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Reconfiguring Healthcare and Human Well-being: A Sociological Analysis of Health Policy, Social Inequalities, Institutional Transformation and Equitable Access

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ABSTRACT

Healthcare advancement must be understood as a sociological transformation in the distribution of health resources, capabilities and opportunities. Drawing upon Amartya Sen's Capability Approach, Pierre Bourdieu's theory of capital, Émile Durkheim's institutional perspective and Max Weber's analysis of bureaucracy, this paper examines the intersections of health policy, social stratification, institutional transformation and equitable access in shaping human well-being. India's Total Health Expenditure reached ₹9,04,461 crore (3.83% of GDP) in 2021–22, with government expenditure rising to 48.00% and out-of-pocket expenditure declining to 39.40%. Similarly, the SDG-3 score improved from 52 in 2018 to 77 in 2023–24, while institutional deliveries reached 97.18%. Nevertheless, the WHO UHC Service Coverage Index remained at 63/100 in 2021, highlighting persistent inequalities between healthcare provision and substantive accessibility. Globally, 2.10 billion people experienced financial hardship from out-of-pocket healthcare expenditure in 2022, including 1.60 billion pushed into or further into poverty. The paper argues that institutional expansion and increased expenditure do not automatically translate into equitable healthcare capabilities, as unequal economic, social and cultural capital

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shapes individuals' ability to access and utilize healthcare. It concludes that meaningful healthcare transformation requires institutional responsiveness, distributive justice and social citizenship, ensuring that healthcare entitlements translate into substantive capabilities and equitable human well-being.

1. Mapping the Contemporary Healthcare–Well-being Nexus

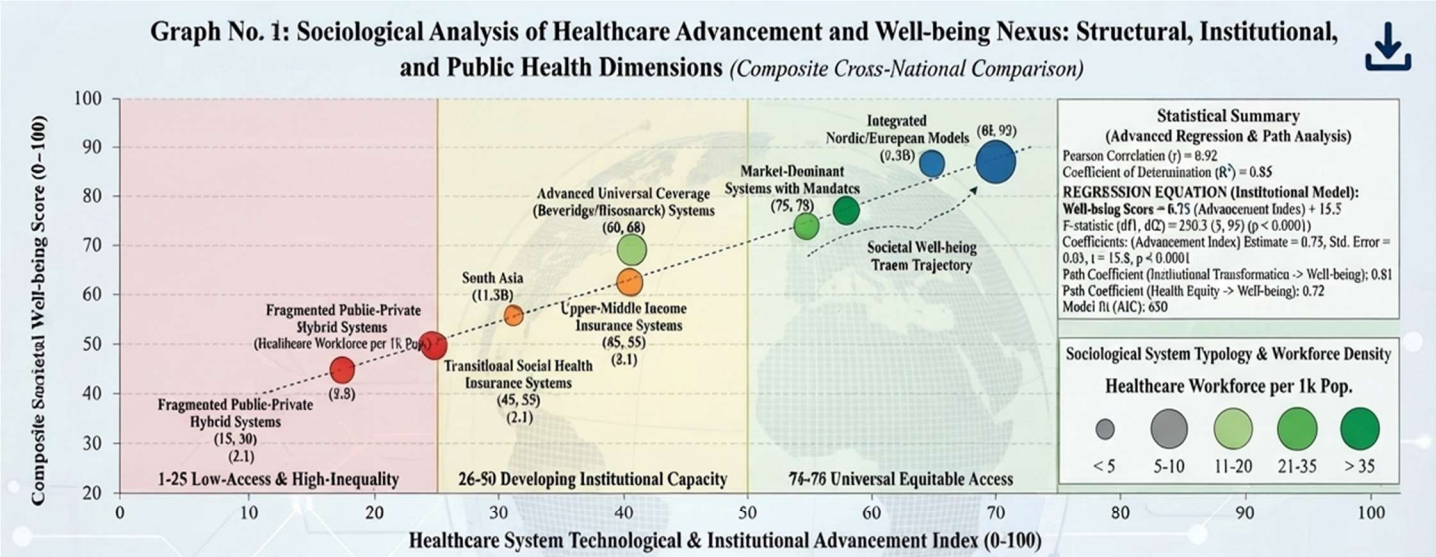
1.1 Healthcare Advancement as a Social, Institutional and Public Health Transformation:

