



# Rural Healthcare Is An Input For And Also An Output Of Equitable Social Development Index

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## Abstract:

Good health to the people increases the participation of human resources in productivity, thus health is the input for any development. Healthcare can be considered both an input and an outcome of social development because it plays a dual role in society, influencing and being influenced by various aspects of development. The robust healthcare infrastructure of any nation ensures sustainable growth resulting in Social Health Hexagon (SHH) comprising Super-Six (S-6) deliverables which are very important in growing economies like India wherein human resources are the biggest asset as the majority of the population falls into active working groups. The rural population that has the greatest need for healthcare has the least accessibility to quality healthcare. Conscious efforts to improve social determinants like potable water, sanitation, clean living conditions, food security, education, and poverty reduction are expected to bring equity in healthcare for a larger population of the country. The gap in Life Expectancy between the poorest rural and richest urban is 7.9 years translating into 12.34% of the life gap between these two wealth quintile groups. This indicates the influence of wealth quintile status and living habitat on the life expectancy of the individual. These reasons are grounded in the idea that access to healthcare is a fundamental human right and that the well-being of individuals contributes to the overall stability and prosperity of society. Governments should encourage the proper funding for projects that call for impact creation rather than just delivering the need-based healthcare service.

## Keywords:

Equitable Social Development Index, Social Health Hexagon, in Life Expectancy, Health Life Expectancy, Healthcare Duality, Quality Of Life, Socio-Economic Inequality, Universal Healthcare Care.

## The Dual Role Of Healthcare:

For any country to develop economically, socially and culturally, health is the pre-disposing factor. Healthcare has a two-way relationship with development as it plays the role of both input and output. Good health to the people increases the participation of human resources in productivity, thus health is the input for any development. Secondly, development can further the policy-making to create a more sustainable healthcare environment through infrastructure and operational resources, thus health is the output for any development. This is how healthcare can be considered both an input and an outcome of social development because it plays a dual role in society, influencing and being influenced by various aspects of development. Healthcare can be considered both an input and an outcome of social development because it plays a dual role in society, influencing and being influenced by various aspects of

development. Healthcare as an input of social development enhances productivity through a healthy population, as individuals are better able to work, learn, and innovate. Further, good healthcare improves life expectancy, cognitive abilities, and physical capabilities, which are essential for education and economic growth. Access to quality healthcare reduces health disparities, promoting equity and social cohesion that have the potential to boost economic performance by lowering disease burdens, and reducing economic losses from absenteeism and premature deaths. Healthy children are more likely to attend school and perform better academically, contributing to overall social development.

Healthcare as an outcome of social development is an indicator of the overall progress of the nation because social development often leads to better governance, which prioritizes investment in healthcare infrastructure and services resulting in improved healthcare systems and lowered mortality rates. Rising incomes and education levels associated with social development typically lead to better access to and demand for quality healthcare. Further, a developed society focuses on reducing health disparities, ensuring that all citizens can access healthcare services. Healthcare's role as both input and outcome demonstrates a cyclical relationship. While social development is achieved through investments in healthcare, the acceleration of social development strengthens healthcare systems and access, further reinforcing a society's growth and well-being. This dual role underscores the importance of integrating healthcare into broader social development strategies.

### **The Social Health Hexagon:**

Successful nations are driven by their healthy population because the health of their citizens determines several developmental factors that contribute to the sustainable economic growth of any country. The robust healthcare infrastructure of any nation ensures sustainable growth resulting in Social Health Hexagon (SHH) comprising Super-Six (S-6) deliverables such as Aggressive Economic Activity, Improved Domestic Productivity, Endurable Civic Amenities, Enriched Human Capital, Less Disease Burden and Better Workforce Participation in this particular order. These deliverables are very important in growing economies like India wherein human resources are the biggest asset as the majority of the population falls into active working groups. Any inaccuracy or inadequacy in this order will not only break the chain of the whole developmental process that will ultimately result in the economic stagnancy or economic downfall of the nation but also increase the disease epidemic burden on the government, ultimately derailing the growth process. A close look at these deliverables will explain the significance of each one of them. The development of rural areas is deeply intertwined with the health of the people living there. A healthy population is both a prerequisite and a catalyst for rural development. Basic public healthcare is not only a fundamental right for the citizens but also a responsibility of the legislature. Infrastructure, human resources, and financial support have always been deficient factors in rural healthcare in India.

