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Health, Migration, and Marginalisation: Understanding Structural Inequalities among Migrants in India through a Social Development Lens

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Abstract

This conceptual paper examines the intersection of health, migration, and marginalisation among informal migrant workers in India, with a focus on the Seemanchal region of Bihar and their experiences in urban centres like Delhi. It aims to understand the structural inequalities and health vulnerabilities that arise due to socioeconomic status, legal invisibility, informality, and limited access to healthcare services. Using a social development perspective, the paper critically examines how policies, social structures, and migration patterns interact to shape the lives of informal migrant workers. This study highlights the complex web of inequalities that migrants face in urban settings, particularly concerning health access and the systemic barriers that perpetuate their marginalisation. Drawing on existing literature, secondary data, and theoretical frameworks, the paper proposes a need for integrated policy approaches that promote inclusive development, enhance healthcare accessibility, and address the root causes of social exclusion faced by migrants, offering a beacon of hope for positive change.

Key words: Health Inequalities, Migration, Marginalisation, Informal Migrant Workers, Social Development, Structural Inequality, Healthcare Access, Urban Migration, Policy and Development.

JEL Codes: R5, J130, J160

Introduction:

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Migration has long shaped India's demographic, social, and economic landscape. As one of the world's most populous countries, India experiences massive interstate and intrastate migration. Internal migration-especially from rural areas to urban centres-has become increasingly prevalent over the last few decades. "This trend is driven by a range of factors, including stark economic disparities, uneven regional development, agrarian distress, climate change-induced vulnerabilities, and chronic unemployment or underemployment in rural parts of the country" (Deshingkar & Akter, 2009; Srivastava, 2020). Individuals and families are often compelled to move for "better livelihood opportunities, access to education, or survival. However, this movement is seldom voluntary in the truest sense and often reflects systemic failures in ensuring equitable development across regions" (Kundu, 2012; Iyer, 2020).

Many internal migrants in India work in the informal sector, comprising construction workers, domestic helpers, street vendors, factory labourers, rickshaw pullers, sanitation workers, and others engaged in insecure and low-paid jobs. "These informal migrant workers typically lack formal contracts, access to institutional credit, social protection, healthcare benefits, and legal safeguards" (NCEUS, 2007; UNDP, 2019). Consequently, their lives in urban areas are marked by persistent insecurity, exploitation, and marginalization

The phenomenon of informal migration is particularly pronounced in India's eastern and northern states, such as Bihar, Uttar Pradesh, Jharkhand, and Odisha, "where poverty and lack of development act as key push factors" (Bhagat, 2017; Tumbe, 2018). The Seemanchal region of Bihar, comprising districts such as Katihar, Purnia, Araria, and Kishanganj, is one of India's most prominent migration-prone belts. CCharacterizedby high population density, recurrent floods, poor infrastructure, low literacy rates, and limited employment opportunities, this region sends thousands of workers annually to metropolitan cities such as Delhi, Mumbai, and Kolkata. Migration becomes a critical coping mechanism for families seeking to diversify income sources and manage household survival. However, moving from a rural to an urban context brings social, cultural, economic, and, most notably, health-related challenges.

While migration can offer certain economic advantages, it often results in new, more complex forms of vulnerability. One of migration's most pressing and under-discussed consequences is its profound impact on health. "Migrant workers frequently live in overcrowded, unsanitary conditions with limited access to clean water and basic health services, increasing their susceptibility to communicable diseases and mental distress" (Bhagat & Mohanty, 2009; Hirve, 2018). Their working environments are often hazardous, contributing to both acute and chronic health issues, "including respiratory problems, injuries, and stress-related disorders" (NCEUS, 2007; Ministry of Labour and Employment, 2020). Moreover, the lack of legal documentation or proof of residence in destination cities "hinders access to public health systems, as eligibility for services often depends on residential proof or identification documents" (UNESCO & UNICEF, 2012). Language barriers, cultural alienation, and systemic discrimination further "obstruct their health-seeking behaviours, contributing to delayed treatment and increased morbidity" (Desai, 2021). These challenges are further compounded by existing structures of inequality, particularly caste, class, "religion, and gender, which play a significant role in determining who migrates, the nature of their employment, and the extent of their access to healthcare and other rights" (Gupta & Das, 2012; Mosse et al., 2002). Muslim migrants from regions like Seemanchal, for example, often face additional layers of mmarginalizationdue to religious identity, "leading to further socioeconomic exclusion in urban settings marked by communal bias and institutional apathy" (Hasan, 2012; Gayer & Jaffrelot, 2012).

Against this backdrop, this paper explores the intersection of migration, health, and marginalization through a social development lens. By focusing on the lived realities of

informal migrant workers from Bihar, especially from the Seemanchal region, this paper aims to unpack the structural inequalities that shape their experiences in urban areas. The paper also examines the systemic barriers that hinder equitable access to healthcare and overall well-being for migrants. "Ultimately, the research advocates for inclusive and integrated policy solutions rooted in social justice, human rights, and development, capable of addressing the root causes of exclusion and vulnerability in the context of internal migration in India" (UNDP, 2019; Standing, 2007).

Objectives:

1) The paper aims to examine the structural inequalities and health-related exclusions faced by informal migrant workers in India, with a focus on the Seemanchal region.

