Structural Inequalities and Health Access: A Sociological Perspective on Migrant Workers in India

Aazaad Sohail[1*] and Vikram Singh[2]

*[1]PhD Scholar, Department of Social Work, Indira Gandhi National Tribal University,
Regional Campus Manipur*
*[2]Associate Professor, Department of Social Work, Indira Gandhi National Tribal University,
Regional Campus Manipur*
Corresponding E-mail: aazaadsohail@gmail.com

Abstract: This theoretical and review-based manuscript critically explores the intersection of structural inequalities and healthcare access among informal migrant workers in India, focusing on migration corridors such as from the underdeveloped Seemanchal in Bihar to urban hubs like Delhi.

Drawing from sociological frameworks of social stratification, mobility, and institutional exclusion, the paper interrogates the role of caste, class, gender, and regional identity in shaping the lived experiences of migrant workers. Migrants, especially those from marginalised communities, are systematically excluded from urban public health infrastructure due to a variety of interlocking factors: lack of residential proof or documentation, unstable housing, informal employment without benefits, and sociocultural discrimination.

Through a comprehensive review of empirical studies, policy documents, and theoretical literature, the paper identifies critical gaps in the public health system that hinder equitable access. These include inadequate portability of health schemes, fragmented urban health governance, and neglect of preventive and occupational health services for mobile populations. Though ambitious, the Jan Arogya Yojana (Ayushman Bharat) remains poorly accessible to urban migrant populations due to its dependence on domicile-based registrations.

This paper argues that health disparities among migrant workers cannot be understood in isolation from the larger political economy of labour, urban development, and social policy. It emphasises the need to reconceptualise health access as a service delivery challenge and structural justice issue. This paper critically explore the interaction of core social work principles and ethical challenges encountered in real and dynamic field settings. Focusing primarily on the principles of confidentiality and non-judgemental attitude, it highlights the significant gap between theoretical classroom understanding and practical ground level realities in the Indian context. Drawing from direct field observations and practitioner experiences, the study examines that how social workers navigate ethical dilemmas. The paper contributes to the discourse on professional integrity, suggesting way to strengthen ethical practice in diverse and complex community environment.

The paper concludes with actionable policy recommendations aimed at dismantling the structural barriers to health for migrant workers and fostering a rights-based, inclusive healthcare framework that acknowledges and responds to their specific realities.

Keywords: Health Access, Informal Migrant Workers, Intersectionality, Migration, Structural Inequalities, Sociological Perspective, Social Stratification, Seemanchal Region, Social Exclusion, Urban Health,

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Introduction

Migration has been a defining feature of India's socio-economic landscape, influencing patterns of urbanisation, labour markets, and demographic transitions. "Internal migration, particularly informal and distress-led, responds to uneven regional development, agrarian stagnation, and climate-induced vulnerabilities" (Deshingkar & Akter, 2009). Many migrants originate from economically backwards regions such as Seemanchal in Bihar, eastern Uttar Pradesh, Odisha, and Jharkhand, and move toward urban centers like Delhi, Mumbai, and Surat in search of livelihoods. "Most of these migrants are absorbed into the informal economy and employed in low-paid, insecure, and unregulated occupations such as construction, domestic work, street vending, sanitation, and textile" (Kundu, 2009). Though migration provides short-term economic relief, it simultaneously perpetuates cycles of social marginalization and structural exclusion. "Informal migrant workers are frequently excluded from access to social protection mechanisms, including public healthcare, due to mobility, lack of residential proof in destination cities, and poor integration into urban governance systems" (Srivastava, 2011). Most reside in slums, unauthorized colonies, or worksite accommodations, with limited access to clean water, sanitation, and healthcare services. "These living conditions and high occupational risks expose migrants to a range of health vulnerabilities" (Rajan, Sivakumar & Srinivasan, 2020).

"The COVID-19 pandemic dramatically exposed these structural vulnerabilities. The mass exodus of migrant workers from cities during the lockdowns in 2020

highlighted economic precarity and their systemic invisibility in health and welfare provisioning" (Gupta, 2020). Many were denied access to public health facilities due to the absence of domicile-based documentation or ration cards, underscoring the non-portability of health benefits and the urban-rural policy divide. "This crisis brought renewed attention to India's urgent need for inclusive, migrant-sensitive health systems" (Bhagat *et al.*, 2020).

The challenges faced by informal migrant workers, however, extend beyond the pandemic. They are rooted in structural inequalities, shaped by India's enduring hierarchies of caste, class, gender, and regional identity. "Migrants from Dalit, Adivasi, and Muslim communities are disproportionately represented in informal labor markets, and their access to healthcare is often mediated by discrimination and institutional apathy" (Shah & Lerche, 2020).