Beyond the primary and community healthcare facilities, the world over, proper healthcare is defined as the accessibility of round-the-clock medical, surgical, obstetrical and anaesthesia facilities within the range of 80 kilometres. However, this is largely limited to the urban geography. At the same time, the rural areas are grossly neglected, forcing the rural population to travel many miles for many hours to reach the proper secondary and tertiary medical centres. To address the shortage of medical professionals in rural areas, China had a concept called "Barefoot doctors" trained by qualified urban doctors in preventive, promotive, and rehabilitative healthcare. This small beginning in China became a backbone for the rural healthcare setup today. These barefoot doctors were adequately trained in both traditional Chinese medicine and modern medicine to handle the primary health issues of their local population. India too had a concept called the "National Village Health Guide Scheme" very briefly, but did not go a long way due to poor incentivization to the health workers, minimal affiliation to the formal healthcare system, and vaguely defined roles and responsibilities of the human resources involved in it (1).

## The QOL Factor In Rural India:

The quality of life (QOL) in rural India is shaped by a combination of economic, social, and environmental factors. While there have been significant improvements in recent decades, challenges persist, particularly in areas like infrastructure, healthcare, education, and livelihood opportunities. One of the highly populated countries, India shares a considerable proportion of the global disease burden with 20% disability-adjusted life-years (DALYs) and deaths to the extent of 20% and 18% respectively. Besides 44% of DALYs due to chronic diseases, communicable diseases, malnutrition, maternal morbidity and perinatal disorders are the biggest cause for concern in India. Socio-economic status, poverty and education are the main factors contributing to healthcare inequalities. Inadequate public expenditure on health by the government forces the public to rely on private health sector services, which causes a greater financial burden due to the high amount of out-of-pocket expenses. The rural population that has the greatest need for healthcare has the least accessibility to quality healthcare. Conscious efforts to improve social determinants like potable water, sanitation, clean living conditions, food security, education, and poverty reduction are expected to bring equity in healthcare for a larger population of the country (2).

Life Expectancy (LE) and Healthy Life Expectancy (HALE) are important indicators used in public health to measure the overall well-being and longevity of populations. While they are related, they focus on different aspects of health and lifespan. Both are essential for understanding the overall health of a population and for designing policies that improve both longevity and quality of life. Life expectancy is the average number of years a person can expect to live, assuming current mortality rates remain the same throughout their lifetime. It is often calculated at birth, but it can also be calculated at different ages. Healthy life expectancy is the number of years a person can expect to live in good health, free from chronic disease or disability. It takes into account the quality of life, not just the length of life. Healthy life expectancy is often calculated by subtracting years lived with illness, disability, or poor health from total life expectancy. In India, socio-economic inequality is a major cause for concern in Life Expectancy too. Overall, in India Life Expectancy at birth was 68.3, but it was 65.1 years for the poorest populace and 72.7 years for the richest populace. This is a clear gap of 7.6 years which translates into an 11.67% life gap between the richest and the poorest in India. The gap between the urban lower middle class and the rural lower middle class is minimum (6.3%), while the gap between the urban middle class and the rural middle class is maximum (7.80%). Further, the gap in Life Expectancy between the poorest rural and richest urban is 7.9 years translating into 12.34% of the life gap between these two wealth quintile groups. This indicates the influence of wealth quintile status and living habitat on the life expectancy of the individual. Availability, accessibility and affordability of quality healthcare also make a significant impact on morbidity and mortality rates (3).

