

CHAPTER 2

REVIEW OF LITERATURE

The present chapter illustrates a detailed review of existing studies about healthcare equity and media communication. The primary intent of this review is to meticulously present all the elements of healthcare equity and the role of communication in advancing health equity, especially the rural healthcare system. The review begins with a discussion on the concept of equity in healthcare and health output. Efforts have been made to distinguish among health inequity, health inequality, and health disparity. Besides, the importance of social determinants is being reviewed along with health equity. The section presents an overview of the logical sequence from the Aristotelian approach of health to Sen's capability approach. However, the study is conceptualized on the Ruger's health capability approach which is extensively discussed across the section. This section of the review also presents studies that focus on the role of health care professionals. It is essential to discuss how healthcare professionals using the four pillars of medical ethics can advance their health equity goals. Finally, a comprehensive review of media strategies in advancing health equity is presented, which connects the thread with the agenda-setting theory and frames a theory for better understanding.

2.1 Health Equity

The public health research drawn attention from a range of disciplines that interrogates the health inequities. Researchers from different disciplines have tried to look at health equity from a varied perspective from economists to biomedical community medicine and social scientists. Health equity research broadly focuses on identifying disparities in health and healthcare across caste (Acharya, 2018; Baru et al., 2010; Bhan et al., 2016), economic status (Fielding, 1999; Sen, 2002), gender (Acharya, 2018; Balarajan et al., 2011) and other relevant social

stratification (Ibrahim, 2010; Idler, 2015; Shumayla & Kapoor, 2017). The research on health inequities has also focused on the trajectory of health governance impacts on accentuating or mitigating the inequity gap and enquiring how health equity features as a priority objective for health and health research (Ravindran & Gaitonde, 2018).

Public health literature across varied disciplines has adopted different terminologies: inequities, inequalities, and disparities to explain the health gap caused by social, economic, and political conditioning. The terms equity, equality, and disparity are mostly used interchangeably across disciplines, however, the usage has important policy implications with practical consequences (Braveman, 2006). Mostly, health inequalities and health disparities are synonymously used because they do not cause a significant policy implication (Whitehead & Dahlgren, 2006). Margaret Whitehead's seminal work has articulated the concept of equity/inequalities/disparities across different nations and groups within the same country not only as unnecessary and avoidable but also considered unfair and unjust (Braveman, 2006; Whitehead, 1992). The health differences that are evitable and avoidable are compartmentalized as health-damaging behavior in which the degree of choice of lifestyle is severely restricted, exposure to unhealthy, stressful living and working conditions, and inadequate access to essential health and other public services. Apart from evitable and avoidable differences, Whitehead (1992) considered a natural biological variation to be inevitable and unavoidable; therefore, the goal to achieve absolute equality is not desirable.

The basic premise of equity in health explains that ideally everyone should have a fair opportunity to attain full health potential, equal access to avail care for equal need, equal utilization for equal need, and equal quality of care for all (Norheim & Asada, 2009). Lu An Aday et al., (1984) defined equity in healthcare as which requires resource allocation and access to health care determined by health needs (Aday et al., 1984). Mooney (1983) distinguished health equity into two aspects: horizontal equity or equal treatment for equal need

and vertical equity or different treatment for different needs (Mooney, 1983). Culyer & Wagstaff (1993) stated equity in health as equal utilization, distribution according to need, equal access, and equal health outcomes (Culyer & Wagstaff, 1993). ‘World Health Organization’ report on “Equity in Health and Healthcare” operationalized the definition of health equity as minimizing avoidable disparities in health and its determinants, between groups of people who have different levels of underlying social advantage or privilege, i.e., different levels of power, wealth, or prestige due to their positions in the society relative to other groups. A paper presented by A. Leenan at WHO/Nuffield Centre for Health Service Studies meeting, Leeds in 1985, defined equity in health as equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all.

Subsequently, The International Society for Equity in Health (ISEqH) defined equity in health as the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population group subgroups defined socially, economically, demographically, or geographically (Braveman, 2006; Starfield, 2005; Macinko & Starfield, 2002). Sen (1992), in "Inequality Reexamined," integrated the concept of equity with the theory of justice, in his work health equity is central to understand social justice (Sen, 1992). He further theorized the concept of equity, as health is a necessary condition for human life and a critically significant constituent of human capabilities (Sen, 1985). The role of health in human life and opportunities that persons have to achieve good health – free from illness, avoidable affections, and premature mortality, cannot be ignored. The integration of equity and justice with the capability approach will be discussed in the subsequent section. The definition of health equity can be summed from the existing literature as a condition where accessibility, availability, quality, utilization, and affordability of healthcare services are not affected by social and economic determinants of any individual.

The definition of health inequalities/ disparities is universally used when it comes to communication with policymakers and public from diverse backgrounds. In general, health inequalities are referred to the differences in health among the people with different positions in a socio-economic hierarchy, health inequalities by gender or less frequently, by ethnic group or national origin (Asaria et al., 2019; Marmot, 2017; Rogério dos Santos Alves; Alex Soares de Souza, 2014). Braveman (2006) conceptualized health inequalities/disparities as a type of difference in health or in the most critical influences on health that could potentially be shaped by policies. Health inequity is a difference in which disadvantaged social groups systematically experience worse health or higher health risks than more advantaged groups (Braveman, 2006; Braveman et al., 2011). The inequalities in health are avoidable and unnecessary differences are caused by socially relatable determinants across populations with different social stratification or hierarchies based on income, wealth, and social class. It can be concisely defined as differences in health status because of being socially disadvantaged. Meanwhile, the ill-health inversely affects the socially disadvantaged groups pushing the disadvantageous group further towards disadvantaged positions.

2.1.1 Difference between Health Equity and Health Equality

It becomes imperative to distinguish the terms in pursuance of understanding the policy implication of equity and equality over the various premises of health research. As mentioned earlier, health inequalities include all differences in health across population groups, including those differences arising from genetic, biological, or random factors (Bhan et al., 2016; Ravindran & Gaitonde, 2018; Zere et al., 2010). Likewise, equity in health minimizes avoidable disparities in health and its determinants, not only limiting to healthcare, but also having different underlying social advantages (Braveman, 2006; Whitehead, 1992). Whitehead and Dahlgren (2006) polarized the concept of equity and equality in three features. The first feature of the difference mentions that health inequities are systematic and illustrates consistent

patterns of advantage or disadvantage across specific population groups. The second feature indicates the difference among the aspects of the social process. Health inequities has conceptualized the differences resulting from social processes, rather than biological or unavoidable processes. Differences which occur from social processes are the underlying agents which can be tackled through policy intervention at the social level to narrow the gap presented by inequities. The third aspect is that health inequities are differences which are created and sustained by unjust social arrangements; in turn resulting in an unequal distribution of the resources essential for good health (Whitehead & Dahlgren, 2006). WHO (2013) on the "Handbook on Health Inequality monitoring with a focus on low and middle-income countries" states health inequity as a normative concept that is non-measurable but can be monitored through health inequalities observed among varied subgroups within a population (World Health Organisation, 2013).

The equity ensues that with the pursuance of equality – that is, eliminating health inequalities is strongly associated with social disadvantage. The strive can be assumed as equal opportunities for all social groups to be as healthy as possible, with selective focus on improving conditions for those groups who have had fewer opportunities (Asada et al., 2014; Braveman, 2006; Camarero & Oliva, 2019; Scott, 2003).

