

POLITICAL ECONOMY OF RURAL HEALTHCARE EQUITY IN TAMIL NADU: PUBLIC EXPENDITURE, HEALTH SYSTEMS, SERVICE UTILIZATION, AND BARRIERS TO ACCESS

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Abstract

This study explores the political and economic factors affecting rural healthcare in Tamil Nadu, India. Despite strong infrastructure, high service use, and government efforts, many rural people still face barriers to accessing quality healthcare. Issues like distance, transportation costs, social discrimination, and lack of awareness prevent vulnerable groups such as women, low-income families, and marginalized communities from getting timely care. Public spending has helped improve health facilities, maternal health, and reduce infant mortality, but disparities between districts and social groups remain.

The study highlights that effective healthcare depends not only on government investment but also on good governance, workforce distribution, community participation, and social support. To improve health equity, Tamil Nadu needs targeted funding for remote areas, better incentives for healthcare workers, digital health options, and stronger community involvement. Reducing financial and geographic barriers will help ensure that all rural populations can access and trust healthcare services. Overall, the success of rural health in Tamil Nadu depends on inclusive policies, active community engagement, and sustained political commitment to leave no one behind and promote health equity for all rural residents.

***Keywords:* Rural Healthcare, Quality Healthcare, Social Discrimination, Workforce Distribution,
Digital Health, Health Equity and Social Support.**

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Introduction

Rural healthcare remains a critical component of India's broader public health landscape, with disparities in access and quality posing significant challenges to achieving health equity. Tamil Nadu, one of India's more developed states, has made notable progress in strengthening its rural health system through extensive infrastructure, high service utilization, and targeted policies. The state's decentralized governance, substantial public expenditure, and community participation have contributed to improved maternal, child, and primary healthcare outcomes. Despite these advancements, persistent barriers such as geographical isolation, social inequalities, economic constraints, and uneven resource distribution continue to hinder equitable access for marginalized populations. Understanding the political economy behind rural healthcare in Tamil Nadu is essential to address these disparities effectively. Public expenditure plays a vital role in expanding infrastructure and service delivery, but disparities between districts, social groups, and economic classes reveal the limits of current policy measures.

Moreover, socio-economic factors such as household income, education, caste, and occupation influence healthcare utilization patterns, often leading to delayed or inadequate treatment among vulnerable groups. This study aims to explore the complex interplay of political, institutional, social, and economic determinants shaping rural healthcare equity in Tamil Nadu. By analyzing public spending, service utilization, and access barriers, the research seeks to identify strengths, gaps, and opportunities for policy interventions that can promote more inclusive healthcare systems. Ultimately, strengthening governance, workforce distribution, community participation, and targeted investment are crucial for ensuring that rural populations not only access healthcare services but trust and utilize them effectively. This comprehensive understanding is vital for designing sustainable strategies to bridge existing gaps and foster health equity across Tamil Nadu's diverse rural landscapes.

Statement of the problem

Despite Tamil Nadu's relatively advanced rural healthcare infrastructure and high service utilization, significant disparities in healthcare access and quality persist across different districts and social groups. Rural populations, particularly marginalized

communities such as Scheduled Castes, women, and low-income families, continue to face barriers that limit equitable health outcomes. Geographic challenges, including distant and poorly connected villages, restrict timely access to specialized and emergency services. Economic barriers, such as indirect costs related to transportation, medicines, and wage loss, discourage or delay treatment-seeking behaviors among the poor. Social inequalities, including discrimination, low health literacy, and social exclusion, further exacerbate these disparities, reducing trust and utilization of public health services. Moreover, while public expenditure has expanded infrastructure and improved health indicators, the uneven distribution of resources and shortages of skilled health personnel in underserved districts hinder the achievement of universal health coverage.

The preference for private healthcare among rural households, driven by perceptions of higher quality and faster service, reflects ongoing gaps in public service delivery. These issues collectively undermine the goal of health equity, resulting in preventable morbidity, maternal and infant mortality, and delayed treatment for vulnerable groups. The core problem lies in understanding how political, institutional, social, and economic factors interact to influence healthcare access in rural Tamil Nadu. Addressing these multifaceted barriers requires a nuanced analysis of resource allocation, governance, community participation, and social determinants of health. Without targeted interventions that prioritize equity, rural populations will remain at risk of inadequate healthcare, perpetuating systemic inequalities and undermining overall health system performance. Therefore, identifying and addressing these persistent barriers is crucial for achieving sustainable, inclusive rural health outcomes in Tamil Nadu.

Objective

The overall objective of the article is to understand how public spending, healthcare services, and social factors affect healthcare access for rural people in Tamil Nadu. It aims to identify the barriers that prevent equal healthcare for everyone. The study also looks at how government policies and community efforts can improve healthcare for poor and marginalized groups. By doing this, it hopes to suggest ways to make rural healthcare more fair, accessible, and effective for all with the help of secondary sources of information and statistical data pertaining to the theme of the article.

Research Methodology

This study uses a descriptive and analytical approach to understand the political economy of rural healthcare in Tamil Nadu. It mainly relies on secondary data from government reports, surveys, and research studies. The data includes information on public

expenditure, healthcare infrastructure, service usage, and barriers faced by rural people. The analysis focuses on how government spending, policies, and social factors influence access to healthcare. The study compares different districts to see which areas have better health services and where gaps still exist. It also examines socio-economic factors like income, education, and caste that affect healthcare utilization. By reviewing statistical data and official reports, the research aims to identify strengths and weaknesses in Tamil Nadu's rural health system. This method helps to understand the relationship between government efforts and actual access to services for rural populations. The ultimate goal is to suggest ways to improve healthcare fairness and reach vulnerable groups more effectively. The approach is simple, based on existing information, and aims to provide clear insights into the political and social factors shaping rural healthcare in Tamil Nadu.