2) It also seeks to analyze how intersecting factors, such as caste, class, gender, and religion, shape migrant experiences while critically evaluating existing welfare policies and proposing inclusive, participatory development strategies from a social development perspective.

Methodology:

This conceptual paper relies on secondary sources to explore migrant vulnerabilities and policy gaps through an interdisciplinary lens. It synthesizes academic literature on migration, public health, urban development, and social policy alongside policy documents from global bodies such as the WHO, ILO, and UNDP, as well as Indian institutions like the Ministry of Labour and NITI Aayog and civil society organizations like SWAN and India Migration Now. Theoretical frameworks, including the Social Development Perspective, Social Determinants of Health, and Intersectionality, guide the analysis. It also incorporates field-based case studies from urban slums and migration corridors, with a particular focus on the Seemanchal region and destination cities such as Delhi and Mumbai. The methodology involves qualitative synthesis to develop a grounded understanding of migrant precarity and systemic exclusions.

Theoretical Framework: Social Development Perspective:

Social development is a multidimensional concept that aims to enhance the well-being and quality of life for all individuals, particularly those who live on the margins of society. "It promotes equity, human rights, and social inclusion through participation and sustainability" (Midgley, 1995). Unlike traditional economic development models, which prioritize growth and productivity, social development emphasizes the importance of social justice, empowerment, and equal opportunities (Sen, 1999). The central assumption of this approach is that societies

must be structured to enable all individuals to survive and thrive politically, socially, and economically (UNRISD, 2011).

This perspective is particularly relevant when examining the complex relationship between health and migration. Health, within a social development framework, is not merely the absence of disease but a holistic state of physical, mental, and social well-being (WHO, 1948; Marmot et al., 2008). It recognizes that health outcomes are profoundly shaped by a wide range of social determinants, including housing, water and sanitation, education, employment, working conditions, food security, and access to quality public services (Solar & Irwin, 2010). Therefore, the experiences of internal migrants in India, particularly informal workers, must be understood about these broader structural conditions.

In the Indian context, internal migration is a defining feature of development, with millions of people moving from underdeveloped states, such as Bihar, Odisha, and Jharkhand, to metropolitan cities like Delhi, Mumbai, and Bengaluru in search of employment. A significant proportion of this migration originates in regions like Seemanchal, a cluster of districts in north-eastern Bihar comprising Katihar, Araria, Purnia, and Kishanganj, characterized by chronic poverty, flood-prone geographies, low literacy rates, and limited access to healthcare and infrastructure. These factors act as "push" forces, compelling migration, while the informal and precarious nature of jobs in destination cities introduces new layers of vulnerability (Deshingkar & Akter, 2009; Srivastava, 2011).

Migrant workers, particularly those in the informal sector, live in a state of "structural invisibility." They are essential to the functioning of urban economies but are rarely recognizedrecognized as rightful urban citizens (Kundu, 2003). This contradiction lies at the heart of the social development critique: that developmental benefits often fail to reach those who need them most due to systemic exclusion and discrimination. Migrants are frequently excluded from health and welfare services because of their lack of documentation, linguistic barriers, absence from electoral rolls, and the non-portability of entitlements (ILO, 2017). The failure of India's urban development planning to accommodate migrants reflects not just an administrative oversight but a more profound neglect of inclusive governance.

The social development approach draws attention to these structural determinants and asserts that development policies must address root causes of exclusion, not merely offer short-term relief (Sen, 1999). It also insists on the centrality of participation- marginalized groups must

have a voice in shaping the policies that affect them (Cornwall & Gaventa, 2001). In this context, intersectionality becomes a powerful analytical tool. Initially developed by legal scholar Kimberlé Crenshaw, intersectionality helps explain how multiple forms of identity—such as caste, class, gender, religion, and migration status—interact to produce overlapping layers of disadvantage (Crenshaw, 1991; Collins, 2000).

For example, a Muslim woman migrant from Seemanchal working in Delhi as a domestic worker occupies multiple marginalized identities. She may be paid lower wages, excluded from healthcare due to lack of ID, vulnerable to harassment at work, and denied housing due to her religion (Desai & Mahajan, 2007; Hasan, 2013; Agarwal, 2021). Addressing her situation requires more than sectoral solutions; it demands policies that are intersectional, inclusive, and responsive to lived realities. Social development frameworks are uniquely equipped to design and advocate for such policies.

Moreover, the approach calls into question development metrics that prioritized growth over social inclusion. Economic growth that leaves millions in informal, insecure employment is neither sustainable nor just (UNDP, 2020). Instead, comprehensive social protection—including universal health coverage, housing rights, food security, legal identity, and inclusive education—must be integrated into development planning (Mehrotra, 2010; ILO, 2017). The urban-rural binary, which has long dominated Indian development discourse, also needs to be reimagined. Migrants are wrongly viewed as "outsiders" in cities when, in fact, they are indispensable contributors to urban life (Shah, 2012; Roy, 2009).

Empirical evidence from the COVID-19 pandemic underscores the urgency of adopting this approach. During the 2020 lockdowns, migrant workers were abandoned by the state, stranded without food, income, or shelter. The crisis laid bare the fragility of India's social contract and highlighted the systemic neglect of mobile and informal populations (SWAN, 2020; Jha, 2021). A social development perspective interprets this not as an emergency failure but as a chronic result of exclusionary policymaking.

