Researching health inequities

OP-46 HEALTH INEQUITIES RESEARCH IN INDIA: A REVIEW OF THEMES, PATTERNS AND OPPORTUNITIES

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Background Research on health inequalities can be instrumental in drawing attention to the health of socially and economically vulnerable groups in India. It can shape the dialogue for public health action, emphasise the need for greater and targeted investments in health, and is a marker for effectiveness of public health services. In this paper, we provide an overview of health inequalities research in India. We describe the historical context of the research on health inequalities and equity in India since 1990. We describe the metrics used and assess what outcomes and populations have been studied.

Methods We conducted an extensive literature search on PubMed, the bibliographic database of the US National Library of Medicine, for research articles published between 1990 and 2013. The time period chosen marked the beginning of economic liberalisation in India. We searched the database using the specialist search terms to identify 7,037 titles and abstracts. Screening of abstracts provided 1,010 final studies for review. Data were extracted from key domains including study type and year, author characteristics, outcome, population group and measure of socioeconomic disparity. Key measures of equity included geography (urban, rural and states), income or wealth, occupation, caste, religion, gender, education and access to water/sanitation.

Findings Studies on health inequalities in India increased in number after 2005. About 76.7% of the studies were authored by Indian lead authors, even as contributions by international researchers as lead authors (mostly from developed nations) have increased over time. A majority of studies were quantitative, with only 7% qualitative or mixed-methods studies. Most studies on equity were descriptive or comparative in nature, while 6.3% of the studies related to effectiveness of health programmes and interventions. Communicable diseases (11.2%), non-communicable diseases (13.9%) and malnutrition (16.1%) comprised the largest proportion of published studies. Other major categories included studies on health services and risk factors. A rise was also noted in studies on mental health. Nearly half of the studies related to women and children. Youth and elderly comprised 2.5% and 3% of the present literature respectively. Among the measures for equity considered, class and income were the most common stratifiers studied (57.4%), followed by education (42.9%) and gender (36.9%). Region, occupation and caste/tribe were represented substantially as well. Proportion of studies examining education, occupation, region, caste/tribe and religion stayed consistent over time, while studies by gender increased over time.

Discussion & recommendations In a country with marked inequities like India, the study of social inequalities or 'gradients' has an important place in health research. Health inequalities studies can go beyond documenting differences and can inform health policies on their progress in reaching disadvantaged groups. Our study showed a predominance of quantitative studies with the contribution of qualitative research remaining largely untapped. Similarly, we found an overemphasis on descriptive or comparative studies, with few evaluations implying that the translation of health inequalities studies to influencing evaluation and policy has been underutilised. The domains and outcomes explored in this literature reflect the politics and changing discourses of priorities of public health. The dominance of mortality and communicable diseases has been gradually giving way to non-communicable diseases, mental health, injuries and risk factors. The importance of income, wealth and social class as main equity measures, followed by education and gender resonates with global equity issues. In the Indian context, caste/tribe and religion occupy an important space, but these have received less attention in research.

We recommend that future research on health inequalities provide disaggregated analyses at district and state levels that can be used by policy administrators and stakeholders for programme delivery. We also recommend the results of this research on health inequalities to be used by state and national administrators for policy and programme formulation and evaluation.

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