2.1.2 Theoretical Approaches to Health Equity

This section maps fundamental theoretical approaches underlying health equity from utilitarianism to Rawls' theory of justice to the contemporary slants. Equity in healthcare is associated with social values and ethical principles. The idea of equity can be traced back extensively to traditional approaches of bioethics and public health ethics. Engels and Rudolph Virchow documented the health inequity by representing health outcomes among the working class and the poor living in the rural areas and traced these differentials to their living and working condition (Gaitonde, 2018). Ruger (2009) has categorized the traditional approaches

of bioethics and public health broadly into five approaches: welfare economics and utilitarian schemes, libertarian theories, communitarian approaches, and egalitarian theories. Welfare economics and utilitarianism focus on the cost-effectiveness, cost-utility, or cost-benefit analyses to aggregate costs and benefits which maximizes overall social welfare. The utilitarian framework requires allocation of resources that maximize social utility (Furler & Palmer, 2010; Ruger, 2016). The assumptions of utilitarianism serve as a standard framework for health policy analysis. The assumption of utilitarianism is that of overall utility maximization. Cost-benefit analysis is central to evaluate health policy, where health status is valued in terms of health preferences, desires, and utilities. Health and policy utilitarian principles pose issues about aggregating wellbeing without taking into account the distribution of advantages and costs in society (Marseille & Kahn, 2019). The cost-benefit analysis significantly overlooks the determinants which cause inequalities. Attempts have been made, however, to include a distributional ethics within the utilitarian method (Nord, Pinto, Richardson, Menzel, & Ubel, 1999). Attempts to aggregate across persons under Kantian and Libertarian principles violate the concept that each individual is an end in himself/herself and cannot be utilized instrumentally to benefit other individuals (Ruger, 2009b).

The proponents of the communitarian approach argue that healthcare provision is an expression of community values, therefore, the justification for healthcare varies by the community (Dutta, 2017; Gasper, 1997; Ruger, 2010). Ezekiel Emanuel offered a communitarian approach that integrates libertarianism, arguing that deliberative and democratic societies might establish common ideas of justice and the good life (Brody, 1993). The ideal form of communitarianism and libertarianism incorporated together rejects the utilitarianism framework (Dionigi & Kleidosty, 2017), and analyses medical ethics by engaging in cost-benefit, cost-utility, and cost-effectiveness techniques to measure the health.

The theories of egalitarian advances equal distribution of certain societal goods. According to John Rawls' theory of justice, justice necessitates the equitable distribution of fundamental commodities (Ruger, 2004). 'Assume that the basic organization of society distributes certain primary goods—those that every reasonable man is supposed to seek,' Rawls suggests. (Rawls, 1971). Rational agents behind a 'veil of ignorance' (Rawls, 1971) about their circumstances would choose principles of justice that maximizes the minimum level of primary goods, 'this ensures that no one is advantaged or disadvantaged in the choice of principles by the outcome of natural chance or the contingency of social circumstances' (Rawls, 1971). Scholars such as Norman Daniels argue that health is a human right by Rawls's theory of justice because it provides equality of opportunity (Daniels, 1985, 2008). Cohen and his colleagues argue that individuals' health is dependent on social conditions (Cohen, Underwood, & Gottlieb, 2000). However, few scholars argue that minimizing the socio-economic inequalities does not necessarily reduce the gap in health. Marmot claims that flattening social hierarchies may not reduce health inequalities (Marmot & Bobak, 2000). Scholars, for example, Ronald Green has interpreted the Rawlsian theory to healthcare in a different way from the equal opportunity approach. Green proposed an income-adjusted price system that enables consumers to establish their priorities for healthcare (Green, 2001). Sen (1992) however, has criticized the Rawlsian approach – that focuses on the means (resources) rather than ends and fails specifically to add human diversity (Sen, 1992). Ruger (2009), on similar lines, argues for addressing societal failures in ensuring the conditions for individuals' health capability (Ruger, 2009b).

On the other hand, proponents of libertarian argue market-based approach as the ideal way to distribute healthcare. The libertarian approach does not consider health as a right. Libertarian theorists such as Nozick (1974) and Lomasky (1987) argued that a pure market-based approach would allow the more affluent and those with strong preferences for certain goods and services to obtain more and better health care, regardless of need or competence (Lomasky, 1987;

Nozick, 1974). The libertarian view does not consider society to have political obligations to provide health resources to its citizens (Ruger, 2009b). This form of market-based health care system is firmly rejected in many countries across the globe, and health largely remains a state subject. However, the healthcare system in many of the developed nations is privatized, with few regulations.

2.2 Health Capability Paradigm

Ruger (2009), in her work, *Health and Social Justice*, criticized the existing framework and highlighted the setbacks of existing theories. Ruger argues from an Aristotelian and capability perspective, which states that health capabilities should be the central focal variable for assessing the justness and efficiency of health policy. Ruger contends that the Aristotelian and capability approaches offer the foundation for the moral relevance of health capacities as the key focus variable for evaluating equality and efficiency in health policy. In every way, giving more attention to enhance people's capability to avoid premature mortality and morbidity should be the prime concern of the health policy morally. Ruger's work also draws attention on social choice theory. Incomplete theorized agreements (ITA) are proposed as an approach to collective decision making in public policy and human rights, concretizing towards health and healthcare decision making, integrating the agreement with the capability approach to operationalizing the capability views. Health capability is a multipronged concept, and people view it from a varied perspective. Therefore, one unique perspective cannot be considered for the evaluation of the capability approach.

Ruger views the health capability paradigm from the Aristotelian perspective of social justice and Sen's capability approach. Human flourishing, according to Aristotle, is the goal of all social and political endeavor. According to Martha Nussbaum, the political aim is the ability to perform properly if one so desires (Nussbaum, 1992). Nussbaum's view functioning should be bought forward by the government, as an indicator to see how the people are doing.

Nussbaum supports for the recognition of people's ability for practical reason and choice—once these capacities are proven, people must be permitted to make their own judgments (Nussbaum & Sen, 1993). The Aristotelian theory views health from the distribution of sufficient goods, services, and conditions to achieve human functioning while allowing the individual to choose the desired life. It is the responsibility of the state or establishment to provide resources and circumstances for proper nourishment, meanwhile respecting the individual's value (Nussbaum, 1992).

In the Aristotelian view resources like healthcare, wealth, and income are merely a means to an end, having instrumental value. These resources may not have incremental value unless they act for an individual's ability to function should be the primary goal of public policy. Aristotle emphasized on 'human flourishing' (Gasper, 1997; Nussbaum, 1992), and calls for 'substantial account if the human good and what it is to function humanly'. The proportionate fairness concept of Aristotle governs the distribution of limited resources to create thriving lives. In health, proportional justice is used to allocate resources to those in greater need in order to bring them as close to a specific level of health functioning as their circumstances allow (Ruger, 2004, 2009b, 2010, 2016).

Ruger's health capability approach is rooted in the idea of the 'capability approach' of Amartya Sen, which is closely linked to the Aristotelian idea of social and political ethics (Sen, 1985, 2002). Sen's capability approach puts forward the idea of freedom of the individual, with choice and opportunities to live a life they choose. Sen asserts that the capability to function consists of an individual's well-being and the freedom to pursue well-being. Functioning is an individual's achievements and includes what they can do be their activities or the state of being. Capability is a person's freedom to achieve functioning that they value.

Capability constitutes the person's freedom to achieve well-being, where a good society aspires to freedom. On the other hand, well-being depends on the capability to function according to Sen's approach. The opportunity to exercise freedom can itself be valuable (Sen, 1992). The capability of an individual is expressed through a set consisting of vectors of functioning. A meaningful existence of an individual rests on multitude factors associating with freedom. A person's capability is substantive freedom to achieve alternative functioning combinations (Sen, 1985). The approach is directly related with the potentialities and the possibilities, both. In this regard Sen's capability approach can be either the realized functioning "what a person actually can do," or the real opportunities (Sen, 1999). Both Aristotelian and capability approach conception of the choice of the people is based on the individuals' conception of the good.

Another significant component of the capability approach is human heterogeneity (Sen, 1992). The idea of human heterogeneity is an indispensable element for measuring equality. Sen asserts that internal characteristics such as age, gender, mental attitude, etc. and external characteristics such as social status, social norms, income, wealth, and geographical locations etc. are essential for measuring equality as equality requires society to aid those people in proportion to their degree of disadvantage.

Freedom is an important component of the capability approach, and it consists of two components: opportunity and process. The opportunity component evaluates public policy in terms of how it affects people' substantive liberties. Process freedom involves the ability to choose freely embodying 'autonomy of decisions' (Sen, 2002). Freedom is categorized as control freedom and effective freedom. Control freedom refers to freedom when it is all brought about by the individual who experiences them. The effective freedom, on the other hand, refers to the realization of individual freedoms and are brought about or generated by another person or external entity (Ruger, 2009b).

The capability approach broadly helps to evaluate public policy and individuals' well-being, nevertheless, the capability approach is underspecified - as a theory of social justice (Pogge, 2002). Critics assert this approach to be minimalistic, with the least guidance on prioritizing different capabilities and functioning. Ruger's health capability paradigm attempts to bring health and social justice concepts together with the Aristotelian view and capability approach of Sen.

