

Health Disparity and Health Equity in India: Understanding the Difference and the Pathways Towards Policy

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Health is essential in all spheres of everyday life. It is crucial for well-being, longevity, and for availing economic and social opportunity. Therefore, resources and services needed to be healthy to go beyond medical care. Living and working conditions which promote health assume greater importance as they have the potential to reduce the need for medical care (Daniels, 1981; Daniels et al., 1999). Therefore, the discourse on health needs to begin from the socioecological framework and move towards the biomedical through the biopsychosocial. The health promoting elements require to be distributed according to need, rather than treated as commodities which can be accessed based on one's economic propensity. Evidences are aplenty that health status is contingent to health promoting environment, and imbalances in this environment are likely to produce disparities, inequities and inequalities in health.

Disparities, Inequities and Inequalities in Health

It is necessary to understand that health disparity is embedded in health differences linked with economic, social, and environmental disadvantages. As evident from the *Healthy People* (2020), 'Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.'

In this definition, economic disadvantage refers to inability to purchase goods and services, due to low income. Social disadvantage includes economic disadvantage, one's position in social hierarchy based on economic resources, ethnicity, caste, religion, gender, sexual orientation, and disability. These characteristics often determine the behaviour of others towards the 'self' and the group to which 'self' may

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belong. The environmental disadvantage refers to a poor neighbourhood with social disadvantages.

Therefore, achieving health equity is possible only when social determinants of health address poverty (Marmot, Friel, Bell, Houweling, Taylor, & Commission on Social Determinants of Health, 2008; Williams, & Mohammed, 2009; Adler, & Stewart, 2010; Braveman, & Gruskin, 2003); discrimination (Williams, & Mohammed, 2013; Braveman, Egerter, & Williams, 2011), and work environment (Burgard & Lin, 2013; Pickett, & Wilkinson, 2015) in which people are born and continue to live. Poverty and discrimination accentuate vulnerabilities, including powerlessness (Wallerstein, 1992), lack of access to resources, services, and opportunities—all of which are crucial for good health. Achieving health equity requires eradicating barriers and improving access to the resources known to affect health. These resources primarily include work opportunities (Burgard & Lin, 2013), education (Cutler, & Lleras-Muney, 2006; Egerter, Braveman, Sadegh-Nobari, Grossman-Kahn., & Dekker, 2011); housing (Banerji et al., 2018; Gordon-Larsen, Nelson, Page, & Popkin, 2006); and healthcare services and health-promoting environment (Gordon-Larsen, Nelson, Page, & Popkin, 2006), particularly for those who lack access to resources and have poor health (Daniels, Kennedy, & Kawachi, 2000; Marmot, 2015). Health and well-being can be impacted positively for everyone, but should be prioritised for the excluded or marginalized groups (Rawls, 1971; Pickett, & Wilkinson, 2015). Thus, poverty and discrimination emerge as core causes of health inequity.

Health equity and health equality—both engage with improving outcomes and increasing access to services, especially for underserved populations and marginalized groups. ‘Health equality’ means giving the same opportunities, care, and services to all. For instance, a medical professional may offer the same service, or provide the same information to all, without taking cognisance of any plausible risk. The likely assumption is that everyone has been treated equally and therefore, they are not biased. Health equality, therefore, focuses on treating everyone the same and ensuring equal access to healthcare. Health equity, however, aims to end, or at least minimise institutional and discriminatory barriers that create inequality. The factors within the healthcare system (racism, casteism and sexism); as well as factors outside the healthcare system (poverty and unequal distribution of resources and opportunities) come under the fold of health equity. It is based on the principles of fundamental justice with a goal to ensure equal access to quality healthcare and good health. It emphasises on distributive justice requiring more support and resources to the underserved, excluded and the marginalised populations.

This issue of the journal has engaged with such realms of health. The essays assorted for this issue have addressed the question of health inequality and health equity; and in doing so, the endeavour has been to understand health differences and health disparity.