Migration and Health in India: A Contextual Overview:

Migration within India is a deeply entrenched and multifaceted phenomenon, encompassing a broad spectrum of socioeconomic motivations, patterns, and implications. "It is not merely a demographic trend but a reflection of deeper structural issues embedded in the country's development trajectory" (Deshingkar & Akter, 2009). The movement of people, particularly

from economically backwards "rural regions to urban centres, is a survival strategy adopted by millions in response to persistent poverty, underemployment, environmental vulnerability, and social exclusion" (Kundu, 2012). Among India's most significant internal migration corridors is the one that stretches from the eastern state of Bihar, specifically from the Seemanchal region, which includes districts such as Katihar, Araria, Purnia, and Kishanganj, to metropolitan cities like Delhi, Mumbai, and Kolkata. This migration pattern is shaped by the region's long-standing economic and social deprivation. "The Seemanchal belt, despite its fertile land and historical significance, has suffered from chronic underinvestment in infrastructure, education, healthcare, and industry" (Sharma, 2020). Recurring floods, poor connectivity, caste and "community-based marginalization and political neglect have exacerbated these problems" (Jha, 2017). With limited employment "opportunities outside of subsistence farming or casual wage labour, migration becomes an option and a necessity for survival" (Tumbe, 2018).

According to the Census of India (2011), Bihar had one of the highest out-migration rates in the country, and this "trend has only accelerated in the past decade due to economic distress and climate-induced agricultural decline" (Shah, 2021). Once in urban areas, these migrants overwhelmingly find work in the informal economy, "which is estimated to employ more than 90% of India's workforce" (International Labour Organisation: ILO, 2018). They work in construction sites, factories, domestic households, markets, and various service delivery sectors, including food distribution and transportation. While essential to urban functioning, these occupations are marked by "insecurity, lack of formal contracts, poor remuneration, and the absence of occupational safety measures" (Srivastava, 2011). For instance, construction labourers frequently work in hazardous environments with inadequate protective gear, and "domestic workers are often subjected to long hours, low pay, and, at times, verbal or physical abuse without any legal recourse" (National Commission for Enterprises in the UUnorganizedSector; NCEUS, 2007).

Meanwhile, "street vendors and rickshaw pullers navigate erratic income patterns and continuous exposure to pollution and road accidents" (Bhowmik, 2010). These occupational settings pose numerous health risks, including both physical and psychological hazards. Physical risks include musculoskeletal injuries, chronic fatigue, skin diseases, "respiratory illnesses due to pollution and dust, and long-term exposure to carcinogenic substances" (Srivastava, 2011; ILO, 2018). For female workers, especially those involved in domestic work

or factory jobs, reproductive "health risks are often compounded by a lack of hygiene facilities and workplace harassment" (NCEUS, 2007; Bhatt & Sharma, 2020). Psychosocial stress is another underreported but significant burden. The uncertainty of employment, the fear of eviction, social stigma, and constant worry about family left behind in the "village contribute to chronic mental stress, anxiety, and depression among migrants" (Kaur & Singh, 2021). "These mental health issues often go undiagnosed and untreated due to stigma, lack of awareness, and absence of mental health services for the urban poor" (Patel et al., 2012).

Housing conditions form another critical determinant of migrant health. Due to unaffordable rent and discriminatory housing practices in cities, most migrants are compelled to live in informal settlements, slums, or unauthorized colonies. "These are typically overcrowded, poorly ventilated, and lack access to clean drinking water, toilets, and waste disposal systems" (Bhan, 2009). The risk of communicable diseases such as tuberculosis, diarrhoea, dengue, malaria, and respiratory infections is considerably higher (WHO, 2010; Dasgupta et al., 2016). "The COVID-19 pandemic starkly highlighted these vulnerabilities, as slum areas emerged as hotspots for viral spread due to the impossibility of physical distancing and inadequate sanitation" (Gupta & Pal, 2020). Migrant families often move together, and children of migrants face distinct health and educational disadvantages. "Many are not enrolled in schools due to the transitory nature of their parents' work and are left unsupervised or made to assist in income generation" (Deshingkar & Akter, 2009). This not only deprives them of their "right to education, but also increases their risk of malnutrition, injuries, and exploitation" (Smita, 2008). Access to routine immunization and nutritional support under schemes like the Integrated Child "Development Services (ICDS) is severely compromised for these children, especially when their families lack proper identification documents or are ineligible under local administrative records" (Nanda et al., 2020).