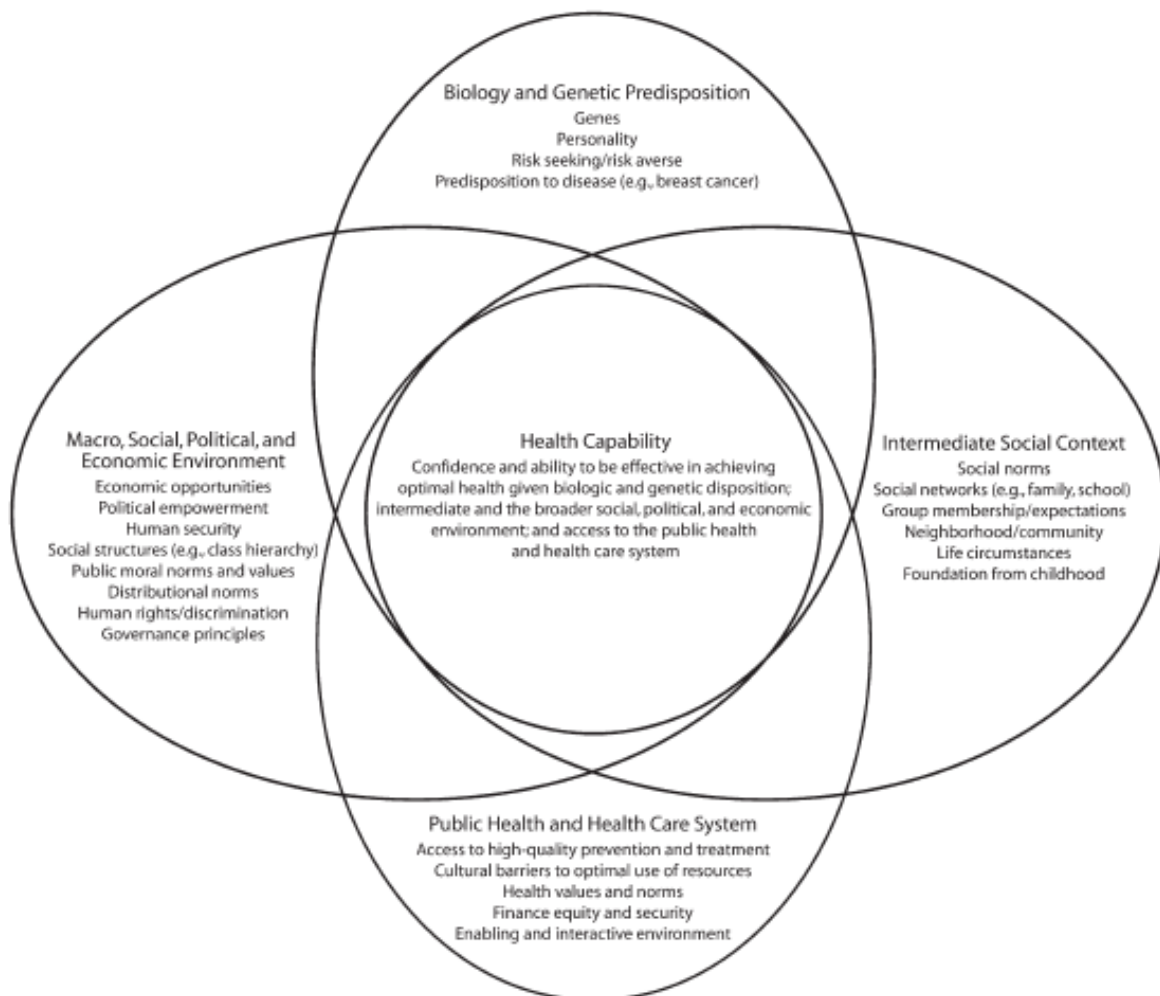
The heterogeneity component in the capability approach is an essential measure for assessing equality. Heterogeneity is significant, because it validates positive freedoms for all, as well as the community duty to equip individuals with the many resources they require to improve their capability to operate. This contradicts the Rawlsian's idea of primary goods. The concept of heterogeneity is essential for health policy as it provides and treats every individual differently. Furthermore, it considers disparities in judging inequality in health capability for social justice. Rawls's theory of social justice, on the contrary, asserts that there will be significant inequalities created in health even if the income and wealth are maximized for the most deprived section (Rawls, 1971). The 'health capability approach' advanced by Jennifer P. Ruger, "enables us to understand the conditions that facilitate and barriers that impede health and ability to make healthy choices. It offers an accurate evaluation of the aim and success of social policies and change" (Ruger, 2009b).

Conceptually health capability consists of health functioning and health agency. A health agency is defined as individuals' ability to achieve health goals they value and act as agents of their health. On the other hand, health functioning is an outcome of the action to improve or maintain a healthy life. Improving and maintaining health life refers to well-being or quality of life, which comprises physical and mental health. Health capability is a delicate balance between the paternalism and autonomy of the individual. Paternalism is the practice of a person or the state interfering with another individual's decision on the grounds that the individual or

population would be better off or protected from harm. Autonomy, on the other hand, refers to the ability to live one's life according to one's own reasons and goals. Ruger explains how health capability allows for the assessment of a broader range of injustices, including attributes and conditions affecting individuals' freedoms, such as self-management, decision-making ability, skills, knowledge and competence, and social norms and relations, as well as structures within which resource distribution occurs.(Ruger, 2010, 2016).

Ruger's conceptual model acknowledged the importance of human motivation as well as a variety of internal and environmental elements that influence an individual's health capabilities.

Figure 4: Conceptual Framework for Health Capability Approach (Ruger, 2009a)



Under a health capabilities paradigm, the conceptual model describes the foundation for intervention design and policy formation. The conceptual framework provides a method for countries and governmental agencies to enhance health policies and public health practices, increasing population capabilities and ensuring equitable and effective health systems. Ruger's approach to health capability could help the policymakers to assess individuals' societal needs and address the Social Determinants of Health (SDH) (CSDH, 2008).

2.3 Measuring Health Equity

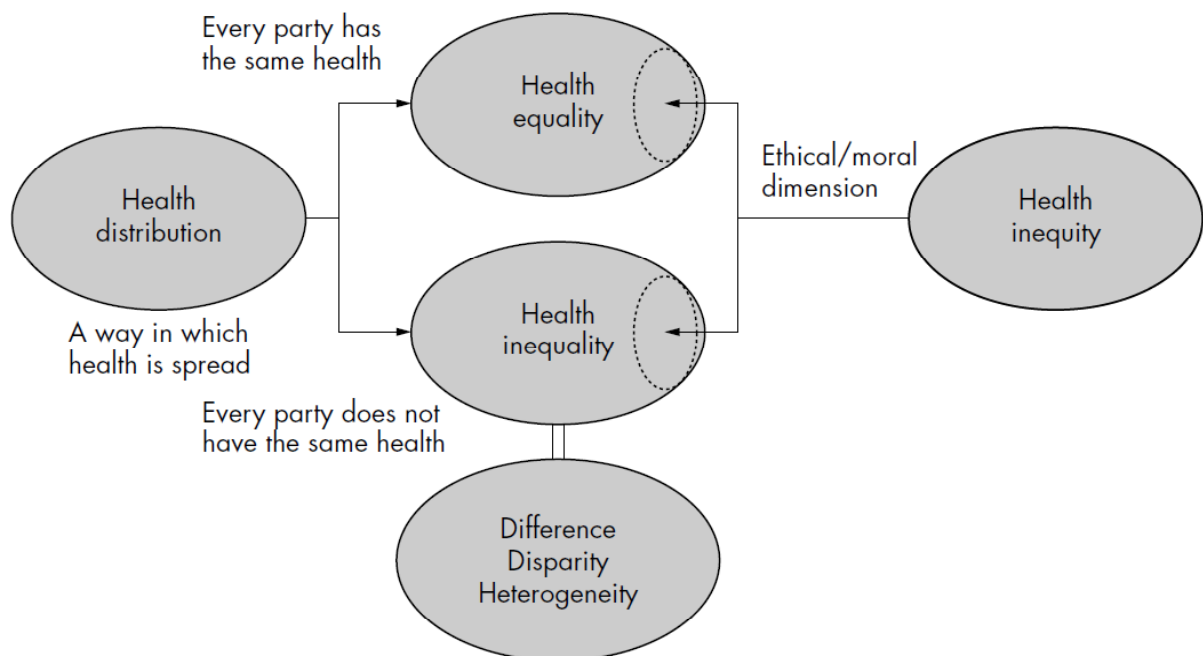
The conceptual understanding of equity in healthcare was extensively discussed. This section will broadly discuss various techniques and measures of equity in health. As discussed earlier, Whitehead, in her work, stated that inequalities in health that are avoidable and health inequities are unfair, this part of the study will specifically explain three measures that are widely used by researchers and scholars across the globe.

