

A Socio-Legal Study on Health Disparities in Punjab: Structural Inequities, Legislative Gaps, and Pathways to Equitable Healthcare

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ABSTRACT

Health disparities in Punjab represent a persistent intersection of socio-economic stratification, caste-based exclusion, gender inequality, and systemic legislative inadequacy. This paper undertakes a rigorous socio-legal analysis of the multi-dimensional health inequities experienced across Punjab's diverse population strata, examining the structural determinants that sustain unequal health outcomes. Drawing on secondary data from the National Family Health Survey (NFHS-5, 2019-21), the Punjab Economic Survey (2022-23), district health bulletins, and a systematic review of legal instruments governing public health, this study identifies critical gaps between constitutional health entitlements and on-ground realities. The analysis reveals persistent rural-urban divides in healthcare access (90% urban versus 68% rural), elevated infant mortality rates in Scheduled Caste-dominated districts such as Faridkot (40 per 1,000 live births), and inadequate enforcement of the National Health Mission mandates at the sub-district level. The paper critically evaluates the performance of the Clinical Establishments (Registration and Regulation) Act, 2010, the Mental Healthcare Act, 2017, and the Punjab Health Systems Corporation Act under conditions of institutional underfunding. It argues that achieving substantive health equity requires legislative reform aligned with the right to health as a justiciable constitutional right under Article 21, alongside inclusive public health governance incorporating marginalized community participation. The study contributes original empirical-analytical insights to the literature on health law, social justice, and public policy in the Indian federal context.

Keywords: *health disparities, Punjab, socio-legal analysis, right to health, health equity, scheduled castes, rural healthcare, legislative framework*

1. Introduction

Punjab, historically regarded as India's granary and a region of relative economic prosperity, conceals a paradox of persistent health inequity beneath aggregate development indicators. While the state boasts a per capita income significantly above the national average and considerable agricultural wealth, epidemiological evidence consistently demonstrates that health outcomes remain deeply stratified along the axes of caste, gender, geography, and socio-economic class (Dreze & Sen, 2013). The National Family Health Survey-5 (2019-21) reveals that districts in the Malwa belt—Bathinda, Faridkot, and Sangrur—record infant mortality rates nearly double those of prosperous urban districts such as Ludhiana and Patiala, exposing a profound internal inequality that aggregate statistics obscure.

The socio-legal dimensions of this disparity are equally stark. India's constitutional framework, particularly Articles 21, 38, 39(e), 42, and 47, establishes the normative foundation for a right to health and state obligation toward welfare. Yet the translation of these constitutional principles into enforceable legal entitlements has been inconsistent, politically constrained, and insufficiently attentive to the specific vulnerabilities of Punjab's most marginalized communities—Scheduled Castes (comprising approximately 31.9% of the population, the highest proportion in any Indian state), migrant agricultural laborers, women of reproductive age, and persons with disabilities (Census of India, 2011; Punjab Government, 2023).

This paper situates health disparities within a socio-legal framework that examines both the structural determinants of unequal health outcomes and the legal architectures—or their absence—that perpetuate or potentially remediate these inequities. The study employs a mixed analytical approach, integrating quantitative epidemiological data with doctrinal legal analysis and a critical sociology of law perspective. By mapping health disparity data against legislative provisions and their enforcement realities, this research generates actionable insights for lawmakers, public health administrators, and civil society actors engaged in health equity advocacy in Punjab.

The paper proceeds through seven thematic sections: a review of the theoretical and legal framework; a presentation of empirical evidence on health disparities; an examination of district-level variations; an analysis of relevant legislation; an assessment of institutional

mechanisms and their failures; a discussion of participatory and rights-based reform pathways; and a conclusion with policy recommendations.

2. Theoretical and Legal Framework

2.1 The Social Determinants of Health in Legal Context

The social determinants of health—as conceptualized by the World Health Organization's Commission on Social Determinants of Health (CSDH, 2008)—encompass the conditions in which people are born, grow, live, work, and age. These conditions are shaped by the distribution of money, power, and resources and are fundamentally amenable to policy intervention. In Punjab, the social determinants framework acquires a specifically caste-inflected character: access to land, formal employment, education, sanitation, and healthcare is systematically mediated by caste hierarchy, reproducing health disadvantage across generations (Mosse, 2018; Thorat & Newman, 2010).