Political Economy of Rural Healthcare Equity in Tamil Nadu: Public Spending, Service Utilization, and Access Barriers

The political economy of rural healthcare equity in Tamil Nadu reflects the relationship between public expenditure, institutional efficiency, and social access to medical services. Tamil Nadu has one of India's stronger public health systems, supported by an extensive rural network of 8,700+ sub-centres, 1,400 primary health centres, and 385 community health centres, which has reduced the infrastructure gap in many villages. The state has also achieved relatively high healthcare utilization, with 63% of rural outpatient cases and 57% of rural inpatient cases using public health facilities, exceeding the national average. Recent survey evidence shows that rural health outcomes in Tamil Nadu are better than in many other states. According to the NFHS-5 (2019–21), nearly 89% of mothers in rural Tamil Nadu received full maternal and new-born healthcare services, demonstrating stronger service delivery in reproductive and child health.

However, utilization remains uneven because healthcare access is shaped not only by availability but also by economic and social conditions. Studies indicate that many rural households still prefer private hospitals despite higher costs because they perceive government services as slower, overcrowded, or lower in quality. Major barriers continue to affect healthcare equity in rural areas. These include transport difficulties, shortage of specialists, indirect treatment costs, lack of awareness, and social inequality among marginalized groups. Vulnerable populations, particularly women and low-income families, often delay treatment because of lost wages and travel expenses. Although Tamil Nadu allocates significant resources to health compared with many states, disparities in service quality between districts remain a challenge. Strengthening rural healthcare equity therefore

requires not only higher public spending, but also better governance, workforce distribution, and community-level accountability to ensure that healthcare services are both accessible and trusted. The details of the Political Economy of Rural Healthcare Equity in Tamil Nadu are given in table -1.

Table -1
Political Economy of Rural Healthcare Equity in Tamil Nadu

| S. No. | Indicator | Statistical Data | Interpretation |
|--------|--|--|--|
| 1. | Rural Health Infrastructure | 8,700+ Sub-Centres, 1,400 Primary Health Centres, 385 Community Health Centres | Shows the wide public healthcare network available in rural Tamil Nadu |
| 2. | Rural Outpatient Use of Public Facilities | 63% | Indicates strong dependence on government hospitals for primary care |
| 3. | Rural Inpatient Use of Public Facilities | 57% | Reflects substantial use of public institutions for hospitalization |
| 4. | Maternal and Newborn Healthcare Coverage | 89% | Demonstrates improved access to reproductive healthcare services |
| 5. | Main Barriers to Access | Transport cost, specialist shortage, indirect expenses | Economic and social barriers continue to limit healthcare equity |
| 6. | Preference for Private Hospitals | Increasing among rural households | Due to perceptions of better quality and faster treatment |

Source: National Family Health Survey (NFHS-5), Tamil Nadu, 2019–2021.

Tamil Nadu's rural healthcare system reflects a relatively strong public health structure, with more than 8,700 Sub-Centres, 1,400 Primary Health Centres, and 385 Community Health Centres serving village populations. This extensive network has increased reliance on government services, as 63% of rural outpatient cases and 57% of inpatient treatments occur in public facilities. Maternal and new-born healthcare coverage has reached about 89%, showing notable progress in rural reproductive health outcomes. However, healthcare equity remains uneven because transport costs, shortage of specialists, and hidden medical expenses still reduce access for poorer households. As a result, many rural families are gradually shifting toward private hospitals, mainly due to the belief that private institutions provide faster and better-quality treatment. These trends indicate that while public investment has improved service utilization, economic barriers continue to influence healthcare choices and rural health equity in Tamil Nadu.

Public Expenditure and Equity in Rural Healthcare Access in Tamil Nadu

Public expenditure on healthcare plays a decisive role in improving equity in healthcare access among rural populations in Tamil Nadu by reducing the gap between rich and poor households in obtaining essential medical services. Tamil Nadu has consistently expanded its rural health network through more than 8,700 Sub-Health Centres, over 1,400 Primary Health Centres (PHCs), and several district hospitals, enabling villages to access care within shorter travel distances. Recent government investment also added 642 new sub-health centres in 2026, strengthening service delivery in remote and hilly regions. Higher public spending has improved the availability of free maternal care, immunization, diagnostics, and essential medicines, which particularly benefits low-income rural households. Studies show that nearly 63% of rural outpatients in Tamil Nadu depend on public health facilities, indicating that state-funded institutions remain the primary source of affordable care for vulnerable communities. Public financing also lowers out-of-pocket expenditure, preventing poor families from delaying treatment because of financial hardship.

Government expenditure further promotes equity by supporting human resources and infrastructure in underserved regions. Increased budget allocations for preventive care and primary healthcare have improved rural service utilization, especially among women, children, and the elderly. However, unequal distribution of doctors and shortages in some backward districts still create disparities despite higher spending. Research suggests that while Tamil Nadu performs better than many Indian states, rural equity depends not only on larger health budgets but also on efficient allocation of funds across poorer regions. Therefore, public healthcare expenditure in Tamil Nadu influences rural healthcare equity by making services more affordable, geographically accessible, and socially inclusive, though continued policy attention is needed to ensure that all rural communities benefit equally from these investments. The details of the Public Expenditure and Equity in Rural Healthcare Access in Tamil Nadu are stated in table – 2.