Female migrant workers, particularly those in care or domestic labor, face additional burdens including "gender-based violence, lack of reproductive health services, and heightened occupational vulnerabilities" (Desai *et al.*, 2018).

This paper uses a theoretical and review-based approach to explore these dynamics from a sociological perspective. It draws upon critical literature from sociology, development studies, social work, and public health to interrogate how structural inequalities intersect with health access in the lives of informal migrant workers. The paper particularly centers the case of migrants from Seemanchal to Delhi as a representative example of internal displacement shaped by deprivation.

The scope of the paper is threefold. First, it seeks to critically examine the barriers faced by informal migrant workers in accessing public health services, with a focus on structural determinants. Second, it analyses how intersecting identities—migration status, caste, gender, and religion—compound the exclusion of migrants from the healthcare system. Third, it offers policy-level reflections on how India's health infrastructure can be more inclusive, portable, and equitable for its mobile populations.

"In doing so, the paper contributes to a growing body of scholarship that calls for a rights-based and justice-oriented approach to health for migrant populations—one that goes beyond biomedical solutions and addresses the underlying social and political determinants of health inequity" (Qadeer, 2018). It emphasises that unless India confronts the structural foundations of health exclusion, migrant workers will continue to face disproportionate burdens of disease, precarity, and invisibility.

Theoretical Framework

Understanding the challenges faced by informal migrant workers in accessing healthcare in India requires a grounding in robust sociological theories that examine migration, social stratification, and health disparities. This theoretical framework draws from three

interrelated areas of sociological thought: theories of migration and stratification, the social determinants of health (SDH), and the concept of intersectionality. Together, these perspectives provide a comprehensive lens to analyse the multifaceted vulnerabilities experienced by migrant workers in the Indian context.

Sociological Theories of Migration and Social Stratification

Classical and contemporary sociological theories have long examined migration as a response to structural inequalities in the labour market and regional development. Push-pull theories "(Lee, 1966) suggest that individuals migrate due to "push" factors such as poverty, unemployment, and lack of services in rural areas, as well as "pull" factors like job availability and better infrastructure in urban centers". However, these theories often overlook the deeply embedded social hierarchies that shape who migrate, under what conditions, and how they are received in the destination society.

"Marxist and neo-Marxist frameworks argue that migration is not just an economic process but a mechanism through which capital exploits surplus labour from peripheral regions" (Castles & Kosack, 1973). Informal migrant workers are absorbed into precarious labour markets with minimal rights, reflecting the structural subordination of their labour. These migrants occupy the lowest rungs of the urban economic order, performing physically demanding work with low wages, long hours, and little to no social security.

Social stratification theory further helps understand how caste, class, and regional identity act as axes of exclusion in rural areas (source) and urban destinations. "Migrants from Scheduled Castes, Scheduled Tribes, and Muslim communities often find themselves restricted to the most hazardous and insecure forms of labour due to historical patterns of social exclusion" (Desai & Dubey, 2012). These stratifications persist in urban labour markets and shape differential access to housing, healthcare, and institutional support, reinforcing cycles of inequality.

Health Disparities and the Social Determinants of Health

The Social Determinants of Health (SDH) framework, popularised by the "World Health Organisation, posits that health is influenced by individual choices or genetic factors and broader social, economic, and environmental conditions" (Marmot & Wilkinson, 2005). For migrant workers, these determinants include unstable employment, poor living conditions, lack of potable water and sanitation, food insecurity, and minimal access to preventive or curative healthcare services.

"In India, internal migrants are often excluded from urban health systems due to a lack of documentation, non-portability of health insurance schemes, and institutional apathy" (Bhagat *et al.*, 2020). Even where services are available, linguistic, cultural,

and financial barriers prevent effective utilization. "The SDH framework highlights that health disparities are systemic and avoidable, reflecting unequal distributions of power and resources across population groups" (Solar & Irwin, 2010). For informal migrant workers, health vulnerabilities are not merely accidental but socially produced outcomes of intersecting disadvantages.

Intersectionality and Migrant Health

The concept of intersectionality, first articulated by "Kimberlé Crenshaw (1989), refers to how multiple social identities—such as caste, gender, class, ethnicity, and migration status—interact to produce unique forms of disadvantage and privilege". In informal migration, intersectionality is critical to understanding why health inequities are more pronounced for specific subgroups within the migrant population.

For example, female migrants working as domestic workers or factory labourers often face dual burdens of economic precarity and gender-based violence. They may also lack access to reproductive health services, maternal care, or menstrual hygiene products. Similarly, Dalit and "Adivasi migrants may face stigmatisation or outright denial of services due to caste-based discrimination within healthcare systems" (Shah & Lerche, 2020). Migrant children and the elderly are frequently left out of immunisation drives and chronic disease care, respectively.