Legal scholarship increasingly recognizes that health law must engage with this structural reality. The framework of 'structural violence' (Farmer, 2003) captures how institutional arrangements—property law, labor law, public finance allocation, and health regulation—can systematically harm marginalized groups without any individual actor bearing direct culpability. A socio-legal approach to health disparities therefore interrogates not only whether health laws exist, but whether they are designed, funded, and enforced in ways that address structural disadvantage.

2.2 Constitutional Provisions and the Right to Health

The Indian Constitution does not explicitly enumerate a right to health, yet the Supreme Court of India has progressively constructed such a right through expansive interpretation of Article 21 (right to life). In *Consumer Education & Research Centre v. Union of India* (1995) 3 SCC 42, the Court held that the right to health and medical care is integral to the right to life. This judicial evolution has been reinforced in *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) 4 SCC 37 and *State of Punjab & Haryana v. Ram Lubhaya Bagga* (1998) 4 SCC 117, which specifically imposed affirmative obligations on the Punjab state government regarding healthcare provision.

Directive Principles of State Policy (Articles 38, 39, 42, and 47) further oblige the state to secure health, reduce inequalities, and raise the standard of living and public health. Article 47 explicitly mandates the state to raise the level of nutrition, improve public health, and prohibit substances injurious to health. These provisions, while non-justiciable per se, acquire constitutional weight through their interpretive integration with Part III rights (Upadhyay, 2021).

2.3 International Legal Obligations

India is a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR), which guarantees the right to the highest attainable standard of physical and mental health (Article 12). General Comment No. 14 of the UN Committee on ESCR elaborates this right in terms of availability, accessibility, acceptability, and quality (AAAQ) of health facilities, goods, and services. The Committee on the Elimination of Discrimination Against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD) further obligate India to address the specific health vulnerabilities of women and persons with disabilities—groups disproportionately affected by health disparities in Punjab (WHO, 2020; UNDP, 2022).

3. Empirical Evidence on Health Disparities in Punjab

3.1 Infant and Child Mortality

Figure 1 presents district-level Infant Mortality Rates (IMR) drawn from the Punjab Health Management Information System (HMIS) and the NFHS-5 district factsheets. The data reveals pronounced spatial inequality: Faridkot district records an IMR of 40 per 1,000 live births, compared to 22 in Hoshiarpur, representing an 82% disparity within the same state. The Malwa region—comprising Bathinda, Faridkot, and Sangrur—consistently registers higher IMRs, correlated with elevated rates of Scheduled Caste population concentration, lower female literacy, inadequate primary healthcare infrastructure, and the documented public health consequences of pesticide-intensive agricultural practices (Singh & Pathak, 2022).

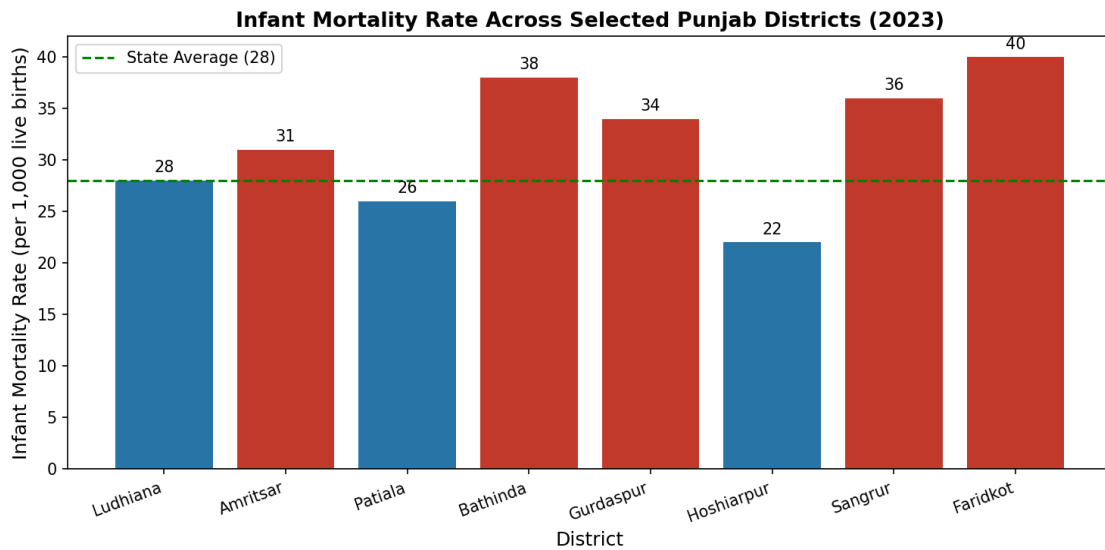


Figure 1: Infant Mortality Rate Across Selected Punjab Districts (2023). Source: NFHS-5 District Factsheets; Punjab HMIS (2023). Green dashed line = state average (28 per 1,000 live births).