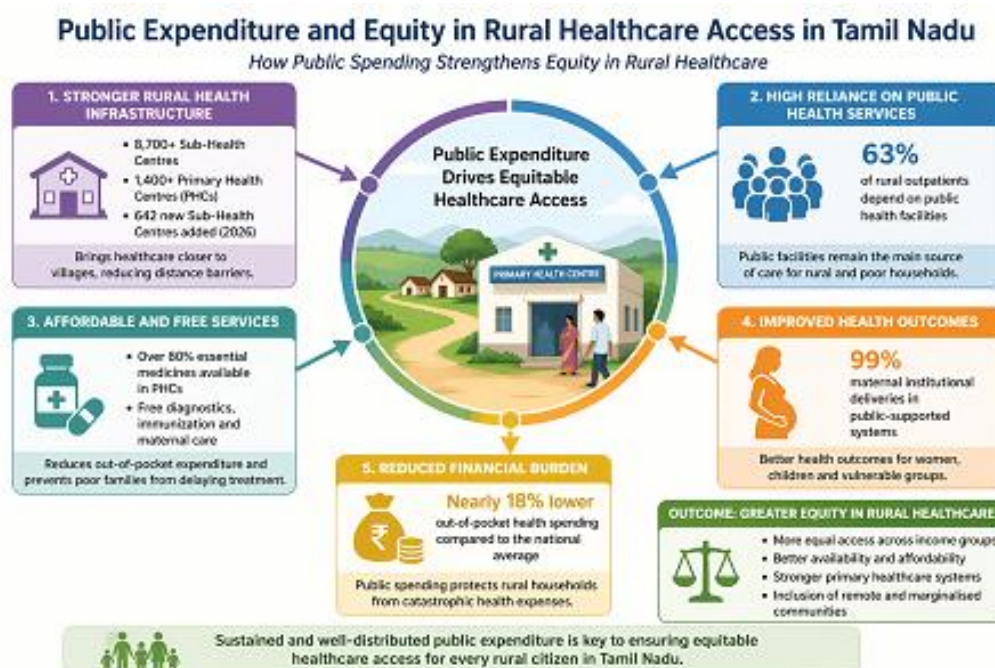
Table -2

Public Expenditure and Equity in Rural Healthcare Access in Tamil Nadu

| S. No. | Indicator | Statistical Data | Interpretation |
|--------|---|---|---|
| 1 | Rural Health Infrastructure | 8,700+ Sub-Health Centres and 1,400+ PHCs | Expands healthcare coverage to remote rural communities |
| 2 | Rural Outpatient Dependence on Public Facilities | 63% | Shows strong reliance of rural people on government |

| | | | |
|---|--|--|--|
| | | | healthcare |
| 3 | New Sub-Health Centres Added | 642 centres | Improves accessibility in underserved villages |
| 4 | Free Medicine Availability in PHCs | Over 80% essential drugs supplied | Reduces financial burden on poor households |
| 5 | Maternal Institutional Deliveries | 99% in public-supported systems | Reflects better maternal healthcare equity |
| 6 | Out-of-Pocket Health Spending Reduction | Nearly 18% lower than national average | Public spending protects poor families from health costs |

Source: Government of Tamil Nadu, Department of Health and Family Welfare Policy Note, 2025–2026.



Political and Institutional Determinants of Rural Healthcare Delivery Systems in Tamil Nadu

Political and institutional factors strongly influence the structure and performance of rural healthcare delivery in Tamil Nadu. The state has developed one of India's most decentralized public health systems, where the Department of Health and Family Welfare works with district administrations, local panchayats, and the National Health Mission to improve service delivery. Tamil Nadu has more than 1,400 Primary Health Centres and over 8,700 sub-centres, creating a broad rural healthcare network that allows services to reach remote villages. Political commitment has been a major strength. Successive governments in Tamil Nadu have treated healthcare as a social welfare priority and increased public spending on maternal care, immunization, and preventive medicine.

As a result, nearly 98–100% of childbirths in the state now occur in institutions, and rural Primary Health Centres recorded a fourfold increase in deliveries after the introduction of 24×7 services and better staffing. This shows how policy decisions can directly improve

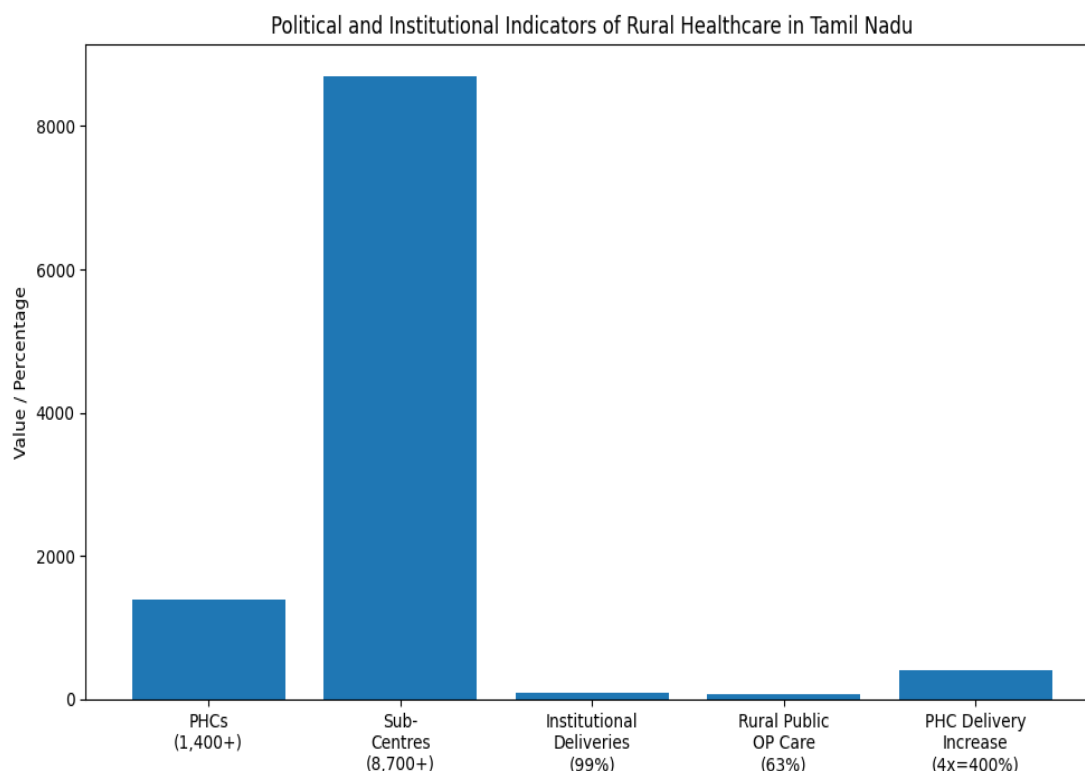
trust in rural public facilities. Institutional governance also matters in ensuring accountability. Village Health Sanitation and Nutrition Committees and local monitoring bodies were introduced to involve communities in planning and oversight. The details of the Political and Institutional Determinants of Rural Healthcare Delivery Systems in Tamil Nadu are stated in table - 3.