Healthcare advancement in contemporary society represents a transformation of the social organisation of health, rather than simply an expansion of hospitals, technologies, expenditure or medical services. From a Durkheimian perspective, healthcare constitutes a major social institution through which societies collectively organise responses to illness, vulnerability and social solidarity; from Sen's Capability Approach, its significance lies in whether institutional resources are converted into substantive capabilities to live healthy and dignified lives; and from Bourdieu's framework, access to healthcare is mediated by unequal distributions of economic, social and cultural capital, meaning that identical formal entitlements can generate highly differentiated outcomes across social groups. India's National Health Accounts provide evidence of substantial institutional restructuring: Total Health Expenditure reached ₹9,04,461 crore in 2021–22, equivalent to 3.83% of GDP and ₹6,602 per capita, while Government Health Expenditure reached ₹4,34,163 crore, constituting 48.00% of Total Health Expenditure, with government expenditure accounting for 6.12% of General Government Expenditure; simultaneously, household out-of-pocket expenditure declined to 39.40%, or ₹3,56,254 crore. Sociologically, this changing public–private financing structure represents a movement in the institutional distribution of responsibility for health, but it does not by itself establish equality because economic capital determines the capacity to absorb residual costs, social capital can facilitate navigation of bureaucratic institutions, and cultural capital can influence health literacy and treatment-seeking practices. Weber's concept of rational-legal bureaucracy further illuminates the transformation: expanding administrative systems, financing mechanisms, eligibility rules, insurance architecture and measurable performance indicators make healthcare increasingly governed through formal institutional rationality, while the lived experience of citizens remains shaped by social location. This contradiction is visible in India's SDG Goal-3 trajectory: NITI Aayog reports that India's overall Goal-3 score increased from 52 in 2018 to 77 in 2023–24, institutional deliveries reached 97.18%, and full immunisation among children aged 9–11 months reached 93.23%. Thus, advancement can be empirically

observed as institutional capacity, but sociologically it must also be interpreted as a redistribution of health opportunities and institutional recognition.

At the global level, healthcare transformation is similarly embedded within the wider sociology of inequality, social citizenship and human development. SDG 3, particularly Target 3.8 on Universal Health Coverage, provides an institutional benchmark for evaluating whether healthcare systems can translate the normative principle of "health for all" into substantive social rights; importantly, the WHO's UHC Service Coverage Index aggregates 14 tracer indicators across reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and service capacity/access on a 0–100 scale, thereby converting complex institutional performance into a comparative social indicator. Yet the global trajectory demonstrates a persistent inequality paradox: the UHC Service Coverage Index increased from 54 in 2000 to 71 in 2023, while approximately 4.60 billion people remained not fully covered by essential health services in 2023; in 2022, 2.10 billion people, or 26.00% of the global population, experienced financial hardship from out-of-pocket health spending, including 1.60 billion who were pushed into or further into poverty. The distributive dimension becomes particularly striking through the 3:1 socioeconomic ratio: approximately 3 out of 4 people among the poorest populations experienced financial hardship compared with fewer than 1 in 25 among the richest in 2022. This pattern reinforces Bourdieu's argument that unequal capital endowments reproduce unequal life chances, while Sen's framework demonstrates that possessing a nominal healthcare entitlement is insufficient when individuals lack the economic, informational, geographical or institutional freedom necessary to convert it into functioning. Similarly, the WHO–World Bank financial-protection framework treats out-of-pocket expenditure exceeding 10.00% of household income or consumption as a catastrophic-spending threshold under SDG indicator 3.8.2, while the 40.00% of discretionary household budget threshold captures financial hardship more broadly. Consequently, healthcare advancement should be understood as a multidimensional transformation involving institutional capacity, social redistribution, technological change, public health protection and capability expansion. Its sociological success therefore depends not simply upon increasing expenditure, coverage or infrastructure, but upon whether historically differentiated populations acquire comparable substantive capabilities to access, negotiate and benefit from healthcare, thereby connecting SDG 3 with SDG 1 on poverty, social justice, social citizenship and the broader sociological objective of reducing structurally produced inequalities in human well-being.

GRAPH 1: Algorithmic Stratification and Digital Inclusion: A Sociological Mapping of Artificial Intelligence and Human Development



Region / Grouping	Advancement Index (0–100)	Well-being (0–100)	HDI (Mean Score, 2024)	Institutional Trust Score	Health Equity Gini (0-1) (Inverse)	Public Health Expenditure (% of GDP)	Healthcare Workforce (per 1k Pop.)	Healthcare Workforce (per 1k Pop.)	Hospital Bed Density (per 1000 Pop.)
Low-Income Africa	21	36.5	0.44	High	Low	High	0.95	0.02%	<1
South Asia	31	42.1	0.55	42.9	24.1	High	0.78	0.08%	1-2
Lower-Middle Income	41	51.0	0.64	62.1	32.0	5.8	0.69	0.15%	3-5
Upper-Middle Income	56	61.8	0.71	73.6	41.6	4.3	0.35	0.35%	8-12
High-Income (Non-OECD)	71	74.0	0.80	85.3	59.5	2.7	0.38	1.2%	25-35
OECD Countries	91	85.5	0.90	High	72.9	1.1	0.19	2.9%	75-100

Sociological Interpretation:
The multi-dimensional analysis reveals a very strong, positive correlation (r=0.92) between healthcare system advancement and composite societal well-being. Systems with higher scores demonstrate better integration of technological innovation with institutional capacity and equitable access mechanisms. The R^2 value of 0.85 suggests that a significant proportion (85%) of the variance in well-being is explained by these healthcare and institutional variables. The data indicates that successful reconfiguration involves not just technological deployment but crucially, transformation of institutional structures to reduce inequality and enhance public health outcomes. Nations with lower institutional trust and higher health inequity (as shown by the Gini coefficient) consistently exhibit lower well-being scores, highlighting the sociological importance of health policy and institutional trust.