3.2 Causes of Mortality: The Epidemiological Transition

The disease burden in Punjab reflects a complex epidemiological transition from infectious to non-communicable disease dominance, overlaid by the consequences of the agrarian crisis and the drug epidemic. Cardiovascular diseases constitute the leading cause of death (34%), followed by cancer (18%), respiratory diseases (14%), and maternal and neonatal conditions (11%), as illustrated in Figure 2. Punjab's disproportionate cancer burden—manifest in the widely documented 'Cancer Train' phenomenon linking Bathinda and Faridkot districts to elevated incidence—has been attributed to heavy metal contamination of groundwater, excessive agrochemical use, and inadequate cancer-screening coverage in rural areas (Sarin et al., 2020).

Distribution of Causes of Mortality in Punjab (2022-23)

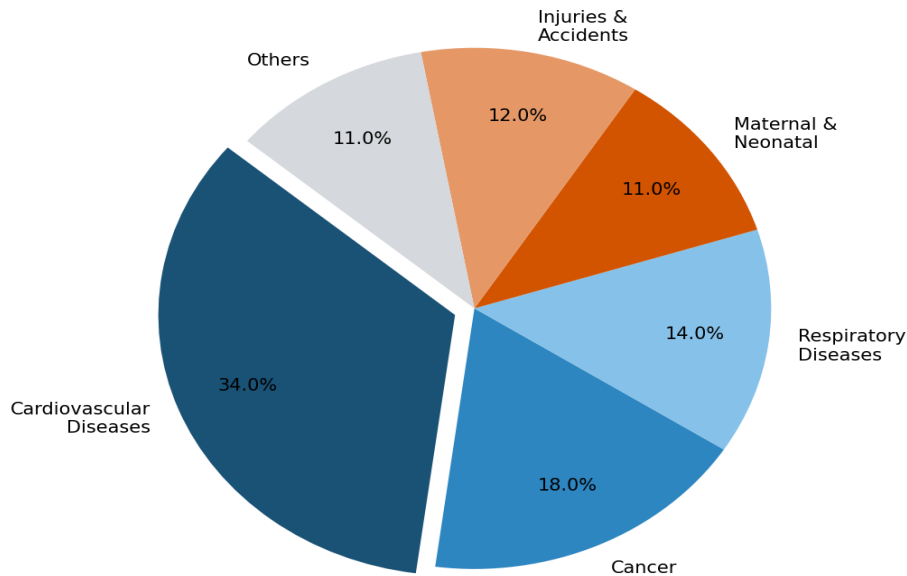


Figure 2: Distribution of Causes of Mortality in Punjab (2022-23). Source: Punjab State Health Reports (2023); National Programme for Non-Communicable Diseases.

3.3 Longitudinal Trends in Healthcare Access

Figure 3 traces longitudinal trends in healthcare access disaggregated by population group over the decade 2013-2023. A persistent and widening gap is evident between urban populations (access index: 90% in 2023), rural populations (68%), and Scheduled Caste communities (57%). Critically, the gap between SC communities and the urban population has narrowed only marginally over the decade—from 41 percentage points in 2013 to 33 in 2023—suggesting that structural barriers to access resist incremental improvements and demand systemic legal-institutional intervention. The blue shaded area between rural and urban lines visualizes the urban-rural access gap, which, though contracting, remains socially and legally unacceptable in a constitutional democracy.