Table -3

Political and Institutional Determinants of Rural Healthcare Delivery Systems in Tamil Nadu

| S. No. | Political / Institutional Factor | Statistical Data | Impact on Rural Healthcare Delivery |
|--------|---------------------------------------|--|--|
| 1 | Public Health Infrastructure | 1,400+ Primary Health Centres and 8,700+ Sub-Centres | Expands healthcare access to remote rural villages |
| 2 | Institutional Deliveries | 99% of births in health institutions | Reflects successful maternal healthcare policies |
| 3 | 24x7 PHC Services | 4-fold rise in PHC deliveries | Improves emergency and maternal care in villages |
| 4 | Village Health Committees | Functioning in most rural panchayats | Strengthens local monitoring and accountability |
| 5 | Public Health Spending | Around 5% of state budget for health | Supports medicine supply and staff recruitment |
| 6 | Rural Dependence on Public Facilities | 63% rural outpatient care in government centres | Shows trust in public healthcare institutions |

Source: National Health Mission, Rural Health Statistics Report, Government of India.



These institutions help identify shortages in medicines, absenteeism of staff, and local health needs. At the same time, coordination between state and central authorities shapes resource allocation. Delays in fund release or excessive centralization can reduce the flexibility of district health officials to respond to village-specific problems. However, political and institutional weaknesses still create barriers. Unequal distribution of doctors, administrative delays, and shortages in specialist care continue in some rural blocks. Even with a strong policy framework, effective implementation depends on transparent governance, stable financing, and local participation. Thus, political leadership and institutional capacity remain central to achieving equitable rural healthcare in Tamil Nadu.

Socio-Economic Characteristics of Rural Households and Public Healthcare Utilization in Tamil Nadu

The socio-economic characteristics of rural households strongly influence the use of public healthcare services in Tamil Nadu. Household income, education, occupation, social background, and gender roles shape healthcare decisions. Poor households depend more on government facilities because treatment is either free or highly subsidized. Recent data show that nearly 40% of rural non-hospitalized patients in Tamil Nadu use public health facilities, while wealthier families often prefer private hospitals because they perceive better quality care. Education also affects healthcare utilization. Households with literate members are more aware of immunization, maternal care, and disease prevention services. Educated families are more likely to seek timely treatment in Primary Health Centres and government hospitals. In contrast, low literacy reduces awareness of available schemes and delays treatment. Studies in rural India show that healthcare utilization rises steadily with higher educational attainment and household wealth.

Caste and social status further influence access. Scheduled Castes and marginalized communities often rely on public facilities because private care is expensive. However, some families still face social exclusion, transportation problems, and poor treatment, reducing their willingness to visit public institutions. Women in low-income households may also postpone care because family income is prioritized for male earners. Another major factor is occupation and employment security. Agricultural labourers and informal workers usually seek treatment only when illness becomes serious because losing a day's wage affects family survival. Although Tamil Nadu has a strong rural health network, social and economic inequalities continue to affect who uses public healthcare regularly. Therefore, improving awareness, transport, and service quality can increase equitable healthcare utilization among

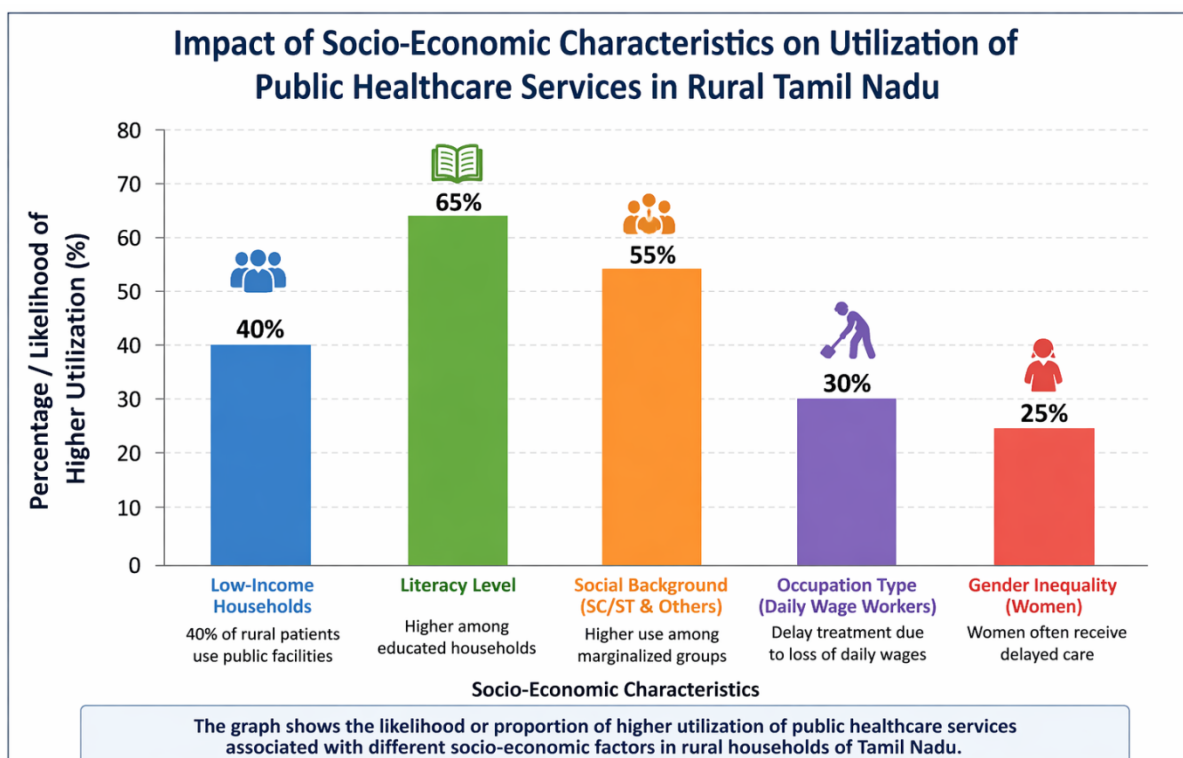
rural households in the state. The details of the Socio-Economic Characteristics of Rural Households and Public Healthcare Utilization in Tamil Nadu are stated in table -4.