Maternal and reproductive health is another area of concern. "Female migrants—particularly those in their reproductive years—face significant barriers to accessing antenatal care, skilled birth attendance, and postnatal services" (UNFPA, 2019). Cultural differences, mobility constraints, gender-based discrimination, and unfamiliarity "with the urban health system contribute to low institutional delivery rates and poor maternal health outcomes" (Singh et al., 2013). Studies conducted in urban slums in cities like "Mumbai and Delhi have reported high rates of anaemia, low birth weights, and maternal complications among migrant women"

(Choudhary et al., 2020; Montgomery et al., 2014). The lack of access to government schemes like the "Janani Suraksha Yojana or Pradhan Mantri Matru Vandana Yojana, often due to documentation issues, further exacerbates these challenges" (Nanda et al., 2020). "Despite these pressing concerns, migrant workers remain largely invisible in urban planning and public health policy" (Desai et al., 2020). Health schemes and services are often territorially bounded—meant for "residents—leaving mobile populations outside their ambit" (India Migration Now, 2020). The absence of portable entitlements—such as health insurance, food security cards (ration cards), and Aadhaar-linked benefits—means migrants frequently fall through the cracks of the welfare state (Khera, 2021). This issue became particularly evident during the "nationwide lockdown in 2020 when millions of migrant workers were stranded without income, food, or shelter, forcing many to walk hundreds of kilometres back to their native villages" (Srivastava, 2020).

Moreover, systemic discrimination based on caste, religion, and ethnicity further hinders access to health services. "Migrants from Muslim-majority districts like Kishanganj or Araria, or those belonging to Scheduled Castes and Tribes, often report mistreatment or reluctance on the part of service providers" (Ghosh & Samaddar, 2021). This deepens mistrust in public institutions and prompts many to turn to unregulated private healthcare providers, where care is often expensive, unscientific, and sometimes exploitative (Rao, 2012). The role of public health infrastructure also needs to be critically examined. Most Indian cities are unprepared for the "scale and needs of the migrant population. Government hospitals are overcrowded, under-resourced, and located far from slum settlements" (Bhan, 2009). Health workers are not adequately sensitized to the "specific needs of migrants, such as language support, cultural barriers, or flexible service delivery hours "(Chatterjee, 2021).

"Furthermore, there is a paucity of health data disaggregated by migration status, which limits the ability of researchers and policymakers to design targeted interventions" (WHO, 2010; NCEUS, 2007). Some progressive initiatives are attempting to address these gaps. For example, the Inter-State Migrant Policy Index (ISMPI), developed by India Migration Now-an initiative of the "South Asia Centre for Migration-tracks state-level efforts to integrate migrants into social protection frameworks" (India Migration Now, 2020). "Certain states have experimented with migrant health clinics, mobile medical units, and the One Nation One Ration Card for food security portability" (PIB, 2021). "However, these efforts remain fragmented and often do not

address the broader structural causes of migrant exclusion" (Roy & Agarwal, 2020). However, Migration in India is not just a demographic or economic process but a deeply social and political one. Health, both as a cause and a consequence of migration, must be viewed through a rights-based, equity-focused, and context-sensitive lens. Migrants from regions like Seemanchal are active economic contributors who deserve dignity, "protection, and well-being, not passive recipients of state aid. Addressing the health needs of migrant populations is not only a moral imperative but a practical necessity for building resilient, inclusive, and healthy societies" (UNDP, 2009).

Structural Inequalities and Marginalisation of Migrant Workers:

"India's internal migrant workforce, at over 100 million people, is emblematic of the country's structural inequalities and persistent development gaps" (Government of India, 2020; Deshingkar & Akter, 2009). These workers form the backbone of the "informal economy, yet they remain among the most neglected and marginalized sections of society" (NCEUS, 2007; Standing, 2014). The conditions under which they live and work are shaped by "economic factors and a broader matrix of legal, social, cultural, and political exclusions" (Srivastava, 2011; Roy, 2015). These exclusions are entrenched in historical patterns of caste, class, religion, gender, and "regional disparities, all of which combine to disadvantage migrant workers systematically" (Banerjee & Knight, 1985; Jodhka, 2012). The marginalization of informal migrant workers is not incidental is "structural and deeply embedded in the policies, governance frameworks, and social hierarchies that govern Indian society" (Kundu, 2003; Breman, 2013).

"One of the most glaring dimensions of this marginalization is the legal invisibility of migrant workers" (Deshingkar, 2012). Unlike citizens with permanent residences, most migrant workers lack proof of residence in their destination cities (Majumdar, 2016). "It excludes them from many state-sponsored welfare schemes that provide food, health insurance, housing, education, and social security" (Government of India, 2019; Bhagat & Mohanty, 2020). For instance, even though the Public Distribution System (PDS) is a national scheme meant to provide subsidized food grains to "people experiencing poverty, migrants without local ration cards cannot access it in their cities of work" (Mishra & Patnaik, 2020). Similarly, schemes like Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), which provide health insurance, remain out of reach for those "lacking Aadhaar-based residence verification or who are not registered in the destination state's health database" (NHSRC, 2019; Gopalan & Durairaj, 2020).

The One Nation, One Ration Card (ONORC) initiative was a step toward the portability of entitlements. However, its implementation has been "patchy and largely ineffective in addressing the core problem of access" (Government of India, 2021; Sharma & Kumar, 2022). Language barriers, lack of awareness, and "bureaucratic red tape further complicate matters" (Deshingkar & Akter, 2009; Srivastava, 2011). The absence of formal rental agreements or voter ID registration at the "destination location often renders these migrants administratively non-existent" (Majumdar, 2016). They live in cities, build infrastructure, run essential services, and contribute to their economy, "yet they are invisible in their records, plans, and policies" (Kundu, 2003; Breman, 2013). Legal exclusion feeds into and reinforces socioeconomic exclusion. "Migrant workers, especially those from marginalized communities—Dalits, Muslims, Adivasis, and Other Backwards Classes—are structurally confined to the lowest rungs of the occupational hierarchy" (Jodhka, 2012; Deshingkar, 2012). They involve physically intensive work, are socially devalued, and are economically unrewarding (Standing, 2014; Banerjee & Knight, 1985). A Dalit man from Bihar working as a sanitation worker in Delhi or a Muslim woman from Kishanganj employed as a domestic help in Mumbai is unlikely to break the cycle of poverty due to the nature of the work "they are pushed into and the systemic discrimination they face" (Bhagat & Mohanty, 2020; Roy, 2015). The wages in these sectors are "low and irregular, and any form of health emergency or income shock can plunge entire families into debt and despair" (NCEUS, 2007; Breman, 2013).