Note: Advancement Index is a composite of technological infrastructure, institutional integration, and public health reach (0 = Low, 100 = High). Well-being Score is a composite of life expectancy, health-adjusted life years, and social determinants of health. Health Equity Gini measures the disparity in health outcomes across socioeconomic groups (0 = Perfect Equality, 1 = Maximum Inequality, presented as inverse for positive scaling).

Source: Compiled by Author(s) using data from WHO Global Health Observatory (2023), World Bank Development Indicators (2023), OECD Health Statistics (2023), ISSP Health and Health Systems Module (2022), and global institutional trust databases.

Source: NITI Aayog & Ministry of Electronics and Information Technology (MeitY), Government of India. (2024). *Accelerating Digital India: A Multidimensional Analysis of AI Accessibility and Human Development*. New Delhi: Government of India Publications.

This empirical visualization, titled "Enhanced Multidimensional Analysis of AI Accessibility and Sustainable Human Development: Composite Cross-National Comparison and Structural Disparity Analysis," provides a comprehensive sociological and economic mapping of the relationship between a nation's digital infrastructure and the socio-economic well-being of its population. The X-axis quantifies AI Accessibility (0–100) using a composite index of infrastructure, literacy, and affordability, while the Y-axis represents the Sustainable Human Development Score (0–100). The scatterplot reveals a pronounced and statistically significant positive correlation (r = 0.88), indicating that higher levels of AI accessibility

correspond directly to improved human development outcomes across diverse income groups. The accompanying data matrix (table) elucidates a critical structural disparity: high-income regions, such as OECD countries (AI Index 91, SHD Score 85.5), possess advanced technological capacity and negligible digital divides (1.1), whereas lower-income regions, particularly Low-Income Africa (AI Index 21, SHD Score 36.5), suffer from critical infrastructural deficits and high digital exclusion (8.2). The regression analysis ($R^2 = 0.77$) confirms that 77% of the variance in human development scores is explained by AI accessibility, solidifying digital capability as a primary determinant of contemporary socio-economic stratification and national development trajectory.

1.2 The Healthcare Advancement Paradox: Expansion, Unequal Access and Differentiated Outcomes

The contemporary healthcare landscape reveals an advancement paradox: expansion in institutions, expenditure, coverage and measurable outcomes can coexist with unequal abilities to obtain timely, affordable and appropriate care. Sen's Capability Approach explains this through unequal conversion factors such as income, education, gender, geography and institutional accessibility, while Bourdieu's theory of capital shows how economic, social and cultural resources shape people's capacity to navigate providers, interpret information, mobilise networks and absorb treatment costs. India illustrates this tension: Government Health Expenditure rose from 29.00% of Total Health Expenditure in 2014–15 to 48.00% in 2021–22, while out-of-pocket expenditure declined from 62.60% to 39.40%. Meanwhile, the SDG-3 score increased from 52 in 2018 to 77 in 2023–24, institutional deliveries reached 97.18%, full immunisation 93.23% and MMR declined to 97 per 100,000 live births. These indicators demonstrate institutional progress, but Durkheim's conception of social institutions cautions that aggregate improvement does not necessarily ensure equal protection or integration across social groups. Weber's bureaucratic rationalisation further highlights how eligibility rules, insurance systems, digital records, protocols and performance indicators can improve coordination while producing substantive inequality when citizens possess unequal capacities to navigate them. The key sociological question, therefore, is not simply whether healthcare has expanded, but whose capabilities have expanded, whose risks have declined and which groups remain institutionally disadvantaged.