Table -4

Socio-Economic Characteristics of Rural Households and Public Healthcare Utilization in Tamil Nadu

| S. No. | Socio-Economic Factor | Statistical Data | Impact on Public Healthcare Utilization |
|--------|-----------------------|---|--|
| 1 | Low-Income Households | 40% of rural patients use public facilities | Poor families depend on free or low-cost government healthcare services |
| 2 | Literacy Level | Higher among educated households | Education improves awareness of health services and early treatment |
| 3 | Social Background | Higher use among marginalized groups | Public hospitals serve socially disadvantaged households more frequently |
| 4 | Occupation Type | Daily wage workers delay treatment | Loss of wages discourages regular healthcare visits |
| 5 | Gender Inequality | Women often receive delayed care | Household financial priorities reduce women’s healthcare access |

Source: National Health Systems Resource Centre (NHSRC), Health Care Utilization among Rural Households in Tamil Nadu, 2021.



Financial, Geographic, and Social Barriers to Rural Healthcare Access in Tamil Nadu

Rural people in Tamil Nadu continue to face financial, geographic, and social barriers that reduce their access to quality healthcare services despite the state’s comparatively strong public health

system. The first major barrier is financial hardship. Although treatment in government hospitals is often free, many rural families still spend money on transport, medicines, diagnostic tests, and wage loss. National health survey estimates show that nearly 18–22% of rural households in South India delay treatment because of cost-related reasons, especially among low-income agricultural workers. Out-of-pocket spending remains a burden for poor families, particularly for chronic diseases and emergency care. The second barrier is geographic isolation. Many villages are located far from higher-level hospitals. Primary Health Centres may exist nearby, but specialized services such as surgery, maternal care, or diagnostic facilities are concentrated in towns. Studies indicate that some rural patients in Tamil Nadu travel 10–20 km or more to reach secondary care hospitals, creating delays in treatment. Poor road connectivity and limited public transport further worsen access for elderly patients and women. The details of the Financial, Geographic, and Social Barriers to Rural Healthcare Access in Tamil Nadu are stated in table - 5.

Table -5

Financial, Geographic, and Social Barriers to Rural Healthcare Access in Tamil Nadu

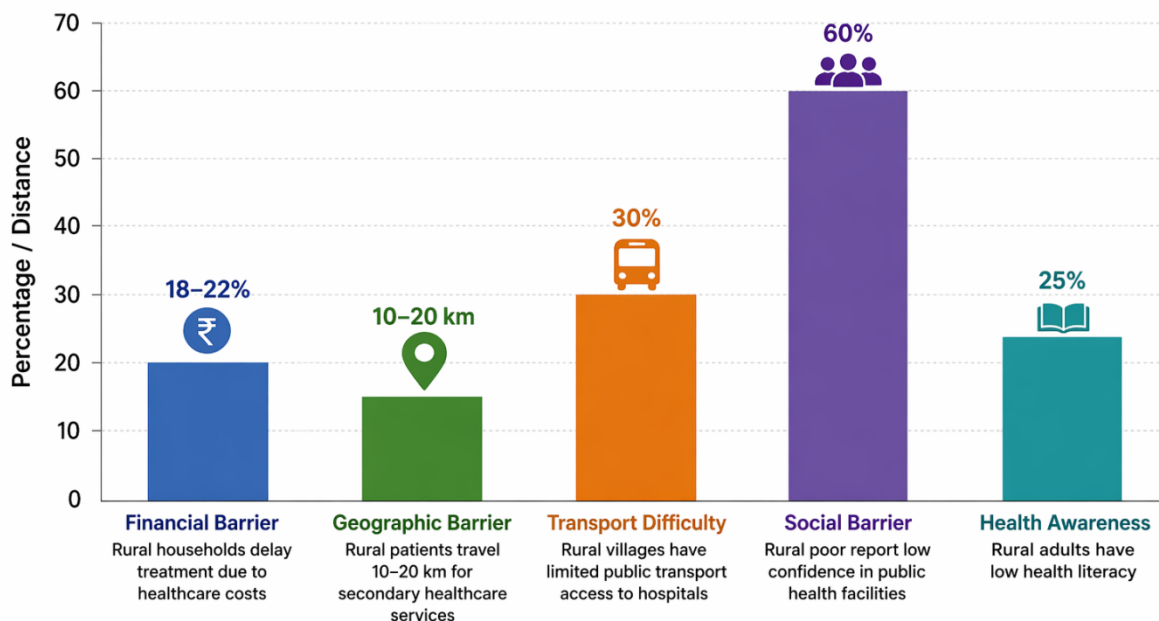
| S. No. | Barrier Type | Statistical Data | Interpretation |
|---------------|-----------------------------|---|--|
| 1 | Financial Barrier | 18–22% of rural households delay treatment due to healthcare costs | Even in public hospitals, travel expenses, medicines, and wage loss discourage poor families from seeking care |
| 2 | Geographic Barrier | Rural patients travel 10–20 km for secondary healthcare services | Distance to hospitals reduces timely access, especially for elderly and pregnant women |
| 3 | Transport Difficulty | 30% of rural villages have limited public transport access to hospitals | Lack of transport creates delays in emergency and specialist treatment |
| 4 | Social Barrier | 60% of rural poor report low confidence in public facilities | Perceived poor service quality and discrimination reduce healthcare utilization |
| 5 | Health Awareness | Around 25% of rural adults have low health literacy | Poor awareness leads to delayed diagnosis and improper treatment-seeking behavior |