Wagstaff et al. (1991) provided a critical review of various inequality and inequity measures that have emerged out in literature in the last few decades (Wagstaff et al., 1991). In his work, he had reviewed six measures and argued that only two out of the six measures are suitable for measuring health inequalities. The six measures of inequality that have been used are: (1) the range (2) the Gini coefficient and Lorenz curve (3) Pseudo-Gini coefficient and pseudo-Lorenz curve (4) the index of dissimilarities (5) the slope and relative index of inequalities (6) concentration index and concentration curve. According to the study, the slope index of inequality and the concentration index meet the requirements for evaluating health inequities. Both measures represent the socioeconomic dimension of health disparities that reflect the experiences of the whole population and are sensitive to changes in population distribution across various socioeconomic categories (Owen O'Donnell, Eddy van Doorslaer, Adam Wagstaff, 2008; Wagstaff et al., 1991).

Yukiko Asada (2005) developed a three-step methodology for evaluating health inequity in his work:

- a) Identifying the point at which a health distribution becomes inequitable.
- b) Choosing measuring techniques to operationalize a chosen equity notion.
- c) Information on health inequity quantification (Asada, 2005)

Figure 5: Health Inequity Framework (Asada, 2005)



Step 1 includes definitions and variety of perspectives on health equity. The definition of inequity views that whether the factors causing inequality are beyond individual control. Measurement strategies changes with the determinants of health as well as the reason for the selection of determinants. Once the operationalization of health equity is completed, deciding the measurement strategies is step 2, which includes the aspect of health and approach undertaken to measure the aspect. The approach to measure health equity is of three types: Whole life approach, Life stage approach, and Cross-sectional approach, in these types of the unit of analysis can be an individual, group, or joint approach. Once the process of deciding

the measurement strategies is done, the final step engages in quantifying health inequity information, and by comparison, identifying the differences, aggregating, and other subgroup consideration.

On the other hand, Fleurbaey and Schokkaert (2011) proposed a two-step process in evaluating inequity in health and healthcare: Defining the factors that explain the observed inequality in health and healthcare, and secondly taking a normative position on whether differences due to each of these factors can be ethically justifiable (Fleurbaey & Schokkaert, 2011). Fleurbaey and Schokkaert primarily focused on inequity caused by the socio-economic conditions of individuals or households. The concentration index and concentration curve were primarily used to measure the inequities (Donnell et al., 2008). The index and curve can be applied to any socio-economic and demographic variables, which is ranked accordingly, from lowest to highest. However, the concentration curve and index have their limitation and primarily debated over the accuracy.

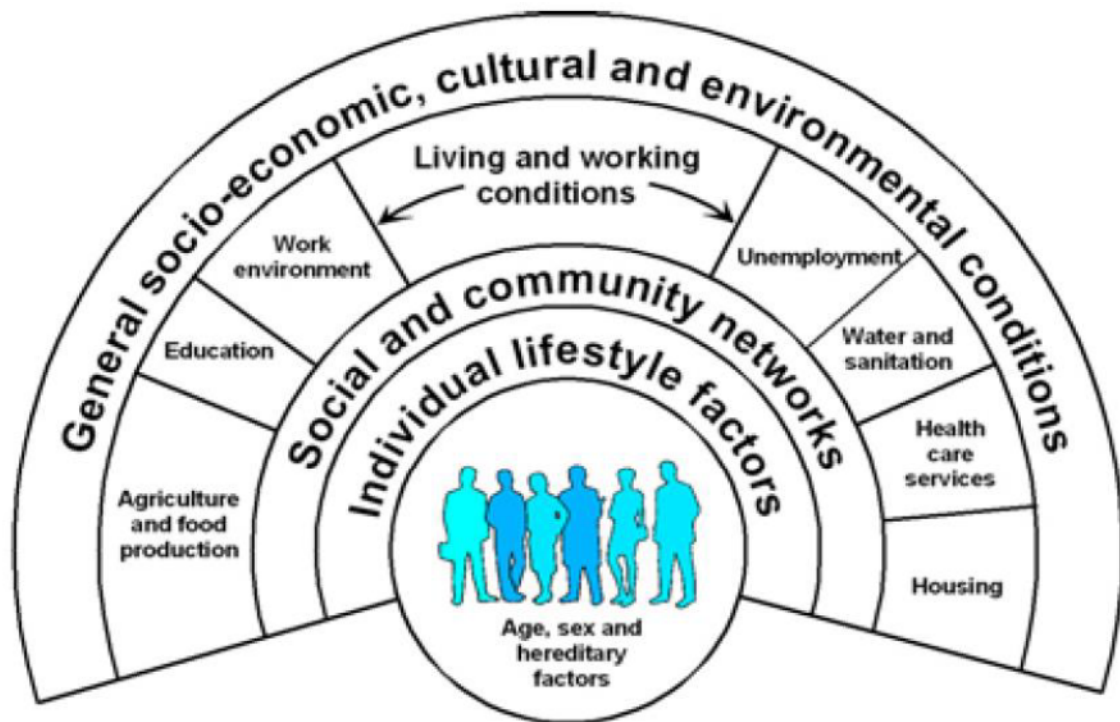
Asada et al. (2014) presented a three-stage strategy to defining health inequity that is explicit and transparent. Univariate health inequality, univariate health inequality, and bivariate health inequalities are the three phases' measurements. The distribution of health among people in a population is measured using univariate health inequality, regardless of any relationship with other characteristics. Univariate health inequality also assesses the distribution of unfair health and health components linked with ethically unacceptable circumstances throughout the population. Bivariate health inequities, on the other hand, describe how much of the total amount of unfair health is independently associated with each ethical and policy-relevant attribute of interest (Asada et al., 2014). The three-stage approach integrates a more systematic manner of assessing bivariate inequities. The three-staged technique documents the bivariate inequalities by decomposing the univariate inequality by characteristics. The regression-based decomposition calculates the independent impact of each univariate inequality characteristic.

With the increase in the rise of health equity research from several paradigms, different methods of calculating health inequity are evident. The slope and relative index, concentration index and curve largely remain common in all equity research. At the same time, not necessarily, the measurement of inequality leads to different conclusions. Irrespective of any method, a close approximation of inequality or inequity can be calculated among any given population. Critics argue that inappropriate method has the potential for misleading results.

2.3.1 Social Determinants of Health

Unequal distribution of healthcare and high burden of diseases over a particular group of people necessitates the conceptualization of Social Determinants of Health (SDH). The SDH is responsible for the prevalence of diseases and increase in morbidity and mortality rate amongst a particular section of the population, at the same time does not provide the freedom to choose the lives they value to live (Marmot et al., 2008; Nussbaum & Sen, 1993; Sen, 1992, 1999). The three principles of action to achieve health equity prescribed by Commission on SDH are: “improving the conditions of daily life – the circumstances in which people are born, grow, live, work, and age, tackling the inequitable distribution of power, money, and resources, and measure the problem, evaluate action, expand the knowledge base, develop workforce trained in SDH and raise public awareness” (CSDH, 2008; Friel & Marmot, 2011).