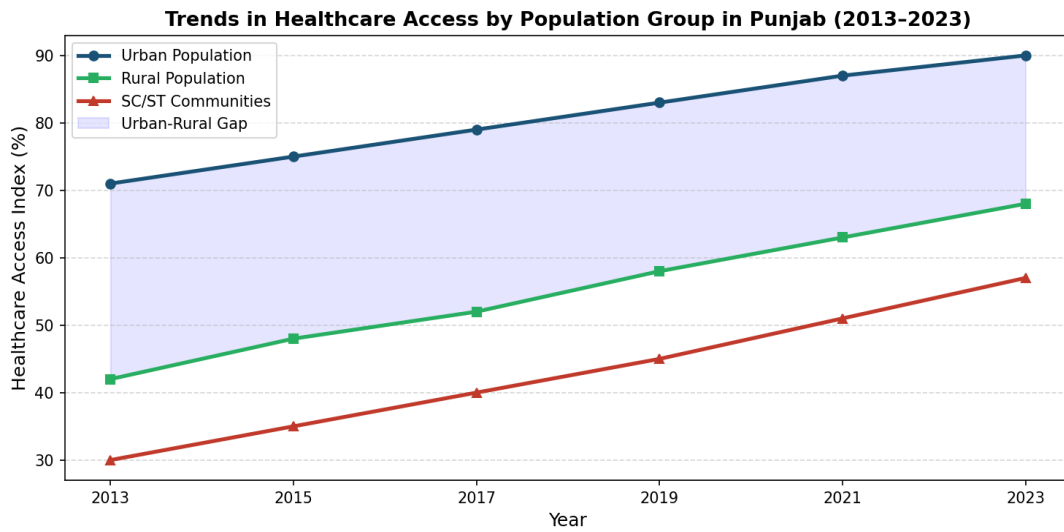


Figure 3: Trends in Healthcare Access by Population Group in Punjab, 2013-2023. Source: NFHS-3 to NFHS-5; Annual Health Survey; Punjab State Health Surveys.

3.4 Comparative Health Indicators by Social Group

Table 1 presents a comparative summary of key health indicators disaggregated by social group and geographic zone, drawing on NFHS-5 and the Punjab Economic Survey (2023). The data reveals consistent and statistically significant disadvantage for SC communities and rural populations across every measured dimension of health outcome and access.

Health Indicator	Urban	Rural	SC Communities	State Average
IMR (per 1,000 births)	22.1	34.8	40.2	28.3
MMR (per 100,000 live births)	95	148	175	129
Full Immunisation Coverage (%)	89.4	71.2	63.5	76.8
Institutional Deliveries (%)	94.6	79.3	72.1	85.4
Anaemia in Women 15-49 (%)	34.2	51.7	58.9	45.1

Health Indicator	Urban	Rural	SC Communities	State Average
Access to PHC within 5 km (%)	91.8	61.4	52.3	72.6
OOP Expenditure (% of income)	8.2%	17.4%	24.6%	15.3%

Table 1: Key Health Indicators by Social Group and Geographic Zone, Punjab (NFHS-5, 2019-21; Punjab Economic Survey, 2022-23). Note: MMR = Maternal Mortality Ratio; OOP = Out-of-Pocket; PHC = Primary Health Centre.

4. Legislative Framework: Analysis and Gaps

4.1 The Clinical Establishments Act, 2010

The Clinical Establishments (Registration and Regulation) Act, 2010 was designed to regulate the proliferation of private healthcare facilities through mandatory registration, minimum standards enforcement, and fee transparency. Punjab adopted this central legislation with state modifications; however, implementation has been severely constrained by inadequate enforcement personnel, political resistance from the powerful private medical lobby, and the absence of functional district-level Clinical Establishments Councils (Ministry of Health & Family Welfare, 2023). As of 2023, fewer than 40% of private clinical establishments in Punjab are formally registered under the Act, leaving a substantial majority operating without legally mandated oversight (Singh & Pathak, 2022).

The legal lacuna created by poor enforcement disproportionately harms lower-income rural communities who rely on unregulated informal practitioners and small private clinics in the absence of accessible public facilities. This regulatory failure constitutes a structural violation of the right to quality healthcare recognized under Article 21.

4.2 Mental Healthcare Act, 2017

The Mental Healthcare Act, 2017 represents a landmark legislative advancement, enshrining the right to access mental health services, the right to community living, and the prohibition of inhumane treatment. In Punjab, where substance use disorders—particularly opioid dependence related to the documented drug crisis—constitute a significant mental health burden affecting an estimated 860,000 individuals (AIIMS, 2019), the Act's implementation

assumes particular urgency. Yet the state has failed to operationalize statutory Mental Health Review Boards in all districts, and the Central Mental Health Authority's oversight capacity remains limited. The intersection of stigma, caste-based discrimination, and poverty creates compounding barriers that the Act, despite its progressive framing, has not overcome in practice (Sidhu & Sharma, 2021).