The essay on ‘Public Policy, Social Identity, and Delivery of Healthcare Services in India’ authored by G. C. Pal, engages with community and the delivery of services through the intersections between the public policy processes, dynamics of social

identity of care service providers and users, and the consequent access to healthcare. Pal, in doing so, highlights that the delivery of healthcare services is *fraught with social injustice*. The dominant socio-cultural norms around social identity supersede the intent of the healthcare centres and the providers to address the health needs of all. This essay brings together the superimposition of inequality and inequity in understanding delivery of care. From the perspective of the providers, health equality has been addressed as they impart care and other related service to all without any difference. However, the differential access to resources due the social identity makes it imperative to ensure that the healthcare providers recognise the impact of social determinants of health and strategize for addressing them as important. A doctor, for instance, has to acknowledge that some people may have limited access to healthy food. Therefore, they would be required to plan the ways to overcome this deficit and minimise the risks for health. Thus, health equity approach takes into account differences in socio-cultural characteristics, access to resources, and economic status (Daniels, 1981; Daniels, Kennedy, Kawachi, 1999; Braveman, Gottlieb, 2014; Dwivedi, 2017).

Structural Hierarchies and Health

Navin Narayan's essay raises some moot questions of structural hierarchies and juxtaposes them on the notion of health justice—drawing from equity framework. In most countries including India, as the author argues, the justice system functions in favour of the *wealthy and powerful* while the underprivileged remain devoid of justice given the context of health equality. He traces the connect between social stratification moorings and access to healthcare and corroborates that in an unequal society, the underprivileged remain entrenched in deprivation and marginalisation (Dias & Welch, 2011) which affects their health (Braveman, 2006; 2010;) all the more when the health professionals adhere to the principles of equality rather than equity (Whitehead, Dahlgren, 2006). Thus, social inequality affects everyday life in which health is intrinsically intertwined. The author argues that in a society dedicated to the ideal of equality, evidence of equality remains non-existent, sporadic at best. He draws an engaging parallel with the science of immunology to explain this persistent inequality. The *culturing* technique from immunology has been used by the privileged Indian society for *culturing casteism* through the *Sociology of Sufferer—or the healthcare seeker—and Sociology of Supremacy*—of the healthcare profession and professionals. The author highlights that casteism is cultured in both these spheres; and uses empirical evidence to establish the dominance of privileged groups in nurturing casteism in health. It is illustrated that the privileged groups occupy best of professional as well as care seeking realms by virtue of their privilege.

Some essays in this special issue of the journal focus on specific population groups to reflect on their health through realms of inequality, disparity and equity. The essays reflect on 'health disparity' which needs to be seen as different from 'health difference'. While the empirical evidence suggests that different groups have different

health outcomes, yet health disparity is not the same as health difference. While difference is reflected through biological markers, health disparities are due to social values which lead to differences that are unjust and preventable.

The essay on Hadis by K. M. Ziyuddin traces the historical disadvantages which have perpetuated health inequalities and hampered the processes of minimising disparities in health. The author traces the historical journey of the Hadis in asserting themselves and opting out of their conventional cleaning occupations in search of alternatives. He also highlights their contribution in building urban spaces. Their engagement in sanitation work keeps the urban environment clean, while they experience health hazards of varying degrees. Health disparities, are socially influenced, and cause different but preventable outcomes across different social groups—as is evident in the case of Hadis. Very little has been studied about this community—certainly not from the perspective of health. The author adds a new dimension to the existing discourse by engaging with the question of right to city for these crusaders of cleanliness. Through the empirical evidences, the author exemplifies their exclusion from the city—which they sanitise at the cost of their own health—to the margins, both metaphorically and physically.