Figure 6 Layers of Social Determinants of Health (Friel & Marmot, 2011)

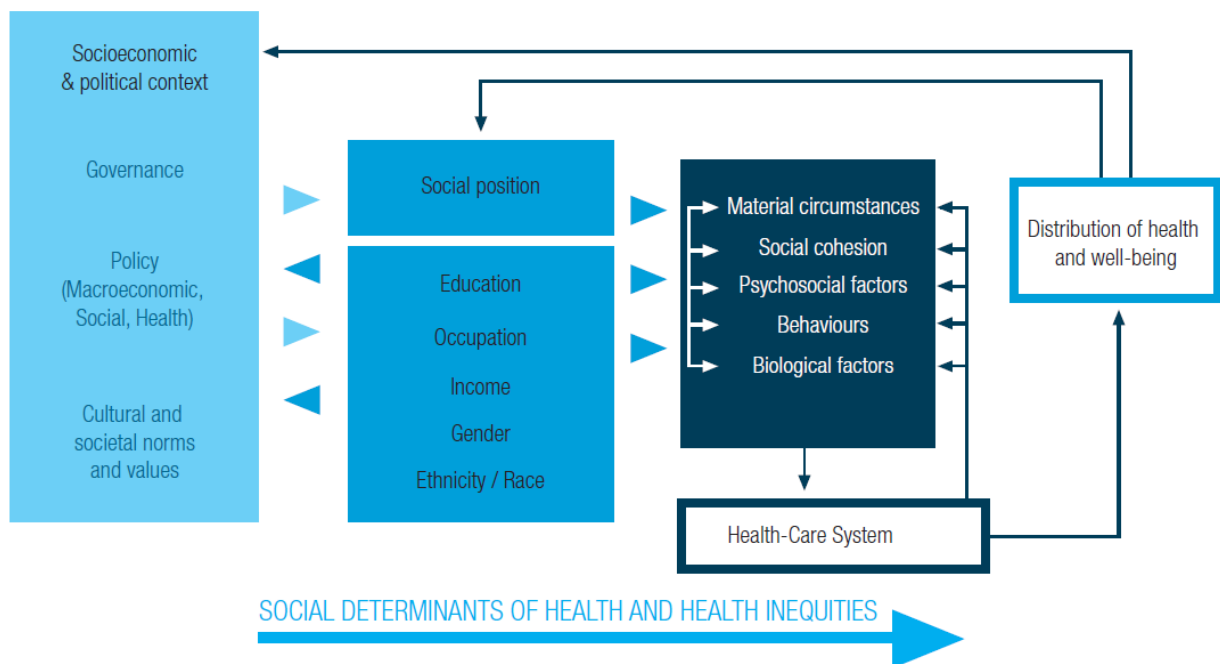


The figure above presents two layers of SDHs. The first layer consists of individual factors responsible for individuals' health, such as age, gender, and hereditary factors. Meanwhile, the second layer consists of socio-economic, cultural, environmental, and political conditions that shape individuals' health. Agriculture and food production, education, working conditions and environment, living condition, employment and occupation, water and sanitation, housing condition, and healthcare services constitute the third layer. These SDHs have a direct impact on health, which predicts a considerable proportion of health outcome variance. Moreover, SDHs are responsible for individuals' lifestyle and health behavior (CSDH, 2008).

The Commission constituted to address health equity through social acting on the SDHs draws upon a conceptual framework that intervention can be aimed at acting on circumstances of daily life and other structural drivers. “Daily life circumstances refer to differential exposure to disease-causing influences in early life, social and physical environments, and work, which are associated with social stratification. Depending on the nature of these influences, different

groups will have different experiences of material conditions, psychosocial support, and behavioral options, which make them more or less miserable health” (CSDH, 2008). The form and degree of social stratification in society—the amount of disparity along the categories outlined—biases, norms, values within society, national economic and social policies, and governance processes are among the structural causes (CSDH, 2008).

Figure 7 Framework for Social Determinants of Health (CSDH, 2008)



The commission's report contains extensive documentation on the impact of SDH on individual well-being. At the same time, the Commission issued three broad recommendations: improving everyday living circumstances, addressing inequitable power, money, and resource distribution, measuring and comprehending the problem, and assessing the effect of the action.

2.3.2 Determinants of Health Inequities

Social Determinants of Health (SDH) have been majorly responsible for the individuals' health outcome gap. In parallel, the widening of health outcomes can be tackled by enhancing three determinants: availability, accessibility, and utilization of healthcare services. These three

determinants play a critical role in improving the quality of healthcare services, which leads to increase in the utilization of services (Acharya, 2018; Camarero & Oliva, 2019; Haggerty et al., 2014; J. K. Sharma & Narang, 2011a). Researchers also claim that the variations in health outcomes result from differences in availability, accessibility, affordability, quality, and utilization of healthcare services (Balarajan et al., 2011; Baru et al., 2010; Baru, 2005; Chaudhuri, 2012a; Sen, 2002). Furthermore, academics in the Indian context have argued that discrepancies in healthcare service delivery quality and inequalities in health service availability, accessibility, use, and cost impact overall health disparities across regions, states, and population groups (Minnery et al., 2013; Shadmi et al., 2014).

2.4 Availability of Services

This section will highlight the determinants of health outcomes, which results in inequities in healthcare. This study takes into consideration the most important determinants of health inequities, i.e., accessibility of services. Studies have proven that the three basic principles to achieve equity is to provide equal access of health care for those in equal need of healthcare, equal utilization of health care for those in equal need of health care, and equal or somewhat equitable health outcomes (Allin et al., 2007).

Equal access for health need requires conditions of equal opportunity to access health for those in equal need of care. The availability of services is required for equal opportunities to access health for those in equal need of health care (Allin et al., 2007). The differences in the availability of healthcare services varies across geographical locations and is predominantly evident in all studies conducted in India and abroad. The availability of healthcare services comprise of infrastructure, human resources, medical supplies, bed-population ratios, and spatial distribution of health institutions (Baru et al., 2010). In the Indian context, despite the increase in the privatization of healthcare services, the concentration of the healthcare services largely remain in a particular geographical location.

WHO (2010) forwarded a health system framework described into six components: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership and governance. These six components largely contribute to improved health, responsiveness, social and financial risk protection, and improve efficiency by ensuring access to coverage and quality of services (WHO, 2010). Ensuring the availability of healthcare services with minimum quality standards and securing access is key to the health system's functioning.

The availability of health care services is usually referred to the number and distribution of health facilities, inpatient beds per 10,000, and the number of outpatient department visits per 10,000 per year (WHO, 2010). The availability of healthcare service is the ratio of health workforce per 10,000 population (Rao et al., 2011). The distribution of services implies equal allotment of services across the urban-rural condition and the private-public system. An indicator of the availability of health care services is service readiness (WHO, 2010) that refers to the increasing availability of components required to provide services. It comprises of items such as medical amenities and supplies, necessary equipment, medical kit for preventive and curative measures, laboratory, and medicines. Other than the necessary curative and preventive measures in the healthcare system, service-specific availability is the key to the smooth functioning of the health system. Specific service comprises of family planning, antenatal and postnatal care, safe delivery, child healthcare, measures to tackle communicable and non-communicable diseases. To conclude, the availability of services is the physical presence of delivery of services and encompasses health infrastructure, core health personnel, and aspects of service utilization (WHO, 2013).

2.5 Accessibility of Services

Access to healthcare refers to the degree of fit between the clients and the system (Penchansky & Thomas, 1981). WHO has referred to three dimensions of accessibility: physical

accessibility, financial affordability, and acceptability (Evans et al., 2013). Physical accessibility is defined as the availability of quality healthcare services within reasonable reach to those who need them. In the Indian context, studies have identified that there is an asymmetrical balance between urban and rural (Barik & Thorat, 2015). The population in the urban areas has a choice between public and private care, while the choice narrows down in the rural areas. Besides, opening hours, appointment systems, and other aspects of service organization and delivery allows people to use the components of physical accessibility whenever necessary.

On the other hand, the determinants of financial affordability can be assessed on the people's ability to pay for healthcare services without any financial hardship (Balarajan et al., 2011; Baru et al., 2010; Binnendijk et al., 2012; Evans et al., 2013; Rodney & Hill, 2014). The affordability takes into consideration both the price of the healthcare services and out of pocket expenditure (Balarajan et al., 2011; Chaudhuri, 2012b; Fielding, 1999) of individuals while accessing the services. The out-of-pocket expenditure takes into account the cost of transportation and the cost of the time as well. Besides, acceptability, as a determinant of health accessibility, captures people's willingness to seek services. The barriers in acceptability for the services can arise from individuals' perception of healthcare services to be ineffective, in addition to social and cultural factors.