This marginalization is profoundly shaped by intersectionality -a concept that describes "how multiple forms of discrimination (based on caste, gender, religion, region, etc.) interlock and intensify each other" (Crenshaw, 1991; Jodhka, 2012). Women migrants, for example, face a unique set of vulnerabilities. They are concentrated in "domestic work, garment factories, or agriculture—all sectors with poor regulation, long working hours, and limited labour protections" (Kaur, 2015; Ghosh, 2016). These women are often excluded from labour laws that "ensure maternity benefits, paid leave, or protection against workplace harassment" (ILO, 2018). Sexual harassment and abuse are common, and the absence of grievance redressal mechanisms or supportive social networks renders them particularly vulnerable (Nair, 2019). Domestic workers, in particular, "live at the mercy of their employers, often isolated and invisible behind the closed doors of urban households" (Majumdar & Desai, 2018).

The religious identity of migrants adds another layer to this marginalization. Muslim migrants

from states like Bihar, Jharkhand, and Uttar Pradesh often "encounter housing discrimination and are systematically excluded from many employment opportunities due to communal prejudice" (Hasan, 2009; Hussain & Varshney, 2021). Housing societies in cities like Mumbai and Ahmedabad are known to deny rental accommodation to Muslims, forcing them to live in segregated, overcrowded, and underdeveloped areas (Zachariah & Rajan, 2012; Mustafa, 2015). "These ghettos are typically underserved by municipal services—clean water, sanitation, health clinics, and waste disposal are inadequate, compromising their residents' health and dignity" (Patel & Sharma, 2020). Structural Islamophobia, combined with poverty and regional identity, pushes these migrants into the margins of urban life, where they "become highly susceptible to exploitation and alienation" (Engineer, 2016; Hussain, 2019). The lack of collective bargaining power is a critical structural constraint that sustains migrant marginalization. Most migrant workers remain outside unions and lack access to worker associations, community organizations or "legal forums for negotiating better wages, working conditions, or entitlements" (Chatterjee, 2019). The informal nature of their employment means an absence of "formal employer-employee relationships, contracts, or dispute-resolution mechanisms" (Kumar & Singh, 2020).

This lack of organization prevents migrant workers from voicing their concerns or influencing policy decisions, "especially inter-state migrants who are often viewed as outsiders and politically disenfranchised due to voting restrictions in host states" (Rao, 2018). The political invisibility of migrants represents a glaring deficit within India's democratic framework. Despite their economic importance, "migrant workers do not possess political power and are seldom a focus in electoral campaigns or political manifestos" (Sharma, 2021). Their exclusion from urban resident vote banks results in their issues being ignored or deprioritized. During social or economic crises, migrants have been accused, as seen during the "COVID-19 pandemic, when they were unfairly labelled as disease carriers and of overburdening urban resources" (Jha, 2020).

Urban planning frameworks exacerbate this exclusion by failing to account for the dynamic nature of migration. "City development plans rely on static population data and often ignore the sizeable floating migrant workforce" (Gupta & Menon, 2019). Urban local bodies lack accurate data and financial resources to serve migrant populations, resulting in "public health, education, housing, and infrastructure policies that do not cater to their needs-creating a systemic policy

vacuum" (Nair, 2020). The COVID-19 lockdown of 2020 starkly exposed these inequalities. Announced with only four hours' notice, millions of migrant workers lost their "livelihoods overnight, with no income, savings, or access to food and shelter" (Patel et al., 2021). Many were forced to undertake "dangerous journeys home on foot, enduring exhaustion, hunger, and violence; numerous deaths occurred en route" (Desai, 2020). The state's fragmented response failed to address the structural roots of the crisis. "Temporary shelters and food camps were insufficient, leaving many migrants reliant on NGOs and community support networks" (Khan, 2021).

"The pandemic highlighted the precarity of migrant lives and the failure of protection systems that do not effectively recognize them as citizens entitled to rights" (Roy, 2021). Effective policy reform must begin with acknowledging migrants' structural exclusion and reimagining governance, citizenship, and welfare frameworks. This includes portable social protection systems, inclusive housing policies, registration of informal workers, "decentralized labour dispute mechanisms, gender-responsive urban services, and proactive political representation" (Verma & Singh, 2022).

Dismantling the structures that produce migrant marginalization requires coordinated action among governments, civil society, labour unions, researchers, and the private sector. Migrant workers' rights must be recognized as non-negotiable elements of human development, not dispensable in pursuit of economic growth. "Only through such inclusive approaches can India build equitable cities that respect the dignity and contributions of all citizens, regardless of origin" (Mukherjee, 2020).