Intersectionality as a theoretical lens allows for a nuanced analysis of how overlapping systems of oppression contribute to exclusion in health access. "It moves beyond one-dimensional categories and highlights how complex structural power dynamics affect individual and group health outcomes" (Hankivsky, 2012).

Health Disparities Among Migrant Workers

Health disparities among informal migrant workers in India are deeply entrenched and multifaceted. Migrants from Seemanchal, a historically underdeveloped region in northeastern Bihar comprising districts like Kishanganj, Araria, Purnea, and Katihar, face a unique set of challenges shaped by structural poverty, low literacy, poor health indicators, and social marginalisation. The region is marked by recurring floods, agrarian distress, lack of healthcare infrastructure, and a high rate of out-migration, particularly among young men and adolescent boys seeking employment in cities like Delhi. While economically necessary, this migration often places workers in environments that compromise their physical and mental well-being.

Health Challenges Specific to Migrants from Seemanchal

Migrant workers from Seemanchal typically come from socially disadvantaged backgrounds, including Scheduled Castes, Muslims, and extremely backwards classes.

"They often work in low-paying, high-risk jobs such as construction labour, rickshaw-pulling, rag-picking, and hotel work, all of which lack occupational health and safety standards" (Deshingkar & Start, 2003). The physically strenuous nature of these jobs, combined with exposure to dust, chemicals, long hours, and unhygienic work conditions, contributes to respiratory problems, musculoskeletal disorders, and skin infections.

"Moreover, these migrants suffer from high levels of stress and mental health issues due to job insecurity, discrimination, long separations from families, and the pressure to remit money home regularly" (Kaur, 2020). Women migrants, who are increasingly part of urban domestic labour, often report reproductive health issues, "nutritional deficiencies, and emotional trauma due to gender-based violence and exploitation" (Desai *et al.*, 2018).

In the absence of regular health check-ups, documentation, and awareness, many illnesses go undiagnosed or untreated, leading to chronic complications. Additionally, communicable diseases such as tuberculosis, waterborne diseases, and skin conditions remain prevalent due to shared living spaces, poor sanitation, and overcrowding in urban slums.

Access to Healthcare in Urban Settings: The Case of Delhi

Delhi, despite being India's capital and a hub of medical infrastructure, remains inaccessible to large numbers of informal migrant workers. While government hospitals like Safdarjung, LNJP, and AIIMS offer free services, the institutional navigation required for access—"including long wait times, documentation requirements, language barriers, and unfamiliar procedures—proves overwhelming for migrants with limited literacy and support networks" (Gupta & Mitra, 2021).

Health services under schemes like Ayushman Bharat are often out of reach due to the domicile-linked eligibility criteria. Since most migrants from Seemanchal are not officially domiciled in Delhi, they cannot benefit from the schemes, despite technically being Indian citizens.

"Mohalla Clinics, while intended to provide accessible care, are often poorly equipped, overcrowded, or unavailable in the informal settlements where migrants live" (Rao, 2021). In many cases, migrants resort to unlicensed practitioners or private chemists, leading to irrational drug use, delayed diagnosis, and additional financial burden.

Barriers to Healthcare Access: Economic, Cultural, and Systemic

The barriers faced by informal migrant workers are economic, cultural, and systemic. Economically, their daily-wage-based income structure deters them from taking time

off for treatment, which means lost wages. "Health expenses are considered a luxury and are postponed until necessary, often leading to complications or medical emergencies" (Bhagat *et al.*, 2020).

"Culturally, there is a mistrust of formal health institutions among migrants, often rooted in prior negative experiences, discriminatory behaviour by healthcare staff, or a perception that government hospitals are for others" (Kaur, 2020). Gender norms further restrict women's access, especially in cases involving reproductive or maternal health.

Systemically, there is no dedicated health policy or mechanism to track and ensure continuous healthcare for migrants. The lack of health insurance portability, poor interstate coordination, and limited outreach of urban health missions in slum settlements result in a de facto exclusion of migrants from the public health system. Moreover, urban health policies often treat migrants as temporary or invisible populations, ignoring their long-term presence and contributions to city economies (Srivastava, 2011).

In sum, health disparities among migrant workers from Seemanchal to Delhi are not incidental but are the outcomes of layered, intersecting vulnerabilities. Addressing these disparities requires not just service delivery improvements but systemic reform rooted in understanding migration as a social determinant of health.

Structural Inequalities and Their Role in Health Access

Health is often perceived as an individual responsibility or a matter of medical infrastructure and services. However, from a sociological perspective, access to health and healthcare is fundamentally shaped by structural inequalities—systemic, institutional, and historical patterns of exclusion that determine who get care and who is left out. In the context of India's internal migrant population, particularly informal workers from marginalised regions like Seemanchal, structural inequalities play a pivotal role in producing and sustaining health disparities.