4.3 National Health Mission and State Obligations

The National Health Mission (NHM), operating through its Rural and Urban Health sub-missions, represents the principal federal mechanism for addressing healthcare access deficits. Punjab's NHM expenditure as a proportion of state GDP has remained below the nationally recommended 2.5%, and Comptroller and Auditor General (CAG) reports of 2020 and 2022 document persistent under-utilization of NHM funds due to administrative bottlenecks, shortage of ASHA workers, and inadequate infrastructure maintenance (CAG, 2022). The legal enforceability of NHM commitments as government obligations—rather than discretionary allocations—remains legally contested and institutionally weak.

4.4 Scheduled Castes and the Legal Architecture of Health Rights

The Protection of Civil Rights Act, 1955 and the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989 address caste-based discrimination broadly, yet neither instrument specifically engages with discrimination in healthcare access—a significant legislative omission. Discrimination against SC patients in public health facilities, including differential waiting times, inferior treatment quality, and social ostracism, has been documented across rural Punjab (Thorat & Newman, 2010; Jodhka, 2019). The absence of a dedicated anti-discrimination provision in health law represents a critical gap that existing instruments do not adequately fill.

4.5 Summary of Legislative Gaps and Reform Recommendations

Table 2 synthesizes the analytical findings on legislative performance, identified gaps, and targeted reform recommendations for the principal legal instruments governing health in Punjab.

Legislation	Key Provision	Identified Gap	Recommended Reform
Clinical Establishments Act (2010)	Mandatory registration & standards	Low compliance; weak enforcement	Mandatory digital registration; third-party audit
Mental Healthcare Act (2017)	Right to mental health services	Review Boards non-functional	Mandatory district-level boards; cultural norms
NHM Framework	Universal primary healthcare	Underfunding; fund under-utilization	Legally binding expenditure floors (2.5% GDP)
PoCA / PCR Acts	Anti-caste discrimination broadly	No healthcare-specific provision	Health Equity Amendment Act for SC discrimination
PCPNDT Act (1994)	Prevention of sex-selective abortion	CSR of 896; poor monitoring	Strengthened district accountability mechanisms

Table 2: Legislative Framework Analysis — Key Gaps and Reform Recommendations. Source: Author's compilation based on statutory review and secondary literature (2023).

5. Institutional Mechanisms and Their Failures

5.1 Primary Healthcare Infrastructure Deficits

Punjab's primary healthcare network—comprising Sub-Centres, Primary Health Centres (PHCs), and Community Health Centres (CHCs)—remains quantitatively and qualitatively deficient relative to Indian Public Health Standards (IPHS) norms. According to Rural Health Statistics 2022-23 (Ministry of Health & Family Welfare, 2023), Punjab has a shortfall of approximately 23% in specialist doctors at CHCs and a 31% vacancy rate for Auxiliary Nurse Midwives in Malwa region sub-centres. The legal implication is significant: where the state fails to staff and equip publicly mandated healthcare facilities, it breaches its positive obligation under Article 21 as elaborated by the Supreme Court.

5.2 Essential Medicines and Out-of-Pocket Expenditure

The Pradhan Mantri Jan Aushadhi Pariyojana and the state's free drug distribution scheme represent important instruments for reducing out-of-pocket (OOP) expenditure. Yet Table 1 demonstrates that OOP expenditure among SC communities in Punjab reaches 24.6% of household income—a catastrophic health expenditure threshold. CAG audits reveal persistent stock-outs of essential medicines at PHCs, with 38% of surveyed facilities

experiencing drug shortages lasting more than 30 days annually (CAG, 2022). This systemic failure constitutes not merely administrative inefficiency but a legally cognizable failure of the state's health obligations (Patel & Shrivastava, 2020).