## The Reality Of Healthcare Duality:

The duality of healthcare reality refers to the contrasting and often paradoxical nature of healthcare systems and experiences across societies. This duality can manifest in various dimensions, highlighting disparities, challenges, and opportunities within healthcare. Income and wealth alone are not the prerequisites for economic development in general and rural economic development in particular. In a rural health survey in the Udaipur district of Rajasthan for 18 months, between January 2002 and August 2003, it was established that the health of the rural population would not only reduce the disease burden but also improve the economic activity for better local development. With a high tribal population, Udaipur is considered one of the poorest districts in India. The literacy rate in the surveyed area was too low barely with 11% female population and 46% male population who could read out of a written script in their local language. Many adult surveyed people (93% men and 88% women) were found to have a BMI way below the cutoff of low nutrition. During the survey period, 45% of the medical personnel in sub-centres and 36% in primary/community health centres were found to be absent from work. Due to this absenteeism, sub-centres were closed for 56% of the working hours. The private health sector in that area was highly represented by unorganized quackery with 41% of the self-labelled doctors did not have medical qualifications and 17% did not even have a high school education (4).

In developed regions or well-funded systems, healthcare may be easily accessible, with advanced infrastructure, skilled professionals, and cutting-edge technologies. On the other hand, in underdeveloped or resource-poor areas, millions face barriers such as financial constraints, lack of infrastructure, and shortages of medical personnel, leaving basic care out of reach. The affluent often enjoy high-quality, personalized care with access to the latest treatments and technologies; and vulnerable populations may struggle with underfunded facilities, long wait times, or no access to care, deepening health disparities. Some systems prioritize public health and prevention, investing in education, vaccines, and screenings to reduce disease burden; whereas others concentrate resources on treating illnesses after they occur, often neglecting prevention, which can lead to higher long-term costs and poorer outcomes. Government-funded systems aim to provide universal access but may face inefficiencies, budget limitations, or quality issues; whereas privately funded healthcare often offers superior quality and shorter wait times but creates inequities based on ability to pay. Wealthy nations and institutions make significant breakthroughs in treatments, surgeries, and pharmaceuticals, often pushing the boundaries of science; but diseases affecting poorer populations may lack research and investment because they are not profitable for the global healthcare market. Cities often have well-equipped hospitals, specialists, and advanced diagnostics; but rural areas may lack basic facilities, trained professionals, and transportation, leading to delayed or absent care. For many, healthcare represents hope, healing, and a promise of better quality of life; and for others, the high cost, long waits, or inaccessibility of healthcare can lead to frustration, suffering, or death. While the healthcare industry sees constant breakthroughs in telemedicine, AI, genomics, and personalized medicine; many communities struggle with basic issues like clean water, sanitation, and access to medications, rendering global innovations inaccessible. Healthcare is often regarded as a fundamental human right, with calls for universal access, but limited resources, profit-driven motives, and unequal distribution challenge the realization of universal healthcare. Success stories like eradication of smallpox, reduction in child mortality, and advancements in cancer treatments highlight healthcare's potential; whereas systemic issues like the opioid crisis, overburdened healthcare workers, and unaffordable care reveal cracks in the system.

## Conclusion:

The healthcare of citizens is considered a responsibility of the government due to several ethical, practical, and economic reasons. These reasons are grounded in the idea that access to healthcare is a fundamental human right and that the well-being of individuals contributes to the overall stability and prosperity of society. Since access to healthcare is recognized as a basic human right in international agreements such as the Universal Declaration of Human Rights (Article 25), the government has a moral duty to protect the lives and well-being of its citizens. Further, health is a public good because an individual's health can impact the community (e.g., through the spread of infectious diseases). Governments must intervene to ensure public health standards are maintained. As the private healthcare sector often excludes marginalized groups or fails to address the needs of all citizens due to profit motives, government intervention ensures equitable access. To achieve sustainable and equitable healthcare across socioeconomic sections and geographical areas, there needs to be more social research to find innovative ways to reach out to the needy. Governments should encourage the proper funding for projects that call for impact creation rather than just delivering the need-based healthcare service.

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