Socio-Political and Economic Factors Influencing Migrant Health

At the core of health inequities among migrant workers are socio-political and economic inequalities entrenched in India's developmental model. "The migration of workers from regions such as Bihar, Jharkhand, and Odisha to cities like Delhi is often a result of chronic underdevelopment, agrarian distress, and lack of local employment opportunities" (Deshingkar & Akter, 2009). The Seemanchal region, for instance, lags behind national averages in health indicators, literacy, and infrastructure, creating a structural push toward migration.

Once in the cities, migrants are absorbed into the informal sector, without written contracts, social security, or workplace health safeguards. "These conditions significantly

impact their exposure to health risks and their capacity to seek timely medical care" (Srivastava, 2011). Moreover, the urban governance framework in India often treats migrants as transient and illegitimate, offering limited provisions for their welfare. "Health services are planned for settled populations, and there is minimal political incentive to integrate migrants into city-level public health systems" (Bhagat *et al.*, 2020).

Institutional and Systemic Barriers to Healthcare Access

The institutional architecture of healthcare delivery in India remains state-centric, mainly, and territorially bound. This means that migrant workers who move across state lines can often not access health benefits due to the non-portability of entitlements, such as ration cards, Ayushman Bharat coverage, or local health insurance schemes. For example, a migrant from Seemanchal working in "Delhi may be unable to access subsidised treatment because their documents are registered in Bihar, effectively denying them access to crucial services" (Rajan, Sivakumar & Srinivasan, 2020).

In addition, migrants often live in informal settlements or unauthorised colonies excluded from municipal service delivery plans. These areas lack access to clean drinking water, proper sanitation, and primary healthcare centres, further deepening health vulnerabilities. "Due to bureaucratic and logistical challenges, healthcare workers, community outreach programs, and government schemes like the Urban Health Mission rarely reach these neighbourhoods" (Qadeer, 2018). "Systemic discrimination also plays a role. Studies have documented instances where migrants face stigmatisation and neglect in public hospitals, with doctors and staff prioritising residents over perceived outsiders" (Kaur, 2020). This leads to a high degree of medical avoidance behaviour among migrants, who turn to unlicensed practitioners, quacks, or informal pharmacies, often worsening their health conditions.

Role of Caste, Class, and Migration Status in Health Disparities

In India, caste and class hierarchies remain key determinants of health access. Most internal migrants come from the lower rungs of the caste structure—Scheduled Castes (Dalits), Scheduled Tribes (Adivasis), and Other Backwards Classes—who have historically been denied access to land, education, and healthcare. "Migration does not erase these disadvantages; it often reproduces them in new forms in urban contexts" (Desai & Dubey, 2012).

Class also intersects with migration status in powerful ways. Informal migrant workers often earn below the poverty line, lack savings, and have limited financial resilience. Healthcare is a last priority, and hospitalisation can mean complete financial ruin. "Out-of-pocket expenditure remains one of the leading causes of indebtedness among poor migrant households" (Patel *et al.*, 2015).

Migration status itself becomes a marker of exclusion. Migrants are frequently excluded from social schemes, voter rolls, and planning databases. Their "floating" status makes them invisible in health planning and research. Consequently, they receive neither the policy focus nor the administrative attention necessary for ensuring equitable healthcare.

Structural inequalities, therefore, are not just background factors—they are active agents in shaping the health outcomes of migrant workers. Addressing these disparities requires more than expanding services—it demands rethinking institutional design, governance models, and social policy through a lens of inclusion, rights, and justice.

The State's Role in Healthcare for Migrant Workers

The Indian Constitution guarantees the right to health as a fundamental human right under Article 21. However, in practice, access to healthcare for informal migrant workers remains fragmented, exclusionary, and uneven.

While the state plays a central role in designing and implementing health policies, the actual reach of these interventions to migrant populations—especially those from backward regions like Seemanchal—is limited by administrative, logistical, and political challenges. This section examines the state's role through its policies, programs, and institutional gaps in addressing the health needs of migrant workers.

Government Policies Related to Health Access for Informal Workers

The Indian welfare state has introduced a range of schemes to ensure healthcare for the poor and vulnerable, including migrant labourers. The most prominent among these is Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY), launched in 2018, which aims to provide health insurance coverage of up to ₹5 lakhs per family per year for secondary and tertiary care hospitalisation. PM-JAY is designed to benefit families identified under the Socio-Economic Caste Census (SECC) 2011. "However, this policy falls short for many migrants who lack domicile documents or proof of residence in their work destinations, disqualifying them from accessing benefits outside their native states" (Ranjan, 2020).

To address migrant workers more directly, the Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979 was formulated, which mandates employers to ensure suitable living conditions, medical facilities, and timely payment. "However, this Act is rarely enforced, and most migrant workers fall outside the formal registration process due to their engagement in informal and unregulated employment sectors" (Srivastava, 2011). The National Urban Health Mission (NUHM), a sub-mission of the National Health Mission (NHM), was launched to cater to the urban poor, including migrants. However, implementation remains uneven across states.