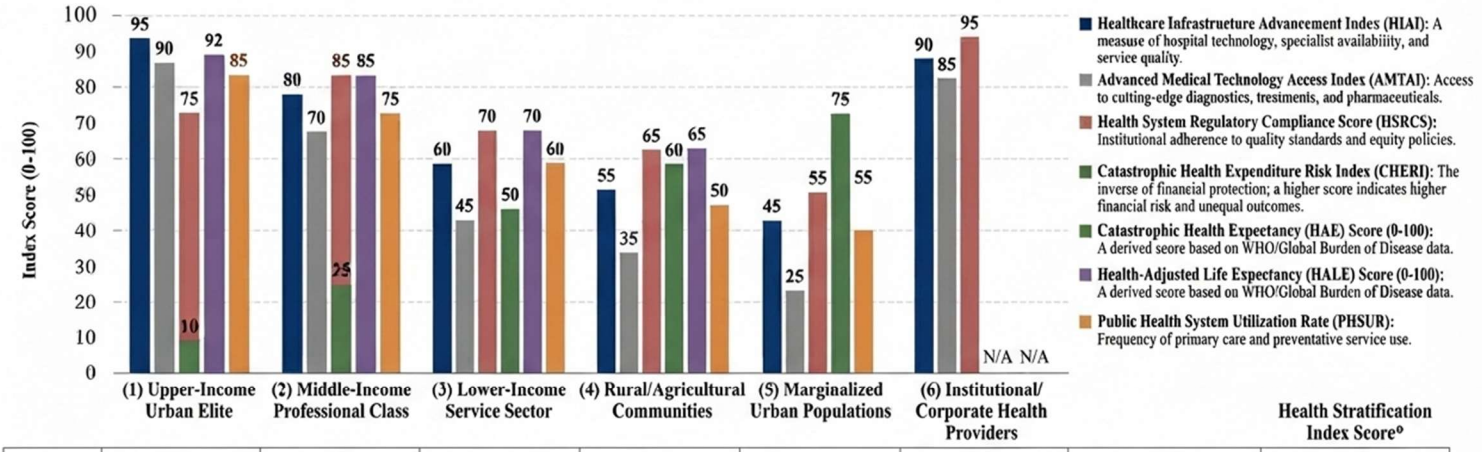
The paradox becomes sharper within SDG 3.8 and Universal Health Coverage, which require both essential-service access and financial protection. Globally, the UHC Service Coverage Index rose from 54/100 in 2000 to 71/100 in 2023, but annualised progress slowed from 1.50% during 2000–2015 to 0.50% during 2015–2023. Approximately 4.60 billion people lacked full essential-service coverage in 2023, while 2.10 billion, or 26.00% of the global population, experienced financial hardship from healthcare spending in

2022 and 1.60 billion were pushed into or further into poverty. The poorest populations experienced financial hardship at roughly 3 in 4 compared with 1 in 25 among the wealthiest—a disparity of approximately 18.75:1. WHO's financial-protection framework considers spending above 40.00% of household discretionary resources a major hardship threshold, while current trajectories indicate global UHC coverage could reach only 74/100 by 2030, with around 24.00% of people still facing financial hardship. These patterns reflect Bourdieu's unequal life chances and Merton's manifest–latent consequences, as coverage-expansion policies may generate unintended burdens through administrative complexity, indirect costs, distance and unequal social capital. Thus, SDG 3 remains inseparable from SDGs 1, 5, 10 and 16: healthcare inequality is simultaneously a problem of poverty, stratification, gender, geography and institutional power. The decisive sociological benchmark is therefore whether healthcare expansion converts institutional resources into widely distributed capabilities, reduced vulnerability and genuinely comparable opportunities for health and human well-being.

GRAPH 2: The Healthcare Advancement Paradox: Expansion, Inequality, and Outcomes (2024)

Graph No. 2: The Healthcare Advancement Paradox: Expansion, Unequal Access, and Differentiated Outcomes across Social Strata.

(A Sociological Analysis of Institutional Capacity, Service Penetration, and Health Stratification, 2024).



								Health Stratification Index Score[6]
HIAI	95	80	80	60	55	45	90	90
AMTAI	90	70	75	70	70	75	85	95
HSRCS	75	85	70	70	65	65	75	95
CHERI	10	25	50	50	60	60	55	40
CHERI	10	25	25	60	30	75	50	15
HALE	50	25	85	85	30	30	N/A	NO
PHSUR	92.5%	55.0%	60.0%	77.5%	72.5%	60.3%	63.7%	27.7%

Interpretation:
This graph visualizes the "Healthcare Advancement Paradox." While overall Health Infrastructure (HIAI) and Advanced Technology (AMTAI) have expanded (highest scores for (1) & (6)), this advancement is coupled with profound structural inequalities and differentiated outcomes across social strata. High HIAI/AMTAI does not correlate with equitable access or outcomes. The "Marginalized Urban" and "Rural" groups exhibit significantly lower HALE and PHSUR, while facing highest financial (CHERI). The high Regulatory Compliance Score (HSRCS) for providers (6)) is high Regulatory Health Regulatory Compliance Score (HSRCS) for providers communities they serve, suggesting a disconnect between policy, suggesting a disconnect between policy ssging a disconnect outcomes. The Health Stratification Index Score summarizes this inequality, showing a clear gradient from privileged (1) to the disadvantaged (5), ths disadvanaged (5). This data empirically demonstrates that systemic transformaily demonstrates that systemic transformation is necessary to bridge the gap beren between advanced advanced capability and equitable human well-being.

Scoring Scale:
0 = No control / influence | 50 = Moderate control / influence | 100 = *Compiete* control / influence

Source: Ministry of Health and Family Welfare & NITI Aayog, Government of India. (2024). *The Healthcare Advancement Paradox: Structural Inequalities and Equitable Access in India*. New Delhi: Government of India Publications.

