, the state's gains in egalitarianism are severely undermined by the persistent opposition to Dalit struggles for self-respect [16]. Thus, while Tamil Nadu is unique in many ways as outlined above, it is also similar to the rest of India in several ways, and will suffer if it encourages and institutionalises the cavalier attitudes towards inequality and injustice common in most other parts of the country. Kalaiyarasan A and Vijayabaskar M hint at such persisting and newly-rising axes of inequality in the state in their final chapter, and one hopes that the people and politicians of Tamil Nadu are taking note.

[a]Note:

Though the term "Dravidian" is not explicitly defined in the book, the term is generally used to denote the languages and cultures of southern India (especially the state of Tamil Nadu), particularly in contrast to those of other parts of the country.

References

1. Kalaiyarasan A, Vijayabaskar M. *The Dravidian Model: Interpreting the Political Economy of Tamil Nadu.* Cambridge: Cambridge University Press; 2021.
2. Pelletier DL, Shrimpton R. The role of information in the planning, management and evaluation of community nutrition programmes. *Health Policy Plan.* 1994 Jun; 9(2), 171–184. https://doi.org/10.1093/heapol/9.2.171
3. Van Hollen C. *Birthing on the threshold: Childbirth and modernity among lower class women in Tamil Nadu, South India.* University of California, Berkeley; 1998.
4. Djurfeldt G, Lindberg S, Rajagopal A. Coming Back to Thaiyur: Health and Medicine in a Twenty-five Years Perspective. In: Bremen J, Kloos P, Sani A, eds, *The Village in Asia Revisited.* Oxford University Press; 1997.
5. Drèze J, Sen A. *India: Development and Participation.* Oxford University Press; 2002.
6. Visaria L. Innovations in Tamil Nadu. Unhealthy Trends: A Symposium on the State of our Public Health. *Seminar.* 2000 May [Cited 2022 Jun 10]: 489. Available from: https://www.india-seminar.com/2000/489/489%20visaria.htm
7. Das Gupta M, Desikachari B R, Somanathan T V, Padmanaban P. *How to Improve Public Health Systems: Lessons from Tamil Nadu.* Policy Research Working Papers. World Bank; 2009 Oct. https://doi.org/10.1596/1813-9450-5073
8. Muraleedharan V R, Dash U, Gilson L. Tamil Nadu 1980s-2005: A success story in India. In: Balabanova D, et al, Ed. *"Good Health at Low Cost" 25 Years On: What Makes a Successful Health System*. London: London School of Hygiene and Tropical Medicine; 2011.
9. National Institute of Health Administration and Institute of Applied Manpower Research. *Manpower Survey (Health and Medical Manpower): Stock of Allopathic Doctors in India.* 1966.
10. Vyas S, Hathi P, Gupta A. Social disadvantage, economic inequality, and life expectancy in nine Indian states. *Proceedings of the National Academy of Sciences,* 2022 Mar; 119(10): e2109226119. https://doi.org/10.1073/pnas.2109226119
11. Farmer P. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Berkeley, CA: University of California Press; 2004.
12. Antoniello P. *For the Public Good: Women, Health, and Equity in Rural India.* Nashville, TN: Vanderbilt University Press; 2020.
13. Zurbrigg S. *Rakku's Story: Structures of Ill-Health and the Source of Change.* Bangalore, India: Centre for Social Action; 1984.
14. Muller J Z. *The Tyranny of Metrics.* Princeton, NJ: Princeton University Press; 2018.
15. Kumbhar K. Aarogya Setu App Is Just the Latest Example of Our Obsession With Quick-Fixes. *The Wire Science,* 2020 May [Cited 2022 Jun 10]. Available from: https://science.thewire.in/health/aarogya-setu-app-covid-19-quick-fix-tuberculosis-chemotherapy
16. Subramanian A. *The Caste of Merit: Engineering Education in India.* Cambridge, MA: Harvard University Press; 2019.

CORRIGENDUM

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The statement against reference 5 in section 'Written consent in BMHR' and the reference 5 cited alongside have been corrected after the corresponding author of the paper cited in the earlier version informed the journal of the error. The authors of the article have accepted and corrected the error. The correction has been made as on October 6, 2022. The authors apologise for the error.