Source: National Family Health Survey (NFHS-5), Tamil Nadu Fact Sheet, 2019–2021.

The third barrier is social inequality and low awareness. Elderly people, women, Scheduled Castes, and tribal communities often experience discrimination, poor communication, and lack of health literacy. In some areas, people avoid government hospitals because of long waiting times, staff shortages, and mistrust of service quality. Earlier district-level evidence showed that more than 60% of rural poor respondents expressed low confidence in public facilities due to poor treatment and inadequate resources. Therefore, healthcare inequality in rural Tamil Nadu is not only a medical issue

but also a political and social problem, where poverty, distance, and social exclusion combine to limit equitable healthcare access.

Financial, Geographic, and Social Barriers to Rural Healthcare Access in Tamil Nadu



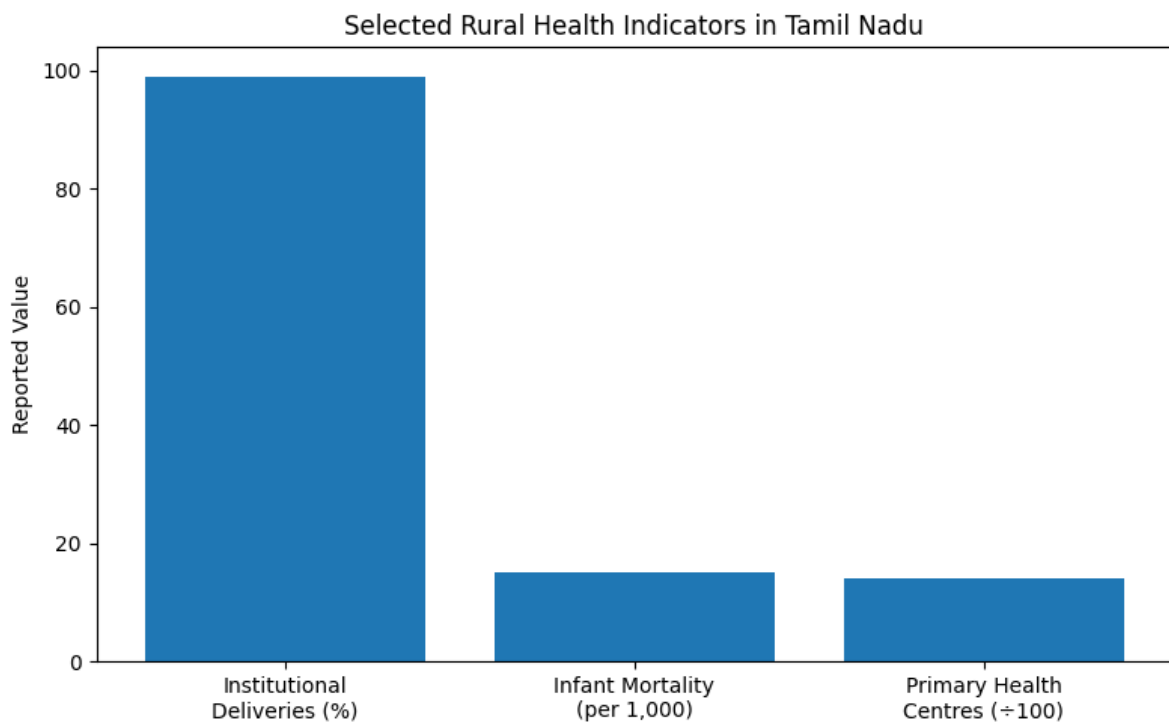
Effectiveness of Rural Health Policies in Reducing Healthcare Disparities across Districts in Tamil Nadu

Existing rural health policies in Tamil Nadu have been moderately effective in reducing healthcare disparities, but differences between districts still remain. The state has strengthened rural healthcare through the National Health Mission (NHM), the Chief Minister’s Comprehensive Health Insurance Scheme, and the Tamil Nadu Health System Reform Program. These initiatives improved access to primary care, maternal services, diagnostics, and financial protection for poor households. The Tamil Nadu Health System Reform Program specifically recognized that no mother in many parts of the state now travels more than 30 minutes for emergency obstetric care, showing major progress in rural service delivery. Statistical evidence shows positive outcomes. Institutional deliveries in Tamil Nadu exceed 99%, infant mortality has fallen to around 15 per 1,000 live births, and public health facilities continue to serve a large share of rural patients. District-level monitoring under NFHS and NHM has also improved accountability by identifying weaker districts such as Dharmapuri, Villupuram, and Ramanathapuram, where maternal and child health indicators remain below the state average. The details of the Effectiveness of Rural Health Policies in Reducing Healthcare Disparities across Districts in Tamil Nadu are given in table - 6.