Healthcare Access and Vulnerabilities of Migrant Workers in India:

Access to healthcare is universally recognized as a fundamental human right. However, this right remains unrealized in practice for "large sections of India's population, particularly for informal migrant workers" (Chatterjee, 2019). Despite being crucial contributors to India's economy, these workers are systematically excluded from healthcare systems due to "legal, structural, social, and economic factors" (Kumar & Singh, 2020). Their health vulnerabilities stem from poor individual conditions, systemic neglect, and policy failures. "The inadequate healthcare access for migrant workers represents one of the most severe and persistent forms of structural inequality in India's development landscape" (Gupta & Menon, 2019). The contradiction between policy intent and ground-level implementation lies at the heart of this

issue. On paper, India has some of the most extensive health programs globally, such as the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), which aims to provide health insurance coverage to nearly 500 million poor and vulnerable individuals. However, migrant workers-arguably among the most in need-often face barriers to accessing these schemes. These include the lack of "portability of benefits, unawareness of entitlements, inability to furnish identity documents and social marginalization in host communities" (Patel et al., 2021).

The first and perhaps most defining challenge is affordability. Most migrant workers in the informal sector have low, irregular, and precarious incomes, making it difficult to "afford even basic healthcare services—especially in urban private hospitals where costs can be exorbitant" (Rao, 2018).

Without health insurance or state support, migrant families bear high out-of-pocket expenditures that often lead to debt or delayed treatment. A single illness episode can "wipe out several months of earnings, affecting their ability to afford essentials like food, rent, or children's education" (Desai, 2020). Closely tied to affordability is the issue of time and distance. Migrants typically work long hours-often, 10 to 12 hours daily-and cannot afford to lose a day's wages to visit government health centres, which may be far from their "residence or work. This opportunity cost discourages preventive care and early medical intervention, resulting in ailments progressing to severe or chronic stages" (Jha, 2020). Cultural and linguistic barriers add another layer of exclusion. Migrants from rural Bihar, Jharkhand, Odisha, or West Bengal moving to megacities like Delhi, Mumbai, or Bengaluru often "encounter unfamiliar languages, food habits, social norms, and bureaucratic systems, which breed distrust and anxiety when accessing public services, including healthcare" (Khan, 2021). For example, a tribal woman from Jharkhand working as a construction labourer in Hyderabad may struggle to "communicate symptoms to a Telugu-speaking doctor. She may hesitate to seek reproductive or maternal healthcare" (Roy, 2021).

The legal status of migrant workers, combined with their lack of documentation, compounds these vulnerabilities. "Many internal migrants do not possess Aadhaar cards linked to their destination address, and fewer still have ration cards, voter IDs, or health scheme Enrollment cards in their city of work" (Singh & Kumar, 2020). Without these, they are ineligible for state-sponsored health benefits or admission to public hospitals under specific schemes. Even in

emergencies, "many are turned away or made to wait for long hours, which can prove fatal in cases of childbirth, accidents, or serious infections" (Patel et al., 2021). These barriers result in a range of adverse health outcomes. Maternal and infant mortality rates are significantly "higher among migrant populations due to a lack of prenatal care, poor nutrition, unsafe delivery conditions, and postnatal neglect" (Chakraborty & Mukherjee, 2019). Occupational health issues are rampant among migrant workers. Construction workers frequently suffer musculoskeletal injuries, back pain, and falls; factory workers report respiratory issues due to "poor ventilation and exposure to toxic substances; street vendors and rickshaw pullers suffer from fatigue, sunstroke, and dehydration" (Rao & Sharma, 2018). Nevertheless, because of the informal nature of their employment, "they are not covered under labour laws or occupational health safety regulations" (Dasgupta, 2020).

Another critical but often ignored dimension is mental health. Migrant workers live in conditions of chronic insecurity-uncertain income, unsafe living environments, job instability, and separation from family. These "conditions foster anxiety, depression, substance abuse, and even suicidal tendencies, particularly when coupled with social isolation in unfamiliar urban settings" (Khan & Verma, 2021). Women migrants face an even more "intense burden—sexual harassment, emotional abuse, lack of privacy, and absence of social support networks" (Roy & Sen, 2020). Mental health services, already "scarce and stigmatized in India, are virtually non-existent for this population" (Patel & Bhattacharya, 2019). India's policy framework for health and migration is fragmented and inadequate to meet these challenges. The Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979, is "rarely implemented and does not cover most informal workers who migrate seasonally or semi-permanently" (Mehta, 2018). While comprehensive, the National Health Mission (NHM) lacks a dedicated migrant health strategy or an urban health mobility framework (Gupta & Menon, 2019). As a result, health planning "assumes stable populations, leaving the floating migrant population out of health budgets, facility provisioning, and data collection" (Patel et al., 2021). Even schemes like Urban Health and Wellness Centres (UHWCs) and Mobile Medical Units (MMUs), which target urban poor populations, have limited reach in informal settlements where migrants reside (Desai, 2020). These areas are often unregistered or under constant threat of eviction and therefore lack permanent healthcare infrastructure. Further, "health information systems do not track internal migrants, limiting evidence-based policymaking for improving

migrant health outcomes" (Jha, 2020). There is a dire need to integrate health and migration data systems to "develop portable health records, mobile health services, and outreach programs" (Khan, 2021).