An essential requirement for a service to be accessible is that the service should be available, with good quality and close to the people. Further, adding to the essential requirement, service readiness is an essential component for any health service to be accessible. Meanwhile, healthcare insurance, reduced direct and indirect, out-of-pocket expenditure, direct benefit transfer to individuals' accounts will help improve the financial affordability of healthcare services. The social, cultural, economic determinants influencing accessibility can be addressed by improving the Social Determinants of Health. The acceptability will ameliorate

only with the individuals' improvement in socio-economic determinants (Albrecht et al., 2012; Kim et al., 2020; Sharma et al., 2020; Smedley, 2006).

2.6 Utilization of Services

Studies have categorized the utilization of health care into preventive and curative services (Baru et al., 2010; McCollum et al., 2016; Shadmi et al., 2014; Weinhold & Gurtner, 2014; Whitehead, 1992). Services such as vaccination and immunization program (Kim-Farley et al., 1993; A. K. Sharma et al., 2020), antenatal care and postnatal care (Mwase et al., 2018), are some of the critical indicators for utilization of healthcare services. On the contrary, the indicators of the utilization of curative services are inpatient and outpatient public services. Studies have also highlighted that utilization is limited not only to preventive and curative services but also to promote services or obtain information for individuals' well-being.

The utilization of services can vary with socio-economic and demographic characteristics. Of all the factors that drive utilization, the patient who has a perceived need for healthcare is probably the single most important independent factor (Carrasquillo, 2013). Besides, many factors influence utilization, such as predisposition, enabling, and need factors.

2.7 Healthcare Providers for Health Equity

This section broadly covers the healthcare workforce working within the paradigm of providing services towards community health. The health workforce, particularly in rural areas, is the direct point of contact in any healthcare needs. In the vast majority of the cases, the healthcare workforce remains under-utilized in tackling the community issues, particularly in the Social Determinants of Health (SDH) (UCL Institute of Health Equity, 2013). Several studies have advanced four core roles of healthcare professionals to achieve health equity through workforce education and training (Ratcliffe & Patterson, 2020; UCL Institute of Health Equity, 2013), work with individuals and communities (Lehmann et al., 2019; Rifkin, 2003; Schneider &

Lehmann, 2016), work in partnership (Bromley et al., 2018; Gracia & Ruffin, 2014; Teitelbaum et al., 2019), and workforce as advocates (Luft, 2017; UCL Institute of Health Equity, 2013).

Imparting education on health equity and SDHs will have a favorable implication for the workforce to tackle the health gap (Thomas, 2016). UCL Institute of Health Equity has recommended two crucial actions in the area of training and educating health professionals for health equity: educating on the nature of SDHs and actions to be undertaken by the health workforce. The Institute of Health Equity also recommended the component that should be included in the education is the graded distribution of health outcomes. It is also critical for the health professionals to understand the effect of socio-economic and demographic factors on health outcomes and the practical implications the healthcare providers can undertake to close the gap in the health disparities (Browne et al., 2012; Jaskiewicz & Tulenko, 2012). Non-health skills such as communication, partnership, and advocacy should be included in the medical curriculum, enhancing the health workforce's capability to undertake activities more effectively (Greiner & Kaldjian, 2018; Shah et al., 2017; Shapiro et al., 2015). Besides, non-medical activities like social history and making patient referrals to external support services were prescribed in effective practice (Albrecht et al., 2012).

Access to the medical profession by minorities, individuals from poorer socioeconomic categories, and those from multidimensionally weaker sections has also been highlighted in studies (Thomas, 2016). Scholars assert that improving access to the medical profession can impact on the SDH in numerous ways (UCL IoHE, 2013). There has been a positive impact on health, and quality of life, that directly have the potential to improve health and reduce the social gradient (Smedley, 2006; Smedley et al., 2001).

Apart from ensuring access to medical education to the marginalized, the Royal College of Physicians of London also recommended training on the SDH during the undergraduate and

postgraduate degree courses (Thomas, 2016). Education-based on community specialties, particularly the community pediatrics and public health, should be considered in the training curriculum (Chervenak et al., 2018; Namazzi et al., 2017). It is critical to incorporate experiential training and internships with community groups, charities, and social care networks into the educational curriculum, allowing students to acquire a feeling of social responsibility (Faulkner & McCurdy, 2000). Therefore, the education curriculum should be so designed to evoke a sense of social responsibility for the health workforce right from the classroom. The classroom integration with the SDH curriculum is more likely to develop interest, which will help to mobilize students to take action on SDH.

The second core role of the healthcare workforce is working with individuals and communities by building a relationship of trust and respect (Greiner & Kaldjian, 2018; Klest & Philippon, 2016; Smailhodzic et al., 2016), gathering medical information (Flach et al., 2017), and providing necessary information to patients' diagnosis process (Kümpel et al., 2015; Rüter & Fröhlich, 2019; Shah et al., 2017). It becomes crucial for every individual health care professionals to interact with patients, in order to better understand the dynamics of socio-economic conditions on the outcome of their health.

Existing studies on relationships with patients focus on understanding the patients' health needs and building trust and respect for health care professionals (Rajkumari & Nula, 2017). Healthcare professionals, along with community health workers visiting households, develop a sense of belongingness, which further helps in gaining the trust of the patients (H. Perry & Zulliger, 2012). Further, this adds to the healthcare professionals responding to the child's health needs, families, and communities, at large to achieve better health outcomes and reduce health inequalities (UCL IoHE, 2013). There has been evidence that regular interaction with patients can positively impact and empower patients for better health (Barlow et al., 2010). Effective communication with the local communities stands to be a powerful tool to tackle

SDH through cooperation and facilitating communities with healthcare resources. Studies suggest the need to shift from vertical disease-oriented ‘programs’ towards ‘horizontal community oriented’ approach, for tackling SDH and building social cohesion (Dean et al., 2013). In a nutshell, building relationship at individual and community level help the health workforce to improve their quality of service, tailoring to the needs of the community, thereby enhancing equity in health outcome.

Working in partnership is essential to take adequate measures and actions on SDH and reduce inequalities in health outcomes (UCL Institute of Health Equity, 2013). Healthcare providers working in close collaboration with the stakeholders of the healthcare system can impact the health outcome of communities at large. The Institute of Health Equity recommended partnerships within the health sector, with external bodies, and Clinical Commissioning Groups. Studies show that to achieve health equity, it is crucial to establish a partnership between the health workforce and professionals from other non-clinical sectors as well as civil society (Gracia & Ruffin, 2014; Israel et al., 2010). Partnerships within the health system, as well as with the community, can improve the delivery of clinical care and assist professionals in understanding and tackling the wider SDHs(UCL Institute of Health Equity, 2013). Multi-disciplinary teamwork and integrated care pathways are increasingly being promoted as an effective strategy for improving patient care (Poulton & West, 1993).

The role of the healthcare workforce, particularly the physician, as an advocate has been stated in professional charters and standards around the world (Blank, 2002). Advocacy in healthcare is generally debated over an increase in access to services and medicines; however, broadly the context of advocacy in the healthcare system is practical to reduce health inequity and improve health (Thomas, 2016). Institute of Health Equity has made few recommendations on the practice of healthcare providers as advocates for individual patients and their families, for changes to local policies, for changes to the health profession, and change in social policy

change (Canadian Medical Association, 2013; Luft, 2017; UCL Institute of Health Equity, 2013).

Advocacy is linked to community-based participatory research (CBPR) by engaging community members in public health advocacy to affect structural change in communities aimed at eliminating them (Israel et al., 2010). Earnest et al., (2010) explained a physician's advocacy to promote social, economic, educational, and political reforms that alleviate suffering and risks to human health and well-being identified via his or her professional work and knowledge (Earnest et al., 2010). Health care professionals work closely with a wide range of people that helps them to understand the patients' social and economic complexities affecting their health. In order to mitigate the economic and financial hardship of the communities the physician is posted, it can advocate for unemployed people to find work and mitigate the ill health effects of unemployment (Earnest et al., 2010).