The Pandemic

In a just society, everyone has to have a fair chance to be healthy, since health is integral to well-being—physical, economic and social. Health differences can be understood by the following example. Uterine cancer affects women aged 50 years and above. Those less than 50 years are less likely to be affected. Therefore age is the factor causing illness differential. However, if women with certain socio-economic characteristics (such as low income and low social rank) are affected more than the others, then it is health disparity. This is a difference that is unjust and preventable. Disparities are socially influenced and cause different but preventable outcomes among groups. In some cases, health equality can overcome disparities, especially when the disparities are due to unequal treatment. The studies on COVID-19 address this aspect. The state was providing safeguards to everyone ‘equally’ without any distinction. But this equality could overcome disparity in certain situations. Differentially endowed care facilities and ill-prepared care providers were restrictively addressing the needs of the underprivileged as compared to the privileged population—both socially and economically. By and large, ‘equal treatment’ accentuated the pandemic. Care provisioning for the privileged groups is likely to have minimised the disparity among them, but not across the social groups—broadly the privileged (or advantaged) and the underprivileged (disadvantaged).

The essay on media coverage of COVID-19 and portrayal of the marginalised population by Achla P Tandon raises questions on the role of media in inducing prejudice, stigmatising and inflating social inequality. The media’s portrayal of ‘infectors’ with specific labels, based on religion (Muslims), region (North-East India), and work (biomedical waste/sanitation/ cremation related) aggravated the

already existing prejudices. It affected the already vulnerable health of all; but more of the disadvantage groups. Media reporting was selective. COVID-19 induced health inequality was reported as disparity, when the need was of health equity in order to address the differential needs of the people, infected as well as affected by COVID-19. The author highlights that the crowdsourced data and the online platforms reflected on the multiple vulnerabilities of those who were stranded in the camps consequent of the lockdown. It is noteworthy that the larger share of these people were from socially and economically marginalised groups. The unprecedented health emergency required to be dealt with caution while reporting the situation, or the safety protocol or the perils of those in need of healthcare. Mainstream media was minimal in reporting on the marginalised population in the camps and as they travelled to their place of origin amidst the lockdown. Much of the information on such groups was made available by the non-government/community-based organisations. Taking this issue of marginalised population and COVID-19 forward, the essay by Dilip Diwakar G. et al. focusses on the migrant workers, more than 90 per cent of whom are from underprivileged populations synonymous with the administrative categories of Scheduled Castes, Scheduled Tribes and the Other Backward Classes. To understand about their health and livelihood issues during COVID-19, the authors have tracked the rural-ward distress migration of the informal sector migrant workers in Kerala. Engaging with health equality notion, the authors use the state mechanism to address COVID-19 in general and its impact on the Dalits (Scheduled Castes) migrant workers in particular. Using the mixed method approach, the authors examine the lives, livelihoods, and healthcare utilisation by the migrant workers; and lived experience of interstate Dalit migrant workers who have adopted Kerala as their workplace. While the quantitative analysis of empirical evidence suggests that health disparities not only existed, but were accentuated by COVID-19, the narratives drawn from the field for qualitative analysis reiterate the higher vulnerabilities among the Dalit migrant workers.

Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. Medical education is often an issue relegated to the background by academics in the area of health as well as education. Khalid Khan draws from his training in economics to confront some stark markers of differentials leading to inequality. He explores access of the students belonging to diverse background, to medical education in India. Using secondary data and robust statistical techniques, he highlights that the social inequalities precede social injustices and thus affect access to a career in medicine which is linked to the caste/ethnicity and religious identities. The author focuses on the differential access to medical education which is aggravated for the students from the underprivileged background. The high cost of medical education in itself becomes a negative factor in creating enabling environment for the underprivileged. The probability of attending medical courses is relatively lower for Scheduled Castes, Scheduled Tribes and the Muslims than the

Hindus High Caste as has been illustrated by the author as supported by data. The essay captures social inequalities and disparities to comment on the access to medical education in the light of its high cost.