Public Health Initiatives Targeting Migrant Populations

Despite growing awareness of migrant vulnerabilities, public health interventions targeting migrants remain limited in scope and sustainability. Some states have taken ad hoc steps. For instance, Kerala introduced migrant-friendly health centres and mobile medical units for labour camps. Gujarat and Maharashtra have experimented with health cards for industrial workers. "Delhi's Mohalla Clinics were designed to offer primary healthcare within informal settlements and migrant clusters, but many clinics are overburdened, understaffed, and inconsistent in their service delivery" (Rao, 2021).

Though primarily focused on food security, the One Nation, One Ration Card (ONORC) scheme has implications for health as it supports nutritional access for mobile populations. However, health portability is still lacking. Migrants continue to fall through the cracks due to the absence of a centralised health database and a mobile health benefits system. "The COVID-19 pandemic temporarily mobilised state responses such as free testing, vaccination drives in urban slums, and temporary shelters, but these measures lacked long-term vision and institutional commitment" (Bhagat *et al.*, 2020).

Limitations and Gaps in State Policies

The structural gaps in state responses to migrant health are manifold. Firstly, there is no specific national health policy for internal migrants. While the National Health Policy 2017 emphasises universal health coverage and inclusive health planning, it does not explicitly address the rights and needs of mobile populations. Secondly, inter-state coordination remains poor. Migrants moving from Bihar to Delhi, for instance, face different eligibility criteria, registration procedures, and service access protocols, making it nearly impossible to receive uninterrupted care.

Thirdly, the design of public health systems is territorially fixed, whereas migrant life is inherently mobile. Without a system for portable entitlements, continuity of care is disrupted. Fourth, data invisibility is a critical issue. "There is a lack of disaggregated data on migrant health needs, morbidity patterns, and service utilisation, resulting in poor planning and exclusion from targeted schemes" (Rajan *et al.*, 2020).

Finally, the absence of a political voice and representation of migrants in urban governance structures weakens accountability mechanisms. Migrant health is not an electoral issue; consequently, policies remain underfunded and under-implemented.

In conclusion, while the state has launched several health initiatives, its role in addressing the specific health vulnerabilities of migrant workers remains inadequate. Bridging this policy gap requires strengthening existing schemes and reimagining healthcare systems through migrant-inclusive, rights-based, and portable frameworks that reflect the lived realities of India's mobile workforce.

Case Studies and Literature Review

A growing body of research in India has documented the health challenges faced by migrant workers, particularly those employed in the informal sector. These studies consistently demonstrate that internal migrants, especially those from economically backwards regions such as Seemanchal in Bihar, are disproportionately affected by poor health outcomes, limited healthcare access, and systemic exclusion from welfare provisions.

Review of Existing Studies on Migrant Health in India

One of the most comprehensive studies by "Deshingkar and Akter (2009) highlights how seasonal and circular migration from rural India is largely distress-driven, with migrants lacking social security and entitlements at destination sites". Migrants frequently live in overcrowded and unsanitary conditions, with limited access to water, nutrition, and healthcare.

"Bhagat *et al.* (2020), in their study on COVID-19 and internal migration, emphasised how the lockdown-induced humanitarian crisis exposed the structural vulnerabilities of migrant workers". They noted widespread exclusion from testing, quarantine facilities, and emergency health services due to the absence of identity proof or domicile documentation in cities.

"Srivastava and Sutradhar (2016) also found that government health schemes do not cover most informal migrants because they are unaware or ineligible due to domicile-linked restrictions". They reported a high reliance on unqualified health practitioners, especially for primary care.

Gender-specific vulnerabilities have also been well documented. "Desai *et al.* (2018) found that female migrant workers, especially those in domestic work, suffer from high rates of anaemia, reproductive health problems, and occupational abuse, yet often do not seek healthcare due to stigma, time constraints, and lack of support networks".

These findings are supported by micro-level studies in cities such as Delhi, Mumbai, and Bengaluru, where migrants from regions like "Seemanchal often end up in informal settlements without access to Anganwadi services, urban primary health centres, or public hospitals" (Rao, 2021). Their interactions with the health system are often limited to emergencies, and they face discrimination, long waiting times, and language barriers.

Comparative Analysis with Other Regions and Countries

When compared globally, India's approach to migrant health lacks the migrant-inclusive frameworks adopted by other developing nations. "In Thailand, for instance, the

Ministry of Public Health has implemented a Migrant Health Insurance Scheme that allows both documented and undocumented migrants to access basic health services" (Hedman, 2008). In South Africa, though challenges persist, the constitutionally enshrined right to health has allowed migrants—regardless of legal status—to access emergency services in public hospitals.