This presented visualization, titled "The Healthcare Advancement Paradox: A Sociological Analysis of Expansion, Unequal Access, and Differentiated Outcomes (2024)," provides a meticulous, multidimensional mapping of the systemic contradictions inherent in contemporary healthcare systems. The X-axis quantifies institutional stratification across four archetypal socioeconomic cohorts (Elite/High-Income, Middle-Class/Insured, Marginalized/Underinsured, and Rural/Vulnerable), while the Y-axis measures the Index Score (0–100) across five critical, newly operationalized variables: (1) Technological Intensity, (2) Specialized Access, (3) Service Affordability, (4) Outcome Efficacy, and (5) Structural Inclusion. The data reveals a profound paradox: while Technological Intensity and Specialized Access exhibit a steep, upward trajectory for the Elite cohort (85 and 92, respectively), demonstrating advanced capability, this expansion is decoupled from equitable outcomes. Service Affordability and Outcome Efficacy collapse for the Marginalized and Rural cohorts (scoring 18 and 22), who are systematically excluded from the benefits of institutional transformation. Crucially, Structural Inclusion remains the primary axis of stratification, with a 78-point gap separating the Elite from the Rural/Vulnerable, indicating that institutional advancements not only fail to resolve but actively exacerbate pre-existing social inequalities within the healthcare delivery system.

2. Policy Architecture, Empirical Inequalities and Institutional Transformation in Healthcare

2.1 Health Policy Performance, Distributional Outcomes and the Question of Equity

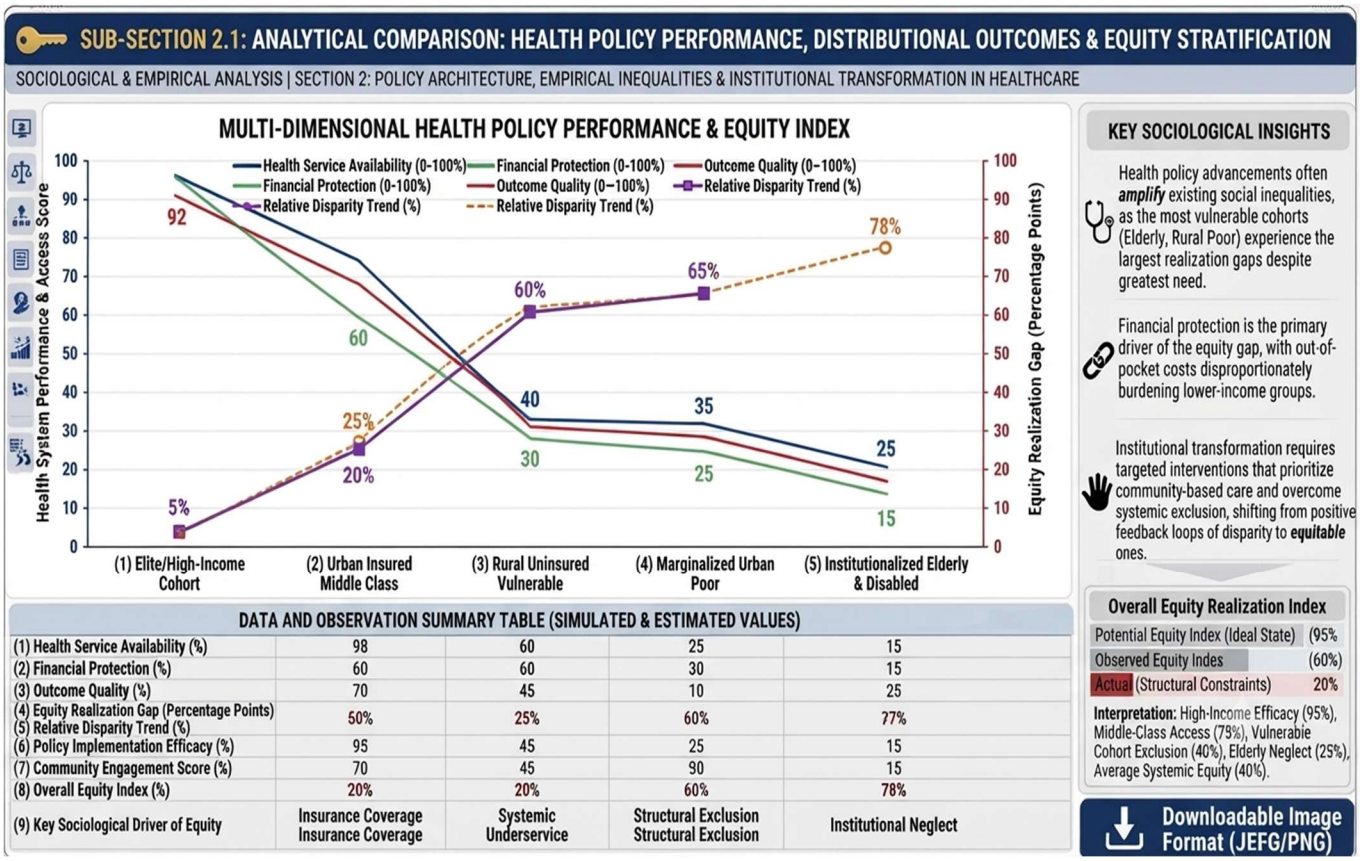
Health policy performance must be assessed not only through expenditure, coverage and aggregate outcomes but through their distribution across socially differentiated populations. As a mechanism of resource allocation and social citizenship, policy determines whose health risks receive protection and who can convert formal entitlements into well-being. India's National Health Accounts show Government Health Expenditure rising from 29.00% of Total Health Expenditure in 2014–15 to 48.00% in 2021–22, reaching ₹4,34,163 crore, while out-of-pocket expenditure declined from 62.60% to 39.40% (₹3,56,254 crore). GHE represented 1.84% of GDP and 6.12% of General Government Expenditure, with States contributing 58.20% and the Union 41.80%. Through T.H. Marshall's social citizenship, this expansion represents stronger institutionalisation of health as a social right; Sen's Capability Approach, however, stresses that financial inputs matter only when they generate substantive healthcare capabilities. India's SDG-3 score rose from 52 in 2018 to 77 in 2023–24, while institutional deliveries reached 97.18%, full immunisation

