Health Inequities in India
A Focus on Some Under-researched Dimensions

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The world has never been as rich as it is today. Yet substantial proportions of the global population live short and brutal lives, haunted by hunger, ill-health and disease. The average life expectancy in Sweden countries in 2015 was 82.4 years; that in Swaziland was 58.9 (WHO, 2017). Over the last 30-odd years, as the world entered a neo-liberal turn to economic growth, along with a growing wealth gap between rich countries and poor countries, and between the rich and poor within countries, there is also a growing health gap. For example, the maternal mortality rate in the black population in the United States is three times higher than that in the white and is increasing. In India itself, a person born in Kerala can expect to live 18 years longer than one born in Bihar or Jharkhand.

Indians are living through a period of unprecedented economic inequality in more than a century, and this is largely true for most countries of the world. In 2017, 73 per cent of the wealth generated in India went to the top 1 per cent of the population, while the poorest 50 per cent were able to corner only 1 per cent. We as a country boast of having 101 billionaires, while 224 million people live below the poverty line of US$ 1.90 per day (Oxfam International, 2018).

Fifty years ago, speaking about justice in access to health and healthcare, Dr. Martin Luther King Jr. said:

> *Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death (50th Anniversary of Dr. King's Healthcare Quote). https://www.forbes.com/sites/danmunro/2016/03/25/the-50th-anniversary-of-dr-kings-healthcare-quote/#54e85ec730b5. Accessed 9 May 2018).*

It is well known that health inequities in India are shaped by region, by socio-economic development, by class, religion, caste, gender and sexuality. In general, states of the south are doing better in terms of human development indicators than states in the North. But there are also sharp differences by regions within states. For example, the Malabar region of Kerala lags behind the rest of the state in health and socio-economic indicators. Similarly, northern Karnataka lags behind Old Mysore in all these indicators. But it is not as if everyone in the backward regions suffers the same unfairness. In all these regions the rich have better access to the social determinants of health and are more likely to live longer and healthier lives. In India, of course, caste and identity are also markers of health inequities. Thus the SCs, STs and Muslims, in general, tend to have poorer health and access to health systems. The public health system, weakened by decades of under investment, has failed to fulfil its expected role of protecting the poor and marginalised from inequities induced by the market mechanism.

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There are other populations too that are marginalized on the basis of disability, mental health, sexuality and homelessness. For example, research suggests that people living with chronic mental health problems tend to die earlier than the general population. What we attempted to do in this project was to bring these to the fore in public health conversations, so that researchers may start exploring these areas in however tentative a manner. The Supreme Court argued that the LGBTQI population was "minuscule". This is no reason for their rights to be snatched away, nor for their health inequities to not be studied. In the Indian context, even a minuscule population comprises a substantial number of people, not to be ignored by public health workers and researchers.

This Special Issue of *eSocial Sciences and Humanities* aims to bridge, in a small way, the evidence gap on health inequities in India. The Special Supplement is being produced as a part of the project *"Closing the Gap: Health Equity Research Initiative in India",* implemented by the Achutha Menon Centre for Health Science Studies (AMCHSS), the Public Health Wing of Sree Chitra Tirunal Institute for Medical Sciences and Technology. The Project is a response to the need for actionable evidence and for policy advocacy on attention to health inequities in the country. Set up in 2014 with financial support from the International Development Research Centre (IDRC) Canada, the "Closing the Gap: Health Equity Research Initiative in India" project aims to

> *contribute to the advancement of a sound, actionable and measurable evidence- base on inequities in health in India with a view to influencing government and civil society initiatives to prioritize the reduction of health inequities.*

During 2014-17 the initiative undertook numerous activities including an evidence-synthesis exercise. This exercise revealed that the evidence-base on health inequities in India is limited and narrow. While the number of studies was not too small, their contribution to our understanding of the processes and mechanisms underlying health inequities was very limited. Studies on health inequities by income/ wealth, caste or ethnicity and sex/ gender tended to describe the nature and extent of gaps and their correlates, but did not examine why these gaps continued to exist. More disconcerting was the discovery that there was almost no published research on health concerns of many population groups such as migrant workers, the homeless, persons living with physical and psychosocial disabilities and persons of diverse gender identities and sexual orientations. We therefore sought to bring out a collection of articles focusing on neglected health concerns and population groups.

About this issue

This special issue of eSocial Sciences and Humanities on health inequities in India started as a modest attempt to bridge the evidence gap on the subject. This issue includes 12 papers on various dimensions of health inequities in India.

Eight of the papers are on sex or gender-based inequities in health. The papers take diverse perspectives. Some focus on unequal burden in the ways illness is experienced or in care-giving roles, or unequal barriers to healthcare. The others use a gender-lens to examine health-systems issues such as health financing and universal healthcare. Together, they constitute a rich collection of studies on health inequities in India by sex and gender.

Of the remaining four papers, two are on health of the urban poor, a population rendered invisible by averages which show urban population to be better resourced than the rural. The 11th paper is on is on social exclusion and health of Muslims in Maharashtra. The 12th is a paper that calls

to question the feasibility of achieving universal health care without recognising the role of and forging a partnership with practitioners of popular traditional medicine, who cater to the healthcare needs of some of the most marginalised sections of society.

Although our call for papers had specifically focused on themes that had the most evidence gap, the final line-up of papers does not include any paper on most of these population groups. This is despite specific efforts made by the editors to actively seek out researchers and activists working with some of these populations. There were many slips between the cup and the lip. The 73 abstracts we received and the 38 abstracts we selected had at least one or two papers on various under-studied population groups. However, their numbers dwindled when we received the full-length papers. Many dropped out also at the stage of revising and resubmitting papers.

There are many reasons as to why this could have occurred. One is the neglect of social sciences in schools of public health. While it is heartening that public health is receiving belated recognition and many schools have come up in the last two decades, they continue to be dependent on mainstream epidemiological methods, with an emphasis on quantitative data and not enough attention being focused on social science theories and qualitative data and processes. It also appears that many advocates for social justice, gender equality and the rights of marginalized groups have not prioritized researching and writing in general, or do not focus on health inequities in particular. This calls, on the one hand, for strengthening social science interventions in public health schools and a greater sensitisation to the needs of marginal communities among health workers and researchers; and on the other, greater involvement by advocates and activists in research and writing to put health inequities and health rights of all on the public health agenda.

References

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