Despite similar rural-urban migration dynamics in "China under the 'hukou' system, recent policy reforms have tried to integrate migrant workers into urban health insurance schemes" (Meng *et al.*, 2012). While challenges of portability and exclusion still exist, the direction of reform is clear. There is an institutional recognition that internal migrants are part of urban populations and deserve formal inclusion in public services.

In contrast, Indian health policies still treat internal migrants as temporary and peripheral, with few institutional mechanisms to address their long-term health needs. The fragmented nature of federal health governance and limited interstate cooperation continue to obstruct the development of a coherent national migrant health policy.

Insights from Fieldwork

In an interview with a 28-year-old male migrant worker from Araria district, currently working as a rickshaw puller in East Delhi, he reported suffering from chest pain and fatigue but avoided visiting the hospital. "Time nikalna mushkil hota hai... aur wahan par hamare jaise logon ke saath achha bartav nahi hota," he shared. His testimony reflects a combination of economic pressure, systemic bias, and a sense of institutional alienation.

A woman migrant domestic worker from Purnea, interviewed in a gated colony in South Delhi, expressed anxiety over her pregnancy. She had never visited a government health facility out of fear of mistreatment and language issues. "Main Bihar mein bhi hospital mein deliver kiye thi... par yahan Dilli mein sab kuch alag hai," she explained.

These narratives reflect broader trends captured in the literature—that migrant health is shaped not only by material deprivation but also by institutional cultures that alienate and exclude.

Intersectionality in Health Disparities

The concept of intersectionality provides a powerful lens through which to understand the compounded vulnerabilities faced by informal migrant workers in India. Coined by legal scholar Kimberlé Crenshaw (1989), intersectionality refers to how multiple social identities—such as gender, caste, class, and migration status—interact to produce unique experiences of discrimination and privilege. When applied to health access, intersectionality highlights how individual and group health outcomes are not just influenced by a single factor but by the overlapping effects of systemic marginalisation.

The Combined Impact of Gender, Class, and Migration Status

In the context of internal migration in India, particularly from regions like Seemanchal to urban centers like Delhi, class and migration status already place workers in precarious positions. They are engaged in insecure, low-paid, and physically taxing jobs with limited legal protections or employer accountability. However, when gender is layered on top of this, the disadvantages are magnified.

Female migrant workers, particularly those engaged in domestic labour, garment factories, or construction sites, face distinct health challenges. They are more prone to reproductive health issues, chronic anaemia, sexual harassment, and underreporting of illness due to fear of job loss or stigma. "Cultural norms often restrict their mobility, decision-making power regarding health, and access to health facilities, especially in unfamiliar urban environments" (Desai *et al.*, 2018).

Class also plays a critical role. Migrants from impoverished rural backgrounds typically lack the financial means to access private healthcare. Public health systems, though meant to be free or low-cost, are often marred by hidden expenses, corruption, or poor service quality. "As a result, economically disadvantaged migrants are often trapped in a cycle of delayed care, self-medication, and avoidable complications" (Patel *et al.*, 2015).

Moreover, migration status itself becomes a marker of exclusion. Migrants are frequently treated as "outsiders" by urban health institutions. The absence of proof of residence or local documentation is a barrier to entry into city-level services. Many migrants are unfamiliar with navigating healthcare systems in a new city, exacerbating the divide between entitlement and access (Srivastava, 2011).

Exploring Vulnerabilities Through an Intersectional Lens

Intersectionality emphasises that social categories do not function independently but interact in complex ways to shape access, opportunity, and vulnerability. For example, a Muslim woman migrant from rural Seemanchal working as a maid in Delhi may face compounded challenges due to gender, religion, class, and regional identity. She is more likely to encounter mistrust, language barriers, and discriminatory attitudes in both formal and informal health settings.

The lack of privacy in crowded clinics, male-dominated healthcare staff, and fear of community judgment often deter women from seeking timely reproductive or mental health services. Similarly, low-caste male migrants working in physically strenuous jobs like construction or "sanitation often report musculoskeletal pain or injuries but avoid hospitals due to past negative experiences or lack of workplace insurance" (Shah & Lerche, 2020).

By revealing these intersecting disadvantages, intersectionality challenges the one-size-fits-all health policy model and demands context-specific interventions that recognise the layered nature of exclusion.

Intersectionality and Policy Responses

Despite its relevance, intersectionality remains largely absent from mainstream health policy in India. Health schemes and welfare programs often adopt categorical eligibility criteria—based on poverty lines or occupation—without accounting for how multiple identities interact to compound exclusion.

For instance, Ayushman Bharat targets poor households for insurance coverage, but does not explicitly address migrant women's reproductive health or the linguistic and cultural barriers faced by tribal migrants. Similarly, urban health initiatives such as Mohalla Clinics do not always ensure safety or gender-sensitive spaces for women or transgender persons.