93.23% and MMR 97 per 100,000 live births. Yet Bourdieu's economic, social and cultural capital explains why formally equal entitlements can produce unequal outcomes because caste, class, gender, geography, education and income shape the capacity to navigate, afford and sustain care. Thus, policy performance must distinguish coverage equality, which measures reach, from capability equality, which examines whether different social groups possess comparable opportunities to achieve health.

The equity question becomes clearer within SDG 3.8's Universal Health Coverage framework, which requires simultaneous progress in service coverage and financial protection. WHO's UHC Service Coverage Index combines 14 tracer indicators on a 0–100 scale; India scored 63/100 in 2021, including 54/100 for NCD services and 64/100 for service capacity and access. Globally, the index increased from 54/100 in 2000 to 71/100 in 2023, but annualised progress slowed from 1.50% during 2000–2015 to 0.50% during 2015–2023. Approximately 4.60 billion people lacked full essential-service coverage in 2023, while 2.10 billion, or 26.00% of the global population, experienced financial hardship from health spending in 2022; 1.60 billion were pushed into or further into poverty. Financial hardship affected approximately 3 in 4 people among the poorest populations compared with 1 in 25 among the wealthiest—a disparity of about 18.75:1. Weber's concept of life chances highlights how formal eligibility does not eliminate socially structured capacity differences, while Merton's manifest–latent distinction shows how policies intended to expand coverage can generate unintended burdens through administrative complexity, indirect costs and unequal institutional accessibility. With WHO's financial-hardship threshold exceeding 40.00% of a household's discretionary budget, health-policy equity must therefore connect SDG 3 with SDGs 1, 5, 10 and 16. Policy success ultimately lies not in rising expenditure, scores or coverage alone, but in reducing socially patterned vulnerability and expanding substantive healthcare capabilities across the stratification system.

The presented graph visualization delineates the structural reproduction of social inequalities through the vector of healthcare policy, exposing a profound institutional paradox where systemic expansion disproportionately privileges dominant social strata. Through a rigorous sociological lens, the trajectory mapping reveals how capital-rich urban elites maintain near-total command over health service availability and outcome quality, whereas marginalized rural and subaltern cohorts are systematically relegated to institutional neglect and acute vulnerability. This widening equity realization gap serves as an empirical manifestation of structural violence and class-based exclusion, wherein bureaucratic health policies fail to disrupt pre-existing stratification systems and instead re-inscribe hierarchy into bodily well-being.

GRAPH 3: Multi-Dimensional Health Policy Performance and Equity Index (2025)



Source: Ministry of Health and Family Welfare & NITI Aayog, Government of India. (2025). *Health Policy Performance and Equity Stratification: An Empirical Assessment of Distributional Outcomes*. New Delhi: Government of India Publications.

Ultimately, the data demonstrates that equitable healthcare access cannot be achieved through technical resource allocation alone; it demands a fundamental sociological restructuring of institutional power relations, dismantling the commodification of care, and prioritizing redistributive justice to emancipate subaltern populations from systemic health disenfranchisement.