2.8 Ethical principles for advancing Health Equity

The paradigm of public health ethics is made up of moral considerations, values, principles, or norms that are important to the field of public health. To give tangible moral direction, ethics in public health care is a continuous endeavour to identify and assign weights to broad moral concerns in the context of specific policies, practises, and acts (Childress et al., 2002). Producing benefits; avoiding, preventing, and removing harms; producing a maximum balance of benefits over harms and other costs; distributing benefits and burdens fairly and ensuring public participation, including the participation of affected parties; respecting free choices and actions, including liberty of action; preserving privacy and secrecy, honouring agreements and obligations; revealing information and speaking honestly and accurately; and establishing and sustaining trust. It is a complex phenomenon between the general consideration and practice of public health. The general moral consideration has two moral dimensions: the first dimension

provides a concrete guidance in public health ethics, and the second dimension determines when different considerations yield to others in cases of conflict (Childress et al., 2002).

The general moral considerations are particularly relevant to understand the complexities of the socially patterned nature of illness and the community's diseases. The social inequality and social gradient largely influence clinical practice; however, they lack inadequate ethical guidance to tackle the issue (Furler & Palmer, 2010). Health care professionals in primary health care services, primarily in the rural healthcare system, have a special place in the community. They are closely associated with the social and economic reality of the community members. An ethical paradigm is interested in the doctor-patient interaction. This ethical paradigm addresses the significant variations in values stated by various groups regarding societal health inequalities and professional accountability (Furler & Palmer, 2010). The healthcare provider who is advancing the goals of health equity is linked to their demographic indicators. The relationship between the doctor-patient can change with the gender of the physician. Gilligan argues in terms of moral orientation-how women reason through moral quandaries using an ethic of caring, whereas males reason on justice and rights (Gilligan, 1993). In particular, the orientation of justice and care appeal to impartial principles (Azétsop & Rennie, 2010). By pointing to the rights of equality and non-interference, justice highlights the need of deliberating from a dispassionate perspective while dealing with moral concerns (Furler & Palmer, 2010). Moral inclinations do not always translate into moral conceptions of behaviour. Little(1989) contends that orientations are best understood as gestalts that influence perceptions of self and others and are active in the same way as subtleties, preferences, and attitudes impact day-to-day behaviour (Little, 1998).

The four pillars of medical ethics: autonomy, beneficence, non-maleficence, and justice, are underpinned with the justice and care orientation of health care professionals to advance health equity. The four pillars of medical ethics relate closely with the care and justice orientation,

where the idea of justice prevails through upholding beneficence and non-maleficence. These can be accomplished through advocating for patients, mobilising resources, improving access to care, and empathising with patients' social and structural constraints. Furler and Palmer framed medical ethics within two moral orientations in their work: social justice and human rights, and care and compassion for the weak.

From the standpoint of social justice and human rights, beneficence is doing good and ensuring that every individual receives the healthcare they require. Opportunities for health accomplishment should not be restricted based on their socioeconomic status, which may entail reorienting services and ensuring that services are available, accessible, and suitable. Likewise, non-maleficence through the lens of social justice and human rights implies not harming paying attention to the social contextual factors that are at play in patients' illness presentation and experience. Autonomy, on the other hand, viewed through social justice and human rights lens involves helping individuals to overcome the social limits that frame the choices through full information to promote access to clinical care. Social justice and human rights conceptualized justice as a premise based on the notion of natural rights to equitable access to health care as an element of a free, dignified, and meaningful life (Furler & Palmer, 2010).

According to the care and compassionate approach, beneficence is defined as giving the best available clinical treatment to each individual in a compassionate, caring, and empathetic setting. Non-maleficence or hurting entails altering one's caregiving based on a person's social standing. Everyone should be treated equally. The care and compassion should understand autonomy as a result of the clinician's complete attention, support, and participation in a relational encounter. Justice is examined through the lens of care and compassion in order to ensure that practitioners see past a patient's social environment to the person within. Inequities must be addressed by physicians through caring for patients from all backgrounds (Furler & Palmer, 2010).

The pillars and aspects sum up to present that social determinants cannot be overlooked during the medical and clinical practice, as they have significant implications on the health outcome of every individual. The obligation and responsibility of the healthcare professionals should not be limited only to the diagnosis and treatment of illness, but also to engage with the inequities and social disadvantage of patients' lives. According to studies, the perspective and direction of normative ethical theories such as virtue ethics, deontology, and utilitarianism are frequently neglected in academic debate while advancing health equity through healthcare professionals.

2.9 Communication for Health Equity

This section presents how the media frames health inequalities into public discourse, and how media advocacy can advance health equity. Elucidating the concept of media frames and agenda-setting, this section focuses mainly on the role of media as public advocacy for health equity. The section also discusses the theoretical aspects of the role of mass media in advancing health equity.

Various academics have intervened to investigate the role of communication in decreasing, sustaining, and even increasing health disparity; nevertheless, the structuring of content and the effect of communication concerning health inequalities has received little attention. Inequalities in health can result from social determinants of health, and communication is an essential thread that connects some of these factors at different levels and that inequalities in communication could potentially contribute to health disparities (Viswanath & Emmons, 2006). The policy intervention to ameliorate health inequalities can only be achieved when it is in the public discourse. Therefore, social actors must perceive health inequalities as an essential social problem that requires attention by community leaders and policymakers (Wallington et al., 2010). Studies have shown that news coverage of health topics and relevant issues influences public agendas and encourage policy-level actions (Hornik & Yanovitzky,

2003; Yanovitzky & Stryker, 2001). News media plays a crucial role in the social control function (Demers & Viswanath, 1999), which influence the agenda of citizens, community leaders, and policymakers alike (Reese et al., 2001). The media's agenda-setting role further elucidates the role of media in influencing the opinion. The agenda-setting role is central to the framing of the media's content to set agenda in the public sphere (Viswanath & Emmons, 2006). The media's agenda-setting is through the selection of news frame that gives the viewers, readers, and listeners a selective interpretation providing casual narratives about problems and their solutions (Gollust et al., 2019; Reese et al., 2001).

2.9.1 Agenda-Setting

Bernard Cohen is generally credited with the theory of agenda-setting. Cohen (1963) refined the idea of Walter Lippman (1922) seminal work *Public Opinion*. Lippman argued that people do not deal directly with their environments as much as they respond to the “pictures in their heads” (Baran & Davis, 2010). According to Cohen(1963), the press is much more than a source of information and opinion. The basic concept of agenda-setting theory is that the media does not tell people 'what to think,' but rather 'what to think about.' In his notion regarding agenda-setting, Cohen took a mass-society approach.

Based on Cohen's work, McCombs and Shaw (1972) explained their interpretation of agenda-setting. "In choosing and displaying news, editors, newsroom staff, and broadcasters play an important role in shaping political reality. Readers learn not only about a given issue but how much importance to attach to that issue from the amount of information in a news story and its position, the mass media may well determine the important issues – media may set agenda of the campaign" (Mccombs & Shaw, 1972). McCombs argues that agenda setting operates at two levels: object level and attribute level. Current agenda-setting research broadly focuses on the object level that generally measures the influence of media coverage which led media to inform *what to think about*, but could tell *how to think about* (Baran & Davis, 2010). The attribute

level of agenda-setting is the framing process, which answers *how to think about* it. McCombs asserts that the explication of a more general theoretical structure describes frames and attributes that are important to the communication process (McCombs & Shaw, 1972). However, a scholar like Dietram Scheufele argued that agenda-setting and framing are quite different from each other because it involves activation of entire schemas, not merely prioritizing individual objects or attributes (Scheufele, 2000).

2.9.2 *Media Framing*

The theory of framing forwarded by Erving Goffman in his work "Frame Analysis," asserts that people interpret what is going on around their world through their initial framework. The initial framework was further categorized into two sections: natural and social. The natural frame views events naturally, quoting it as it is, not enforcing any other attribution. On the other hand, the social frame views events that are socially driven occurrences due to whims, goals, and manipulations of other social actors (Goffman, 1974). The underlying assumption from Goffman's work is that individuals are capable of users of the natural and social frameworks on their daily activities.