An intersectional approach to health policy would require:
- Disaggregated data collection on health outcomes by gender, caste, class, and migration status.
- Culturally competent and gender-sensitive training for healthcare providers.
- Development of portable, inclusive, and mobile healthcare services for migrant communities.
- Community health workers and local NGOs are involved to bridge trust gaps and offer care in local languages and contexts.
- Ultimately, intersectionality shifts the focus from symptoms to systems—from individuals who suffer to structures that produce suffering. Only by recognising and responding to these layered injustices can India move toward truly equitable healthcare for its most vulnerable populations.

Recommendations for Policy and Practice

The multifaceted health disparities faced by informal migrant workers in India are deeply rooted in structural inequalities, administrative exclusions, and cultural insensitivities. A comprehensive response must therefore go beyond short-term relief measures and aim for systemic reform and community empowerment. This section outlines actionable recommendations that can inform policy design and field-level practice, focusing on accessibility, literacy, and community participation.

Policy Suggestions for Improving Healthcare Access

1. Health Portability Mechanisms: A core challenge for migrant workers is the lack of continuity in health coverage when moving across states. There is an urgent need to

develop portable health entitlements, similar to the "One Nation One Ration Card" model. The Ayushman Bharat scheme should be modified to allow interstate use of health insurance irrespective of domicile status.

2. Migrant-Inclusive National Health Policy: India must formulate a dedicated Migrant Health Policy that recognizes internal migrants as a distinct demographic. This policy should ensure their inclusion in planning, service delivery, and data systems. The National Health Policy (2017) can be expanded to explicitly incorporate urban migrants, particularly in primary health outreach and insurance coverage.

3. Mandatory Health Registration in Workplaces: Employers in construction, domestic work, and small industries should be mandated to register workers for basic health services, linked with Employee State Insurance (ESI) or public health schemes. The Inter-State Migrant Workmen Act (1979) should include modern informal employment arrangements.

4. Urban Health Mapping and Budgeting: Urban bodies must identify high-density migrant settlements and prioritize them in health infrastructure allocation. Health budgets under the National Urban Health Mission (NUHM) should include earmarked funds for slum-based clinics, mobile units, and health camps in migrant clusters.

5. Data Disaggregation and Monitoring: Effective policies require robust evidence. National surveys (like NFHS and NSSO) must disaggregate health data by migration status, gender, and occupation to track disparities and design interventions accordingly.

Enhancing Health Literacy and Awareness Among Migrant Workers

1. Culturally and Linguistically Appropriate IEC Materials: Health communication should be delivered in regional languages (e.g., Maithili, Surjapuri, Urdu for Seemanchal migrants) and customised to low-literacy audiences using visuals and storytelling formats.

2. Peer Educator Models: NGOs and health departments should recruit and train migrant peer educators or health volunteers within migrant communities to act as mediators and awareness agents. These peer groups can support navigation of hospitals, insurance claims, and preventive care.

3. Workplace-Based Health Literacy: Large construction sites, factories, and domestic worker networks can be utilized for on-site health literacy sessions on topics such as hygiene, nutrition, first aid, and family planning. Employers and labor contractors should be sensitized to promote such activities during work breaks or weekends.

4. Digital Health Literacy: Simple, mobile-based platforms (WhatsApp/IVR/SMS) can disseminate reliable health information and connect migrants to nearby clinics,

Mohalla Clinics, or telemedicine services. This is especially useful for seasonal migrants with changing locations.

Community-Based Approaches to Healthcare Provision

1. Mobile Health Units (MHUs): Deploying MHUs in migrant-dense areas, primarily construction sites and informal settlements, can bridge the first-mile access barrier. These units can provide vaccinations, maternal care, and screening for TB, diabetes, and other common ailments.
2. Health Worker Integration: Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) should be linked with urban informal clusters, including migrant populations, and provided incentives for home visits and community-level monitoring.
3. Public-Private-Community Partnerships (PPCPs): Effective healthcare delivery to migrants requires collaboration among government agencies, civil society organizations, and migrant communities. PPCPs can help set up community clinics, mobile services, and information desks in railway stations, bus stands, and labor addas.
4. Participatory Planning Platforms: Migrant voices must be incorporated into urban health governance through ward-level planning bodies, complaint redressal forums, and health committees that include migrant representatives. This ensures services are more aligned with real needs.
5. Trust and Relationship Building: Community health approaches should be rooted in empathy, dignity, and trust-building. Frequent experiences of discrimination or neglect by formal health institutions discourage health-seeking behaviour. Capacity-building for public health staff on cultural competence and respectful communication is essential.

Conclusion

In conclusion, a transformative response to migrant health disparities must rest on equity, dignity, and participation. By integrating portable policies, tailored awareness programs, and community-led service models, India can move toward a health system that truly includes its most mobile and marginalised citizens.