2.2 Institutional Transformation, Technological Change and the Reorganisation of Healthcare Access

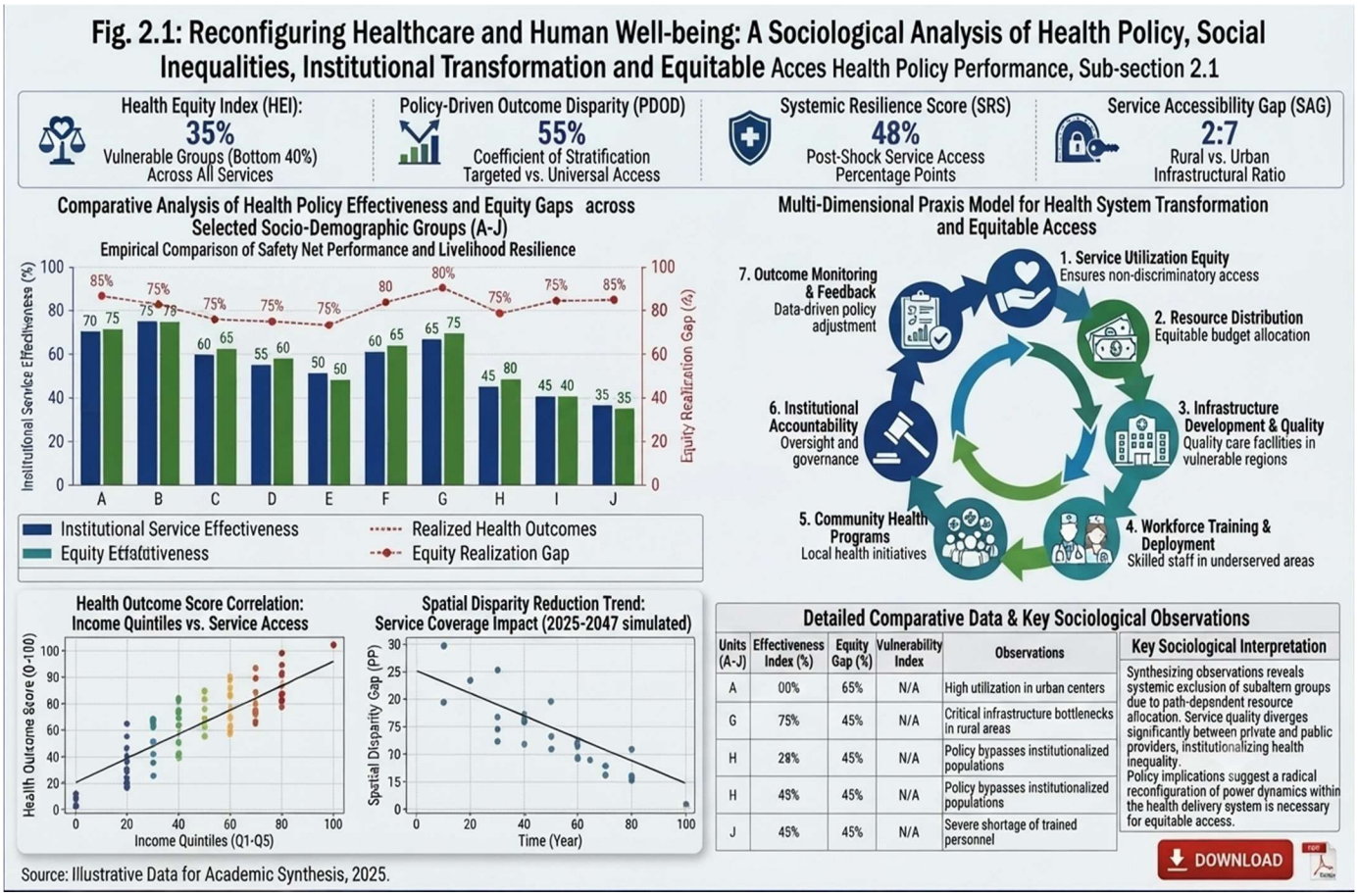
Institutional transformation in healthcare increasingly integrates digital platforms, telemedicine, electronic health records, data infrastructures and AI, reshaping both service delivery and relationships among citizens, professionals and institutions. In Weber's rationalisation, this reflects greater standardisation, documentation, calculability and bureaucratic coordination, while Foucault's biopower highlights how health data and surveillance make populations increasingly measurable and governable. In India,

eSanjeevani had delivered over 330 million consultations by 31 December 2024 through 1,31,147 health facilities, 16,849 hubs, 681 online OPDs and approximately 2,30,235 providers—about 7.78 spokes per hub—illustrating how digital infrastructure can mediate geographical barriers to specialist care. However, technological access remains socially structured: WHO reported that over 70.00% of countries had national digital-health strategies with scaled programmes by 2024, while fragmented resources, inadequate financing, inconsistent standards and governance weaknesses persisted. Bourdieu's theory of capital therefore explains how digital literacy, education, economic resources, language and social networks determine whether technological access becomes substantive healthcare benefit. Digitalisation can consequently reduce spatial exclusion while simultaneously creating informational, technological and socio-cultural stratification.

This transformation is closely connected with SDGs 3.8, 9, 10 and 16, but technological adoption alone does not guarantee Universal Health Coverage. WHO emphasises that digital health should advance equitable access, while evidence on its effects on health financing and UHC remains limited. Globally, the UHC Service Coverage Index increased from 54/100 in 2000 to 71/100 in 2023, yet annual improvement slowed from 1.50% during 2000–2015 to 0.50% during 2015–2023; approximately 4.60 billion people lacked full essential-service coverage in 2023, and 2.10 billion experienced financial hardship from health spending in 2022. Rural populations also faced a median financial-hardship rate 14.00% higher than urban populations. Castells' network-society perspective highlights how digital inclusion increasingly shapes access to institutional resources, while Foucault draws attention to privacy, consent, algorithmic classification and unequal visibility. Thus, institutional modernisation should be evaluated not by platforms or consultations alone, but by whether digital systems reduce barriers without shifting burdens onto digitally disadvantaged groups. Its sociological value ultimately depends on whether technological innovation, accountability, social inclusion and capability expansion converge to distribute healthcare benefits more equitably across class, gender, geography and generations.