Entman(1993) states in his work that framing entails selection and salience. The choosing of some components of seen reality is referred to as framing. It emphasises them in a communication text in order to advocate a specific issue description, cause interpretation, moral judgement, and/or therapeutic prescription for the object presented (Entman, 1993). The Entman draws few insights from Gamson et al. (1992) that argue that frames diagnose, evaluate, and prescribe events (Gamson et al., 1992). However, Entman's perspectives on frames help to characterise issues – – determine what a causal agent is doing with what costs and benefits, usually measured in terms of shared cultural values, diagnose causes – identify the forces creating the problem; make moral judgments–evaluate causal agents and their

effects, and suggest remedies – offer and justify treatments for the problems and predict their likely effects (Entman, 1993).

Entman goes on to say that frames may be found in at least four places during the communication process: the communicator, the text, the receiver, and the culture. When determining what to say, communicators make conscious or unconscious framing judgements, which are influenced by frames that structure belief systems. The presence or absence of certain keywords, stock phrases, stereotyped pictures, sources of information, and sentences that offer thematically reinforcing clusters of facts or judgements constitute frames in the text. The frames that direct the receiver's thoughts and conclusions may or may not correspond to the frames in the text and the communicator's framing purpose. The culture is the stock of commonly invoked frames, which can be defined as the empirically demonstrable set of common frames exhibited in the discourse and thinking of most people in a social grouping (Entman, 1993).

The main concept of Chong and Druckman's framing is that a problem may be examined from a number of viewpoints and be interpreted as having consequences for different values or concerns. The process through which people establish a certain understanding of an issue or redirect their thinking about an issue is referred to as framing (Chong & Druckman, 2007). The framing can be expounded in a positive and negative connotation. Understanding framing from the public opinion framework usually takes a negative connotation because framing effects suggest that the distribution of public preferences is arbitrary and that political elites can manipulate popular preferences to serve their interests (Chong & Druckman, 2007).

Media plays a crucial role in framing public health debates and shaping public perceptions by selecting issues that can interest policymakers and the community. The contextualization of frames in the healthcare system and health inequalities is explained by Dorfman et al. (2005)

and involves more than a message, and knowing what change will advance public health interests, followed by a clear understanding of what it will take to make the change happen, is equally essential (Dorfman et al., 2005). Framing of health inequalities in the mass media entails a significant change in the way the public and policymakers see and act to ameliorate the inequalities. Studies suggest various systematic areas through which communication strategies can be advanced for health inequalities. Niederdeppe et al. (2013) elucidated that communication about health inequalities can be defined as communication that describes, calls attention to, or make salient, differences in health outcome between groups. Niederdeppe and his colleague further explained that communication about health inequalities in the mass media might come from efforts to publicize findings of health disparities through governmental efforts; outreach by researchers, universities, or journals; journalists or editors who choose to cover the issues; and grassroots efforts to disseminate inequality-related messages through social or digital media (Niederdeppe et al., 2008, 2013a).

The effect of framing on the communication of health disparities can shape several policy-relevant outcomes among the public and policy sectors. Studies have focused on the content of the message about health inequalities through the source of media content that is likely to shape the volume and content of communication (Cooper et al., 2015; Gollust et al., 2009; A. E. Kim et al., 2010). Empirical studies highlighted that the structural factors like news value and journalistic practices play a significant role in bringing health-related inequalities to the news media and how they are framed (A. E. Kim et al., 2010; Niederdeppe et al., 2008). Studies reflected on the journalist's challenges in reporting health inequalities, where journalists expressed reluctance about covering health disparities (Gearhart et al., 2018; Gollust et al., 2019; Wallington et al., 2010). The outreach of mass media communication also depends on the quantity and quality of news coverage. Lack of health inequalities related news coverage stems from hesitation among journalists to cover stories due to institutional constraints or

personal perceptions about inequalities, or broader patterns of communication inequalities in the ownership and control over the traditional mass media channels (Niederdeppe et al., 2013a). Studies have stated that the nature of the communication of health inequalities is likely to shape attributes about disparities and political willpower to reduce inequalities. Journalistic silence on the issue of health inequalities hinders the outreach process among the public and policymakers (*ibid.*).

2.10 Media Advocacy for advancing Health Equity

Media advocacy is equipped to bring together the elements of communication, politics, economics, and advocacy to advance the practice towards health equity. The strategies of media advocacy programs have attracted interest from several fields, from science to health to politics. Numerous studies have focused on media advocacy conviction towards social change, particularly public health. Media advocacy emphasizes on taking personal problems and translating them into a social issue (Mills, 1959). Mills stated that the primary strategy of media advocacy is to work with individuals and groups to claim the power of the media to change the context or environment in which the problem occurs (*ibid.*). The goal of media advocacy is to create changes in the policies that improve health chances for communities through planning media message and framing information for maximum reach (Wallack, 1994). Media advocacy is a tool for a policy change that assists communities to the advantage of the role media plays influencing public policy (Jernigan & Wright, 1996). Media advocacy, as defined by Waisbord (2016), is the strategic use of the media to promote behavioral and social changes and advance policy initiatives (Waisbord, 2016).

Advocacy in media uses mass communication focusing on supporting community organizing to reach a narrow audience of one or two people who have the power to make the policy decision that shapes the given environment (Dorfman & Krasnow, 2014). Dorfman & Krasnow listed strategies and tactics for media advocacy: defining and structuring the problem the

advocates seek to solve and identifying which individual or body can create the change they seek to change. Once the overall problem identification is completed, media, message, and access strategy need to be considered. Further, Dorfman & Krasnow put forward strategies to be followed from determining the means of communication or the media, followed by the content of the message, and gaining access to the journalists, bloggers, and others who have access to the desired audience (Dorfman & Krasnow, 2014). Once the media message of the advocacy program is in the public discourse, the evaluation of the program is also necessary to note whether the desired policy is passed. The evaluation of the media message advocates is by examining the news coverage they generate to ascertain whether they got what they intended, and how the news is covered. The success of media advocates can also be measured if they become a regular source for journalists. The advocates have great opportunities to provide data and information in the stories that are told about their issue (De Bruycker, 2019; Dorfman et al., 2005; Dorfman & Krasnow, 2014; Servaes & Malikhao, 2010). The underlying measure is that more the people reinforce and deliver a compelling health message, the more policymakers will feel the pressure to create suitable health policy, and this will result in the success of media advocates.

2.11 Research Gap

The review of the relevant kinds of literature is based on the three broad domains: health system, healthcare workforce, and the role of media in portraying health, which formed the basis of conducting the study at hand. There have been numerous studies on health equity in both the Indian context and globally. However, studies on the healthcare system in the context of disadvantageous populations or regions are generally overlooked. Studies conducted globally focused on the racial and ethnic disparities of health and in the Indian sphere studies are based on the rural-urban dichotomy. There is a paucity of literature on the health outcome of the marginalized section or multidimensionally weaker section, particularly in the peripheral

region. Also, many of the studies conceptualized health from the economic perspective relating it directly to poverty, with the less focus on the perspective of social justice.

Existing studies in the healthcare system in the Indian context focuses on the utilization of healthcare services. Studies have found that Social Determinants of Health (SDH) is a crucial factor that influences individuals' utilization of services. On the other hand, ensuring the availability of services among the sections of the community is the responsibility of governmental agencies. Relevant literature mostly focuses on the utilization of services overlooking the availability of services. Studies were based on standardized norms set by the healthcare agencies that ensure availability but significantly low empirical evidence was presented on the availability of services across India.

There has been a dearth of literature on the role of the healthcare workforce and their action towards addressing health inequality. The literature on the healthcare workforce focuses mostly on ethical practice and relationship with the patient. There has empirical evidence on four principles of bioethics/medical ethics; however, it lacks a comprehensive analysis of the role of healthcare professionals in advancing health equity. There have been recommendations from various academic institutions on the role of the healthcare workforce for ameliorating the health equity across the population, but lacks depth in the multidimensional weaker section.

The existing data shows that communication has a role in decreasing, sustaining, and increasing health disparities, but relatively little attention has been paid to the content and effect of communication. There have been few studies on the difficulties of bringing attention to, framing, and covering health disparities in the news media. Little is known about the methods and priorities of media professionals in health journalism and reporting. This necessitates a more in-depth knowledge of how media professionals frame health information, healthcare inequalities, and the challenges they encounter when utilising health inequalities frames in their

news articles. Therefore, the present study seeks to address the gap by comprehensively focusing on three broad domains tightly knitted to each other and having a vital role to play at different steps to advance towards health equity goals.