From a social development perspective, addressing the health vulnerabilities of migrants requires a multi-sectoral and intersectional approach. Health cannot be isolated from "housing, employment, education, sanitation, and social protection" (Das & Sengupta, 2020). Improved housing and sanitation directly affect health outcomes; access to education enables better "health awareness, and job security reduces stress-related illnesses" (Bhattacharya & Sen, 2019).

Community-based organizations and NGOs working with migrants have demonstrated successful models, including mobile health clinics, peer health educators, and urban health resource centres. However, these need to "be scaled and institutionalized with government support" (Kumar & Reddy, 2021). Moreover, public health communication must be personalized for "migrants, especially in local languages and through trusted community channels" (Singh & Mishra, 2020). Migrant support cells in urban local bodies, which could act as one-stop centres for information and grievance redressal, are essential (Patel & Rao, 2019). Labour contractors and employers must be made accountable for providing at least basic "health insurance and emergency care, particularly in high-risk sectors like construction, manufacturing, and domestic work" (Verma & Joshi, 2018).

To achieve universal health coverage in India, migrant workers must be recognized as a priority population. This includes developing portable health benefits that follow the "worker across states, digitized health records that can be accessed anywhere, and mobile health units that serve unregistered urban clusters" (Mehta & Kulkarni, 2020). Policymakers must also recognize the economic rationale-investing in the health of "migrants increases productivity, reduces absenteeism, and enhances national human capital" (Chatterjee & Ghosh, 2019). However, the healthcare vulnerabilities of migrant workers are a microcosm of the wider inequalities embedded in India's development model. They are symptomatic of a system that prioritizes economic growth over equitable welfare and celebrates infrastructure while ignoring those who build it. Unless these issues are addressed with "urgency, inclusiveness, and integrity, migrant workers will continue to pay the price not just with their labour but their lives" (Saxena & Roy, 2021).

A Social Development Approach to Migrant Health in India:

Improving healthcare access for migrant workers in India is not merely a matter of expanding services or facilities. However, it requires a fundamental rethinking of public health through the lens of social development. A social development approach transcends the narrow boundaries of biomedical models, integrating principles of social justice, equity, participation, and empowerment. It views health not as the mere absence of disease but as a state profoundly shaped by social, economic, political, and cultural conditions. Consequently, addressing migrant health holistically requires a rights-based, sustainable, and participatory framework that addresses both the structural determinants and the day-to-day vulnerabilities experienced by migrant workers.

At the core of migrant exclusion in India lies the territorial and static design of welfare schemes. Most public health and food security programs, such as the Public Distribution System (PDS) and Ayushman Bharat, are administered by individual states and are tied to permanent residency, local ration cards, or state-specific documentation. Migrant workers, who often cross state boundaries or move frequently for employment, find themselves outside the reach of these schemes. As Deshingkar and Akter (2009) noted, this exclusion from essential services, be it ration support, maternal care, or insurance coverage, arises because migrants' documentation remains registered in their native places, rendering them invisible in their host locations.

A social development framework mandates the portability of entitlements. This includes not only access to subsidized food but also health benefits, educational support, and insurance schemes. The "One Nation, One Ration Card" (ONORC) initiative is a promising beginning, allowing beneficiaries to access food rations regardless of their current location. However, without widespread awareness, operational clarity, and seamless integration across state systems, its transformative potential remains underutilized (Government of India, 2021). Expanding this logic, the creation of a National Migrant Health Card linked to Aadhaar could serve as a mobile identity, enabling continuity of care regardless of the migrant's place of residence. To ensure its effectiveness, inter-state coordination between health departments is essential, allowing health information, insurance coverage, and patient referrals to follow the migrant.

Equally critical is embedding community participation into the healthcare architecture. Migrants often face linguistic barriers, distrust of public institutions, and a lack of familiarity

with urban health systems. Recruiting Community Health Workers (CHWs) from within migrant communities to the rural ASHA and Anganwadi models—can bridge this divide. As Nair and George (2017) argue, community health workers (CHWs) drawn from the communities they serve are more effective at translating medical advice into accessible information, mobilizing residents during health drives, and building trust. When trained and supported, such workers become first responders and advocates who improve health-seeking behaviour and reduce attrition in treatment cycles.

Moreover, a decentralized approach to health governance is indispensable. Migrants are frequently left out of planning processes because they are not counted within local jurisdictional boundaries. Empowering Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs) to map migrant households, allocate local health budgets, and plan mobile health camps based on seasonal migration patterns is crucial. Kerala and Tamil Nadu provide compelling examples of the potential of local governance to improve health outcomes. These states have integrated migrants into local planning mechanisms, ensured inclusive service delivery, and facilitated access to housing, sanitation, and health services through participatory planning (Thomas et al., 2020).

A foundational barrier to effective migrant health policy is the paucity of accurate and disaggregated data. National health surveys and monitoring systems often fail to capture the scale and specific needs of migrant populations adequately. As IIPS & MoHFW (2017) pointed out, this data invisibility leads to underfunding and neglect. A dynamic data ecosystem is needed—one that includes digital health registries linked to migration flows, periodic surveys in migrant-concentrated urban zones and worksites, and the use of technologies like GIS mapping and AI-assisted dashboards. Such tools would enable policymakers to identify hotspots of health vulnerability and tailor responses more effectively (Mukherjee & Dasgupta, 2021).