Allopathic Supremacy in Medical Hierarchy

The discourse on health inequality or disparity usually engages with the healthcare system predominated by the allopathic supremacy. Despite the rich legacy of alternative systems and local healing traditions, the advent of allopathic medicine systematically eroded the existing systems. Supported by the market, largely pharmaceuticals, the local systems embedded in AYUSH and local healing were relegated to secondary positions. The process also affected the care providers, many of whom, such as bone setters and traditional birth attendants, for instance, have a specific social identity (Acharya, 2022). They mostly hail from scheduled communities—both caste and tribe. Aptly titled '*Addressing Hegemony within the System of Medicine for an Inclusive and Sustainable Health System: The Case of Traditional Medicine in India*', the essay authored by Nemthianngai Guite, showcases the dominance and interplay of the power relations and social structural inequalities. She illustrates that power relations and social structural inequalities are crucial to encourage and perpetuate medical hegemony. The author's commentary on codification of and regulations for traditional medicine systems, raises some pertinent question on inequalities in health—of yet another kind—in professionalization, commoditization and in access to intellectual property rights. The initial superiority attributed to the allopathic medicine is due to the 'supremacy of the 'developed' West as compared to the 'developing' and colonised oriental countries including India'. However, at present the transition is largely due to differential access to medical education (see Khalid Khan's article); and medicine systems for care-seeking as well as care-provisioning. The author argues for the due recognition to the practitioners of traditional medicine systems; and preservation and protection of their knowledge for inclusive, equitable and sustainable health system.

Caste Identity-induced Inequality

Similar to COVID-19 specific studies, Raushan et al. examine caste identity-induced inequality in child health outcomes such as mortality, malnutrition and anaemia. Using the NFHS data of two decades, the authors examine the association of socioeconomic factors with child health outcomes through Disparity Ratio (DR) and Concentration Index (CI). The association of socioeconomic factors was also tested using logit regression. It was found that the marginalised groups were more likely to have poor health outcomes as compared to the other. This essay becomes relevant in the context of the public policies. Health equality ensures for all the same opportunity to access healthcare, while health equity prioritizes justice. The authors draw a connect between the two by emphasising on the need for transition from *same opportunity to all*, to prioritising access to the most needy, thereby moving towards health equity. For the public policy process, the authors allude to an intersection between *equality-based*

approach, whereby everyone would get the same healthcare funding and services; and an *equity-based approach*, where by access to care services would depend on the care seekers' needs. For example, all the *Hadis* engaged in the cleaning occupations (see Ziyauddin's essay), would have the option to have a regular medical check for their infections, etc., and fitness test to carry out the work. This essay establishes the persisting disparity and inequality in child health and nutrition with high burden among the underprivileged populations of the Scheduled Castes and the Scheduled Tribes despite the affirmative action induced progress in emancipating some such groups.

Public Spending on Health: We Need to Invest More

The policy environment for health in India inevitably crosses paths with health investment. Given the low share of public spending on health, despite increase post COVID, we still remain one of the countries with lowest public health spending: 1.0 per cent of the GDP. Even countries like Bhutan (2.5 per cent), Sri Lanka (1.6 per cent) and Nepal (1.1 per cent) with lower national income, spend more on their people's health. Notably, India's per capita public expenditure on health increased from ₹ 621 in 2009–10 to ₹ 1,112 (around \$16 at current exchange rate) in 2015–16. However, it is still nominal, compared with other countries. Switzerland spends \$6,944 on health per capita, the United States spends \$4,802 and UK \$3,500. The Union Budget 2021–22 proposed to increase healthcare spending to 2.2 trillion Indian rupees (\$30.2 billion). The need to enhance public health spending to at least 5 per cent of the GDP has been proposed for a very long time. The pandemic affected all sectors, but the already weak health sector was worst hit. The government increased the expenditure on public healthcare in 2021–22 by 73 per cent from 2020–21 to ₹ 4.72 lakh crore (Economic Survey, 2022). According to the National Health Accounts estimates for 2014–15 (MoHFW, 2016), the Government Health Expenditure (GHE) per person per year is only ₹ 1,108, or about ₹ 3 per day. In contrast, the Out-of-Pocket Expenditure (OPE) of ₹ 2,394, accounts for 63 per cent of the total health expenditure. The WHO's health financing profile for 2017 shows 67.78 per cent of total expenditure on health in India was paid out of pocket, while the world average is just 18.2 per cent. It is noteworthy that if such is the scenario for all, then given the marginalisation and exclusion of the underprivileged population, GHE of ₹ 3 per day is likely to further reduce for the underprivileged groups.