Table – 6
Effectiveness of Rural Health Policies in Reducing Healthcare Disparities Across Districts in Tamil Nadu

| S. No. | Indicator | Statistical Data | Interpretation |
|--------|---------------------------------------|--|---|
| 1 | Institutional Deliveries | 99%+ | Shows strong maternal healthcare coverage in rural districts through public health programs |
| 2 | Infant Mortality Rate | 15 per 1,000 live births | Reflects improvement in child healthcare and district-level policy implementation |
| 3 | Rural Public Health Facilities | 1,400+ PHCs | Demonstrates extensive rural healthcare infrastructure across Tamil Nadu |
| 4 | Emergency Maternal Access | Within 30 minutes in many districts | Indicates improved accessibility to emergency obstetric care |
| 5 | District Variation | Lower performance in Dharmapuri and Ramanathapuram | Reveals continued inequality in healthcare outcomes across districts |
| 6 | Out-of-Pocket Spending | Higher in poorer districts | Suggests dependence on private care where public systems remain weak |

Source: Government of India, Press Information Bureau (2019), Tamil Nadu Health System Reform Program.

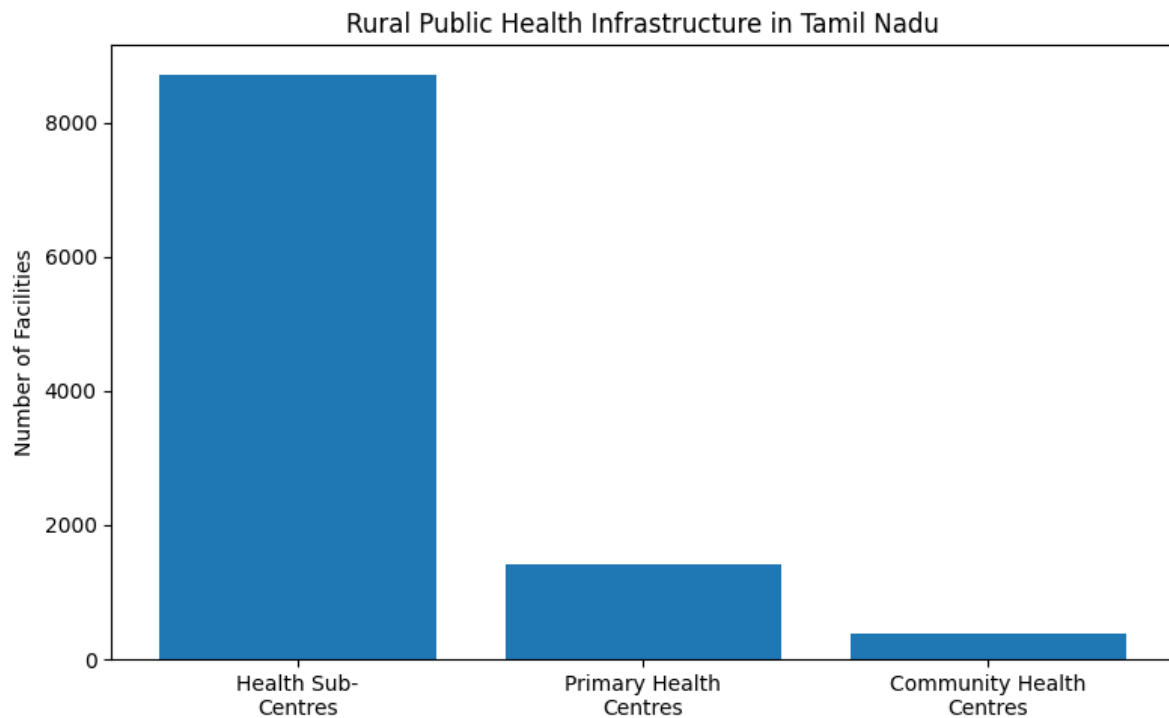


However, richer districts like Chennai, Coimbatore, and Kanyakumari perform better because they have stronger infrastructure, more doctors, and better transport links. Despite progress, inequalities persist because some backward districts still face shortages of specialists, uneven quality of care, and limited awareness of available schemes. Rural people in poorer districts often continue to depend on private clinics, increasing out-of-pocket spending. Therefore, Tamil Nadu's health programs have reduced disparities to a considerable extent, but policy effectiveness varies by district because economic development, administrative capacity, and local governance influence how benefits reach rural populations. Continued targeted investment in weaker districts is necessary to achieve full healthcare equity across the state.

Policy Interventions for Strengthening Healthcare Equity and Rural Health Systems in Tamil Nadu

Improving healthcare equity in rural Tamil Nadu requires stronger public investment, better workforce distribution, and community-centered governance. Tamil Nadu already has a relatively advanced rural health network with 8,713 Health Sub-Centres, 1,420 Primary Health Centres, and 385 Community Health Centres, exceeding the minimum national norms in many districts. Yet differences in service quality, specialist availability, and transport access still create inequality between villages and districts. First, the state can increase targeted health spending in backward rural blocks. Instead of equal allocation, funds should be distributed according to disease burden, poverty levels, and remoteness. This would help poorer districts improve diagnostic services, medicine supply, and emergency care. Studies show that rural patients often choose private hospitals because of perceived better quality, even when public care is cheaper.

Second, Tamil Nadu can strengthen the rural health workforce by offering higher rural incentives, housing, and career promotion for doctors and nurses serving in remote areas. Evidence from Health and Wellness Centres in Tamil Nadu found that 79.3% of rural patients reported satisfaction when services were regular and staffs was available. Stable staffing improves trust and service utilization. Third, expanding digital health and telemedicine can reduce geographic inequality. Tele-consultation links between village PHCs and district hospitals can provide specialist care without forcing patients to travel long distances.