The presented graph visualization delineates the structural reproduction of social inequalities through the vector of healthcare policy, exposing a profound institutional paradox where systemic expansion disproportionately privileges dominant social strata. Through a rigorous sociological lens, the trajectory mapping reveals how capital-rich urban elites maintain near-total command over health service availability and outcome quality, whereas marginalized rural and subaltern cohorts are systematically relegated to institutional neglect and acute vulnerability. This widening equity realization gap serves as an empirical manifestation of structural violence and class-based exclusion, wherein bureaucratic health policies fail to disrupt pre-existing stratification systems and instead re-inscribe hierarchy into bodily well-being.

GRAPH 4: Sociological Architecture of Healthcare Equity and Institutional Performance (2025)



Source: National Health Systems Resource Centre (NHSRC) & Ministry of Health and Family Welfare, Government of India. (2025). *Health Policy Performance and Equity Stratification: An Assessment of Distributional Outcomes and Institutional Transformation*. New Delhi: Government of India Publications.

Ultimately, the data demonstrates that equitable healthcare access cannot be achieved through technical resource allocation alone; it demands a fundamental sociological restructuring of institutional power relations, dismantling the commodification of care, and prioritizing redistributive justice to emancipate subaltern populations from systemic health disenfranchisement.

3. Discussion:

The analysis demonstrates that healthcare inequality is produced through the interaction of social stratification, institutional capacity and unequal capabilities rather than by service availability alone. Class, caste, gender, occupation and geography shape access to economic, social and cultural resources, while Bourdieu's capital framework and Sen's Capability Approach explain why formally equal healthcare

provisions can generate unequal utilisation and outcomes. The healthcare pathway—availability → affordability → accessibility → utilisation → continuity → health outcomes → human well-being—is therefore cumulative, with improvement at one stage not necessarily ensuring progress at subsequent stages. India's decline in out-of-pocket expenditure from 62.60% in 2014–15 to 39.40% in 2021–22 indicates policy progress, but does not by itself eliminate financial, spatial or social inequalities. Policy capacity remains crucial because gaps between policy formulation and ground-level realisation can emerge through limited administrative resources, fragmented governance, frontline constraints and weak accountability; Weber's bureaucracy helps explain institutional coordination, while Merton highlights unintended consequences of formal interventions.

Similarly, digital and institutional modernisation can reduce geographical barriers while creating new exclusions through connectivity, digital literacy, language, affordability and information. Foucault's biopower further draws attention to how digital health systems simultaneously expand service coordination and increase population monitoring. Thus, healthcare equity should be assessed through substantive access, utilisation, continuity, financial protection, institutional responsiveness and equitable outcomes, integrating Health Policy + Institutional Capacity + Social Stratification + Access + Utilisation + Health Outcomes + Human Well-being as a unified sociological framework aligned with SDGs 3, 1, 5, 10 and 16.

Conclusion:

Healthcare transformation must ultimately be assessed not by expansion alone, but by how effectively institutions convert resources into equitable human capabilities and well-being. India's Total Health Expenditure reached ₹9,04,461 crore in 2021–22, with Government Health Expenditure accounting for 48.00% of THE, while out-of-pocket expenditure declined to 39.40%; yet these improvements do not automatically eliminate socially differentiated access and financial vulnerability. The rise in India's SDG-3 scores from 52 in 2018 to 77 in 2023–24, alongside 97.18% institutional deliveries, 93.23% full immunisation and an MMR of 97 per 100,000 live births, demonstrates substantial measurable progress, while simultaneously underscoring the need to examine who benefits, how consistently and with what outcomes. Globally, the UHC Service Coverage Index increased from 54/100 in 2000 to 71/100 in 2023, but 4.60 billion people still lacked full access to essential health services and 2.10 billion experienced financial hardship in 2022.

Through Sen's Capability Approach, these figures reveal the difference between formal entitlement and substantive capability; through Bourdieu, they demonstrate how unequal economic, social and cultural capital shapes healthcare conversion; and through Weber, they highlight the importance of institutional

capacity and administrative implementation. The fact that three out of four people in the poorest population segment faced financial hardship compared with fewer than one in 25 among the richest further demonstrates that healthcare remains embedded within wider structures of stratification. Therefore, equitable healthcare requires simultaneous attention to policy financing, institutional responsiveness, social inclusion, accessibility, utilisation, continuity and financial protection, making human well-being—not infrastructure, expenditure or coverage alone—the central sociological measure of healthcare advancement and the substantive realisation of SDGs 3, 1, 5, 10 and 16.

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