Indrani Gupta's essay titled 'Health investments to reduce health inequities in India: do we need more evidence?' co-authored with Avantika Ranjan, illustrates this. Authors categorically states that inequalities in health outcomes and treatment-seeking behaviour contribute the most to multi-dimensional poverty. High out-of-pocket spending continues to be a critical for India's health sector, as, they reiterate, the negative impact of continued low of public investment on health. They illustrates with the COVID pandemic reflecting on the inept preparedness of the country to address the health needs due to the pandemic. The authors have unequivocally advocated for a *resilient health sector* which can be put in place by improving the infrastructure,

recruiting personnel, and enhancing supplies and training. While this essay does not deal with social identity-induced inequalities, the authors rest their argument on regional and economic disparities leading towards inequalities in health. They also relate these persistent inequalities with the COVID situation. Drawing from the evidence that most poor are among the underprivileged groups—largely the SCs and the STs, their observations on multidimensional poverty and its linkage with health outcomes mark the accentuated vulnerabilities of the underprivileged groups.

Taking this forward is the essay on the hierarchy in the health workforce in the public and private sectors authored by Rama V. Baru and Seemi Zafar. This essay adds to the idea of enculturating casteism in health (see Navin Narayan in this issue). Intersecting religion, class, caste and gender, the authors reiterate that the health workforce is hierarchical in structure (skill and capacity); and social composition. This essay highlights that most of the studies on the health workforce have focused on the public sector, although the private sector in health has a significant share of the total health workforce. Baru and Zafar hinge on the existing literature and relevant data—drawn from primary and secondary sources, to inform that there is *under-representation of minorities and women as owners of private health services*. The authors also highlight the gender bias in the health workforce whereby the middle and lower rung positions are occupied by women and men located at the lower end of the caste-class hierarchy. In contrast, those at the higher end of the social rank are also located at the higher work hierarchies. Drawing from the statistics on composition of occupational groups, the authors reiterate that there is domination of Hindus, followed by Muslims and other minorities respectively as ‘Physicians and surgeons’. As ‘Nursing and Other Technicians’ too, proportion of Muslims was lower than other minorities. The authors observe that the representation of Christians in the healthcare workforce reduced with increase in participation by Hindu and Muslims women. Corroborating the earlier work (Baru, 2005; Iyer et al., 2005) they reiterate that these nurses were mostly from the underprivileged groups and their remuneration was very low. The *untrained workers like dais (traditional birth attendants) were predominantly from the Scheduled Castes*; and about two-thirds of the Auxiliary Nurse Midwives (ANMs), were upper and middle class Hindus, while only one-fifth were from underprivileged communities (SCs and STs); and a negligible share was from the Muslims and Christians. This essay establishes the connect between social inequalities and access to resources needed to become care providers, thereby also reflecting on social disparities which perpetuate the inequalities in access to medical (and para medical) education (see Khalid Khan in this issue). Access to medical education is determined by disparities which are socially influenced, very often, unjust and therefore preventable. Better socio-economic propensities, act as enablers for access. Among those who can access, some reach higher positions in their work hierarchies while the others have to settle for lower positions in their work hierarchies. Thus, given the differential access to resources consequent of marginalisation, the outcomes are different. However, these differentials which act as the barriers in access, are preventable through affirmative action policy. However, it is noteworthy that while state’s motive of affirmative action as defined,

is to bring about parity between historically deprived and the advantaged population groups, the social reality induce prejudices and biases which inevitably demand more competence from the deprived to be able to prove themselves equal to the privileged.