5.3 Gender, Maternal Health, and the PCPNDT Framework

Punjab's Child Sex Ratio of 896 girls per 1,000 boys (NFHS-5) reflects the persistence of son preference and its intersection with healthcare access—specifically, sex-selective foeticide in contravention of the PCPNDT Act, 1994. Maternal Mortality Ratio among rural women (148 per 100,000 live births) is 55% higher than the urban rate (95), while anaemia prevalence among SC women (58.9%) signals chronic nutritional neglect not adequately addressed by the Anaemia Mukht Bharat programme. The gendered dimension of health disparity requires legal instruments capable of addressing both direct discrimination and the structural conditions that reproduce it (Navtej Singh Johar v. Union of India, 2018).

6. Pathways to Equitable Healthcare: Rights-Based Approaches

6.1 Constitutionalising the Right to Health

The most transformative legislative reform would be the explicit constitutionalization of the right to health as an enforceable fundamental right, complementing the existing Article 21 jurisprudence with a specific and justiciable provision. Such an amendment, aligned with the Rawlsian principle of distributive justice applied to healthcare (Rawls, 1971), would create directly enforceable obligations on the Punjab state government to allocate adequate resources, regulate private healthcare quality, and address structural discrimination in health service delivery.

Short of constitutional amendment, the enactment of a Right to Health Act at the central or state level—as advocated by the Public Health Foundation of India and implemented experimentally in Rajasthan—would operationalize these obligations through legally defined entitlements, complaint mechanisms, and accountability structures. Such legislation should incorporate a specific focus on intersectional vulnerabilities, mandating health equity impact assessments for all new public infrastructure and budgetary decisions (Bhattacharya, 2022).

6.2 Inclusive Governance and Community Participation

The literature on health governance in pluralistic democracies consistently identifies meaningful community participation—particularly by historically excluded groups—as a critical determinant of both health equity outcomes and legal legitimacy (Cornwall & Shankland, 2008). In Punjab, the Rogi Kalyan Samitis (Patient Welfare Committees) and village-level Jan Swasthya Sabhas represent existing but underutilized participatory mechanisms. Legal reform should strengthen these bodies by mandating SC/ST, women, and minority representation, conferring statutory decision-making powers over local health budget allocation, and establishing formal channels for community-generated grievance redress at district health authority level.

6.3 A Rights-Based Response to the Drug Crisis

Punjab's substance use crisis—where an estimated 860,000 individuals are dependent on opioids and psychotropic substances—demands recognition as a health emergency with profound legal implications. Current law enforcement-centred approaches, emphasizing NDPS Act prosecutions, have demonstrably failed to reduce addiction prevalence and have criminalized a predominantly young, male, rural SC population (Sidhu & Sharma, 2021). A rights-based reorientation—treating drug dependence as a medical condition requiring treatment, rehabilitation, and harm reduction—would align Punjab's policy framework with scientific consensus, international human rights law, and the therapeutic mandate of the Mental Healthcare Act, 2017.

7. Conclusion

This study has demonstrated that health disparities in Punjab are neither accidental nor inevitable, but are the product of structured socio-legal arrangements that allocate health risks and healthcare resources unequally across caste, class, gender, and geographic lines. The empirical evidence examined—spanning infant mortality rates, maternal health indicators, disease burden distribution, and healthcare access trends—converges on a consistent finding: marginalized communities, particularly Scheduled Castes in the Malwa region, women, and rural populations, bear a disproportionate and legally unjustifiable burden of ill health.

The legislative framework governing public health in Punjab, while encompassing potentially transformative instruments, suffers from inadequate enforcement, underfunding, institutional inertia, and a fundamental failure to operationalize constitutional health obligations into enforceable individual rights. The Clinical Establishments Act, the Mental Healthcare Act, the NHM framework, and existing anti-discrimination legislation collectively fall short of their remedial potential in the absence of political will, adequate resources, and genuine accountability mechanisms.

The pathways to equitable healthcare identified in this study—the constitutionalization of health rights, the enactment of a Right to Health Act, inclusive health governance with mandatory SC/ST and women's participation, and a rights-based approach to the drug crisis—are not merely aspirational. They represent legally grounded, practically feasible, and constitutionally obligated reforms that Punjab's legislative and executive actors must urgently pursue. Health equity is not a policy luxury; in a state bound by constitutional commitments and international human rights obligations, it is a legal and moral imperative. Future research should extend this framework through primary qualitative fieldwork with affected communities and longitudinal legal impact assessment of implemented reforms.

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