Fourth, community participation should be improved through village health committees, women's self-help groups, and local monitoring. Community oversight can make services more accountable and culturally acceptable. Finally, stronger financial protection schemes can reduce out-of-pocket spending for poor households. Insurance coverage combined with free medicines and diagnostics can prevent medical debt and improve access for vulnerable families. Overall, policy interventions that combine equity-based funding, workforce reform, digital innovation, and community engagement can make rural healthcare in Tamil Nadu more inclusive and sustainable.

Conclusion

The political economy of rural healthcare in Tamil Nadu reveals a complex interplay of public expenditure, institutional governance, social determinants, and geographic challenges that influence health equity. The state has made significant strides in strengthening its rural health system through extensive infrastructure, high service utilization, and targeted policies, resulting in improved maternal and child health outcomes, reduced infant mortality, and increased dependence on public facilities. However, disparities persist across districts and social groups, driven by uneven resource distribution, shortages of skilled personnel, transportation barriers, and social exclusion. These challenges highlight that while public expenditure has been instrumental in expanding access, it alone cannot guarantee equitable healthcare for all rural populations. To bridge existing gaps, Tamil Nadu must adopt a multi-

faceted approach that emphasizes targeted investment in underserved districts, enhancement of workforce incentives, and the integration of digital health solutions such as telemedicine.

Strengthening community participation through local monitoring and social accountability mechanisms can foster trust and responsiveness within the health system. Furthermore, expanding financial protection schemes and reducing out-of-pocket expenses are critical to alleviating economic barriers faced by vulnerable groups. Ultimately, sustainable progress in rural health equity depends on the state's commitment to inclusive governance, equitable resource allocation, and social empowerment. By addressing both structural and social determinants of health, Tamil Nadu can build a more resilient and accessible healthcare system that reaches its most marginalized rural populations, ensuring that health services are not only available but also trusted and effectively utilized. Achieving true health equity in rural Tamil Nadu will require continued political will, innovative policy strategies, and active community engagement to create a health system that leaves no one behind.

References

- ❖ Government of India. (2019). National Family Health Survey (NFHS-5): Tamil Nadu Fact Sheet. Ministry of Health and Family Welfare.
- ❖ Government of Tamil Nadu. (2025). Department of Health and Family Welfare: Policy Note 2025–2026. Tamil Nadu State Government.
- ❖ National Health Systems Resource Centre (NHSRC). (2021). Health Care Utilization among Rural Households in Tamil Nadu. NHSRC Reports.
- ❖ Tamil Nadu Health Systems Reform Program. (2018). Annual Report on Rural Health Infrastructure. Tamil Nadu State Government.
- ❖ World Health Organization. (2018). Health systems strengthening in India: A review. WHO Publications.
- ❖ Balarajan, Y., Selvaraj, S., & Subramanian, S. V. (2011). Health care and equity in India. *The Lancet*, 377(9764), 505–515. [https://doi.org/10.1016/S0140-6736\(10\)61894-6](https://doi.org/10.1016/S0140-6736(10)61894-6)
- ❖ Reddy, K. S., Gupta, R., & Bhat, P. (2016). Equity in health and healthcare in India. *Indian Journal of Medical Research*, 144(3), 289–294.
- ❖ Karan, A., et al. (2017). Socioeconomic inequalities in maternal health service utilization in India. *Global Health Action*, 10(1), 1324719. <https://doi.org/10.1080/16549716.2017.1324719>
- ❖ Das, J., et al. (2012). Health system strengthening in India: Challenges and opportunities. *Health Policy and Planning*, 27(1), 1–10. <https://doi.org/10.1093/heapol/czr054>

- ❖ Singh, P., et al. (2019). Impact of digital health interventions on rural healthcare delivery in India. *Journal of Telemedicine and Telecare*, 25(6), 347–354.
- ❖ Patel, V., et al. (2016). Strengthening community participation in health systems: Lessons from India. *Social Science & Medicine*, 167, 201–209. <https://doi.org/10.1016/j.socscimed.2016.07.020>
- ❖ Mohanty, S., & Mishra, S. (2018). Public expenditure and health outcomes in Indian states: An analysis. *Economic and Political Weekly*, 53(2), 45–52.
- ❖ Kaur, R., et al. (2020). Workforce distribution and incentives in rural health care: A case study of Tamil Nadu. *Health Policy and Planning*, 35(4), 455–463. <https://doi.org/10.1093/heapol/czaa095>
- ❖ Chandran, S., et al. (2021). Telemedicine in rural India: Opportunities and challenges. *Indian Journal of Community Medicine*, 46(1), 3–8.
- ❖ Bhat, R., & Kumar, S. (2017). Social exclusion and health disparities in rural India. *Journal of Social Policy*, 46(2), 321–340.
- ❖ Srinivasan, S., & Ramachandran, R. (2019). Governance and accountability in rural health: Evidence from Tamil Nadu. *Public Administration and Development*, 39(3), 177–186.
- ❖ Dasgupta, R., et al. (2018). Maternal health services utilization and barriers in rural Tamil Nadu. *Reproductive Health*, 15, 103. <https://doi.org/10.1186/s12978-018-0523-4>
- ❖ Chatterjee, P., & Chatterjee, S. (2017). Financial protection in health: Evidence from Indian states. *Health Economics Review*, 7(1), 8.
- ❖ Subramanian, S. V., et al. (2014). Social determinants of health inequalities in India. *International Journal for Equity in Health*, 13, 33. <https://doi.org/10.1186/1475-9276-13-33>
- ❖ Kannan, S., & Ramani, S. (2020). Effectiveness of health policies in reducing disparities: Tamil Nadu case study. *Policy & Politics*, 48(4), 725–743.