Several innovative community-based models already demonstrate how social development principles can transform migrant health. Mobile Medical Units (MMUs), which deliver services to worksites like construction sites and brick kilns, offer basic diagnostics, health education, and referral services. Staffed by small teams, including doctors and nurses, these units eliminate the logistical barriers migrants face in accessing care (Ghosh & Sen, 2019). Urban Primary Health Centres (UPHCs) under the National Urban Health Mission (NUHM) also hold promise.

Strategically located in urban slums, these centres offer maternal and child healthcare, non-communicable disease screening, and family planning. However, they require extended hours, multilingual staff, and better staffing to become truly migrant-friendly (National Health Mission, 2020).

Kerala's Aawaz Health Insurance Scheme exemplifies what inclusive migrant health policy can look like. Explicitly designed for inter-state migrants, Aawaz offers free treatment in empanelled hospitals and links health access with housing, awareness campaigns, and help desks in multiple languages. Crucially, local institutions and the Labour Department collaborate to ensure proactive migrant registration, and hospitals are instructed not to deny care due to documentation gaps (Kannan et al., 2019). Civil society efforts, such as the Jan Swasthya Abhiyan (JSA), complement these policies by building migrant health literacy, conducting participatory research, and advocating with local government bodies for inclusive health planning (JSA, 2021).

India can also draw inspiration from global practices. The Philippines' Overseas Workers Welfare Administration (OWWA) mandates health insurance for workers before they migrate and provides reintegration support through counselling, job placement, and healthcare. This integrated, lifecycle approach to migrant well-being offers valuable lessons for India's circular and seasonal migrant population (International Organisation for Migration, 2018).

Ultimately, the promise of Universal Health Coverage (UHC) in India will remain unfulfilled without addressing the needs of over 100 million internal migrants. A social development approach requires not only stronger service delivery but also institutional reforms that view migrants as rights-holding citizens rather than transient labour. It requires robust inter-ministerial coordination, community ownership, dynamic data systems, and a strong political will. Only through participatory, equity-driven, and scalable strategies can India build a truly inclusive health system that leaves no migrant behind.

Findings of the study:

Migrants from backward regions like Seemanchal face persistent structural inequalities that predate their migration and persist in cities, manifesting as chronic socioeconomic disadvantages. They are often excluded from healthcare due to non-portable entitlements and lack of documentation, limiting access in emergencies and for chronic conditions. Intersectional discrimination based on gender, caste, religion, and regional identity further marginalizes

groups like Muslim and Dalit migrants and female domestic workers. Migrant workers in informal sectors endure hazardous jobs without safety gear, social security, or legal protections, affecting their physical and mental health. Urban planning often ignores migrants, relegating them to underserved slums. Despite reforms such as the One Nation One Ration Card and mobile health services, weak implementation fails to address the deep-rooted systemic inequalities.

Conclusion:

Hence, this paper has explored the structural inequalities and systemic marginalisationmarginalization experienced by informal migrant workers in India, particularly in terms of access to healthcare. Migrants from regions such as Seemanchal who relocate to urban centres in search of livelihoods often face heightened health vulnerabilities due to inadequate housing, precarious and hazardous work environments, lack of social protection, and legal invisibility within existing governance structures. Adopting a social development perspective offers an integrated and human-centred framework for understanding and addressing these challenges. This approach moves beyond traditional biomedical or economic models, advocating for inclusive policy frameworks, participatory planning, and intersectional strategies that centre on human dignity, equity, and well-being. The COVID-19 pandemic exposed the fragile scaffolding that supports migrant workers in India, yet it also presented an opportunity to reimagine the system. Migrants, integral to the urban economy, must now be recognized as rights-bearing citizens, not peripheral contributors.

To achieve health equity and social justice, systemic reforms are necessary that institutionalize the portability of benefits, strengthen community-based healthcare delivery, and ensure that the voices of migrants are represented in policy design. Additionally, state-level innovation, civil society partnerships, and robust data systems are critical to this shift. Future research should investigate the gendered aspects of migrant health, regional disparities in access to healthcare, and policy models that prioritize the well-being of migrants. There is an urgent need to produce evidence-driven, community-informed policies that reflect the lived experiences of migrants. We can only move toward a truly inclusive, equitable, and healthy India.

Suggestions:

To ensure the well-being of migrants, policies must strengthen social protection portability by universalizing access to PDS, Ayushman Bharat, and welfare schemes, regardless of the state

of origin, while fully implementing the One Nation One Ration Card and interoperable health ID systems. Inclusive urban planning should recognize migrants as city residents, providing affordable rental housing and migrant resource centres. Gender-responsive, intersectional approaches must extend labour protections, maternity benefits, and grievance mechanisms to informal sector women, alongside training healthcare staff in anti-discrimination. Investment in health infrastructure, including mobile clinics, community health workers, and telehealth, is crucial, supported by disaggregated migration data. Lastly, targeted interventions in source areas, such as Seemanchal, must prioritize education, rural employment, and disaster resilience and strengthen the NRHM and MGNREGA to reduce distress migration.

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