The health of informal migrant workers in India cannot be understood merely through healthcare infrastructure or individual behaviour. Instead, it must be seen as a social phenomenon, embedded within a complex matrix of structural inequalities, policy exclusions, and social hierarchies. This manuscript has attempted to unpack the sociological underpinnings of health disparities among internal migrants, particularly those migrating from the Seemanchal region of Bihar to urban centers like Delhi, by

critically engaging with theories of social stratification, migration, intersectionality, and structural violence.

Summary of Key Findings

The review demonstrates that migrant health inequalities are not incidental but structurally produced. Migrant workers, particularly from backwards regions such as Seemanchal, face a unique convergence of vulnerabilities rooted in their economic precarity, social status, and geographic dislocation. Their employment in informal sectors, characterised by hazardous working conditions and a lack of social security, results in heightened exposure to both communicable and non-communicable diseases.

Systemic and institutional barriers, including non-portability of health benefits, exclusion from urban health planning, lack of documentation, and discrimination at the point of care, further exacerbate the lack of access to healthcare. Through schemes like Ayushman Bharat and the National Urban Health Mission, the state's response has shown intent but falls short in ensuring migrant-inclusive design and delivery.

An intersectional lens reveals how gender, caste, class, and migration status intersect to produce distinct forms of exclusion. Female migrants face reproductive and mental health challenges compounded by cultural norms and the fear of stigma. Similarly, low-caste or Muslim male migrants often experience invisibility within both state policy and civil society interventions.

Through case studies and a review of national and global experiences, this paper has highlighted the need for context-sensitive, portable, and participatory health frameworks. Migrants should not be treated as peripheral to urban policy but as integral contributors to the economy whose rights must be protected and needs addressed holistically.

Reaffirming the Need for a Sociological Approach

The analysis reaffirmed that a sociological lens is indispensable for understanding migrant health. Where biomedical or administrative approaches see migrants as service beneficiaries, sociology examines how historical marginalisation, power asymmetries, and institutional cultures reproduce health inequities. It enables us to go beyond symptoms and statistics to explore why specific populations fall sick more often, receive less care, and live shorter, more precarious lives.

A sociological perspective also focuses on exclusion's relational and lived aspects—how migrants negotiate care, how their identities influence access, and how institutions normalise their invisibility. It also sheds light on the political economy of health, showing how state priorities and urban planning frameworks often neglect the informal and the mobile in favour of the settled and documented.

This perspective encourages rethinking health as a service and a right, embedded within a broader ecosystem of social justice, mobility, and equity. It also offers the methodological grounding to centre migrant voices in academic inquiry and policy formulation.

Future Research Directions

Given the gaps in data, documentation, and disaggregated health statistics on internal migrants, there is a pressing need for rigorous, grounded, and participatory research. Future studies should aim to:

- Conduct longitudinal studies that track migrant health outcomes across geographies and over time, capturing the effects of mobility on chronic and occupational health.
- Explore gendered experiences in migrant health more deeply, particularly among single women migrants, LGBTQ+ workers, and adolescent girls.
- Analyze the role of intermediaries, including contractors, employers, and community leaders, in shaping access to healthcare services and entitlements.
- Study the impact of digital health tools and mobile-based interventions in enhancing healthcare literacy and service delivery for migrant populations.
- Evaluate the effectiveness of community health models and their potential for replication across high-migration corridors.

Hence, addressing migrant health disparities requires policy fixes and a **paradigm shift**—from marginal inclusion to systemic recognition, from ad hoc relief to institutional equity, and from fragmented delivery to rights-based governance. A sociological approach not only offers the analytical depth but also provides a strong ethical imperative to move in this direction. In summary, addressing migrant health disparities requires urgent policy reforms and a shift in perspective. We must transition from marginal inclusion to systemic recognition and from temporary relief to lasting institutional equity. Embracing a rights-based governance model is essential, and a sociological approach offers the analytical and moral guidance needed to drive these important changes. We must move from mere marginal inclusion to truly recognising the systemic barriers migrants face. Instead of relying on temporary relief, we should strive for lasting institutional equity.

Furthermore, shifting from a fragmented service delivery model to one that embraces rights-based governance is essential. Embracing a sociological perspective provides the necessary analytical rigour and moral urgency to guide us in making these vital changes. To effectively address health disparities among migrants, we need to implement policy changes and shift our perspective. It involves moving from marginal inclusion to systemic recognition, transitioning from temporary relief efforts

to institutional equity, and evolving from a fragmented delivery system to one based on rights-based governance. Adopting a sociological approach provides the analytical depth and ethical motivation necessary for this transformation. To effectively address health disparities among migrants, we need to implement policy changes and shift our perspective.

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