Sub-group Disparities

The differences in access to health resources are analysed to understand disparities among Dalit sub-castes in the essay authored by Kanhaiya Kumar. The author examines the disparities in socio-economic status of various sub-castes within Scheduled Castes, drawing from a study located in a selected district of Uttar Pradesh, the state with largest population in India. Using mixed method approach, perceptions about health, illness and disease have been studied to provide the context of the prevalence of morbidity across subcastes among SCs. The concentration curves based on the primary data and quantitative methods, reflect on the disparities in out-of pocket expenditure, possession of landholding and income among the sub-castes within the SCs (or Dalits). The author corroborates that like major social groups (SCs, STs, OBCs) and Others) have differences and disparities, there are differences in access to health resources among various sub-caste of Dalits (SCs) too. Using the empirical evidences, the author establishes that these disparities are a function of an intersection between social identity, socio-economic status and geographic location of healthcare services. Therefore, it is imperative to understand and identify the differences and distinguish them from disparities within sub-castes. This will enable one to overcome the gap between their health needs and accessibility to healthcare services; and also build a transition from health equality to health equity. For instance, the most marginalised sub-caste is likely to be worst affected by a given illness condition as compared to the least marginalised sub-caste. When adjusted for social, economic, infrastructural and environmental differences, such as access to quality care, distance and availability of the health providers, there is no significant difference in morbidity conditions between the most and the least marginalised sub-caste. This suggests that preventable issues account for the higher morbidity among the most marginalised sub-caste group, rather than any pre determined differences. These issues include access to quality care, the type of care a person receives, and social inequality that undermines health (Daniels et al., 1999; Deshpande, 2000, Goli et al., 2013; George, 2015).

Health Disparities, Equality and Equity: Why We Need to Know the Difference

Health disparities and health equity are interlaced. Health equity connotes social justice in health. In other words, no one is prevented from availing the opportunity to be healthy, because of belonging to a historically disadvantaged group(s). Health disparities enable measuring progress toward achieving health equity. Low health disparities reflect on greater health equity. This can be achieved by selectively improving the health of those who are economically and socially disadvantaged, not by providing equal access to all; or by impairing the health of the privileged or advantaged groups (Keleher, & Murphy, 2004; Whitehead, Dahlgren, 2006).

Health inequality and disparity are known to be discriminatory. It is difficult to identify and prove intentions and actions as discriminatory. The often extended reason is that medical practitioners are wedded to the Hippocratic oath and hence have very little scope for discrimination. But as humans, located in the hierarchical social structure, greater harm to health may be done as a result of unintentionally discriminatory processes and structures (Williams, Mohammed, 2009; Borooah, 2010). Considering that the discrimination no longer exists, processes and structures which persist as the socially sanctioned prejudices and biases—religious and ethnic segregation, caste based exclusion, call for enforcement of affirmative action for ensuring access to health resources—ranging from medical educational and training and care. Even when the conscious intent to discriminate is often not recognised and passed as unintentional, such intent perpetuates economic and social disadvantages and influences health consequences across generations and population groups.

The essays in this issue of the journal may not have addressed the human rights issue as central to health, but all are knitted through the understanding and addressing of the links between health equality and equity; difference and disparity. The authors converge in thinking about the transition from equality to equity; and distinguishing between health difference and disparity; and alluding to the need to work toward minimising the disparities in the process of enhancing health equity. The human rights principles of non-discrimination and equality are inevitable in addressing health disparities. These principles are based on equal rights (to health) for all. The State is obligated to promote health through public policies and affirmative action embedded therein. The State is also required to prescribe policies that are prejudiced and discriminatory against particular social groups. Therefore, predominance of health literature from equality perspective needs to be understood from disparity and equity lens.

In addition to the articles based on the theme of this special issue, two more articles feature in the forum section. In his article, Chief Justice, High Court of Orissa S. Muralidhar has touched on the theme of access to justice and legal representation of the marginalised communities in the Indian justice system. He has not only highlighted the challenges faced by the marginalised communities, but has also tried to make comprehensive suggestions towards institutional reforms in the justice system. The article by C. Jerome Samraj discusses the manifestations of academic untouchability and exclusionary practices in admissions in higher education institutions. The essay attempts to understand the nature of the practice of untouchability in higher educational institutions in India and the politics behind the method of implementing reservations in admissions in higher education institutions.

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