



Determinants of Health and Development in Contemporary India: The Bio-Politics of Stratification and the Post-Colonial Growth Paradox

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Abstract: Contemporary India presents a profound post-colonial growth paradox: rapid macroeconomic expansion runs parallel to stagnant domestic human development parameters. This structural divergence necessitates an epistemic shift toward the Social Determinants of Health (SDH) framework. Rather than evaluating population wellness through localised, apolitical biomedical interventions, this study examines how health inequalities are structurally manufactured by rigid caste hierarchies, gendered labour divisions, and sub-national geographical fragmentations. By integrating fundamental cause theory with critical political economy, the paper analyses the bio-politics of graded inequality, the gendered autonomy gap, and the dual-burden nutritional transition driven by ultra-processed foods. Furthermore, it explores contemporary environmental traps and digital frontiers that induce youth psychiatric crises. Ultimately, this paper argues that addressing India's health crisis requires shifting from technocratic interventions to a comprehensive, state-funded structural redesign that treats physical well-being as a fundamental democratic right.

Key Words: Social Determinants, Post-Colonial Paradox, Bio-politics, Graded Inequality, Nutritional Transition, Structural Redesign.

1. Introduction

The Epistemic Inversion of Indian Development

Contemporary India exhibits an exceptional macroeconomic contradiction within global development discourse. While major international monitoring agencies, including the United Nations and the World Bank, repeatedly project India as a global outlier maintaining a robust gross domestic product (GDP) growth trajectory between 6.6 per cent and 6.9 per cent, this external fiscal dynamism stands in sharp contrast to stagnant domestic human development parameters. As Amartya Sen (1999) conceptualises in *Development as Freedom*, true development cannot be measured merely by gross macroeconomic metrics; it must be evaluated by the substantive freedoms and foundational capabilities that citizens possess to lead lives they value. This profound structural divergence requires an epistemic inversion in public health and economic planning, shifting away from isolated biomedical access toward the Social Determinants of Health (SDH) framework championed by the World Health Organization (2010).

Preliminary findings from the sixth round of the National Family Health Survey (NFHS-6, 2024–25) indicate that despite continued macroeconomic expansion, substantial disparities persist in maternal health, nutritional status, and access to quality healthcare across caste, gender, and regional lines. While several indicators show incremental improvements relative to NFHS-5, the pace of progress remains uneven and geographically fragmented. The persistence of anaemia, childhood under nutrition, and inter-state inequalities demonstrates that economic growth alone is insufficient to generate equitable health outcomes. Rather, social location continues to mediate access to the material and institutional resources necessary for biological well-being.

Further, the traditional SDH paradigm posits that population health and physical resilience are structural manifestations of the precise conditions in which human beings are born, grow, live, work, and age (World Health Organization, 2010). When applied to the post-colonial Indian state, this framework must be critically integrated with a political economy of health. As Link and Phelan (1995) theorise in their foundational formulation of "fundamental cause theory," socio-economic status

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operates as a fundamental cause of health inequalities because it dictates access to "flexible resources" such as money, knowledge, prestige, power, and social connections that can be deployed to avoid risks and adopt protective strategies regardless of changing disease regimes.

In India, these flexible resources are not merely distributed along a fluid, market-driven class gradient; they are rigidly dictated by historical, institutionalized caste hierarchies, gendered divisions of labour and geographical sub-national fragmentations. Health in the Indian context is therefore a highly politicised, structurally manufactured product of social stratification rather than an isolated biological variable. The state's persistent reliance on technocratic, disease-specific public health mandates functions as an "epistemic inversion". By treating biological symptoms as isolated, apolitical phenomena, the state effectively masks the underlying socio-political sorting machines that systematically mal-distribute material resources and bodily safety. Consequently, marginalised populations bear an extreme physiological penalty, requiring a critical analysis of the country's bio-politics and structural inequalities.

The post-colonial growth paradox may be defined as a condition in which sustained macroeconomic expansion coexists with persistent deficits in human capabilities and unequal biological outcomes. Under such conditions, aggregate growth indicators obscure the unequal conversion of economic gains into health, nutrition, and social opportunity. The paradox therefore reflects not merely a failure of redistribution but also the persistence of historical social structures that govern access to life-enhancing resources.

2. Objectives

The primary objectives of this study are to:

- **Deconstruct the Post-Colonial Paradox:** Analyse the structural divergence between India's rapid macroeconomic growth and its stagnant human development indicators.
- **Examine Graded Inequalities:** Evaluate how historical caste hierarchies, geographic fragmentations, and gendered autonomy gaps systematically drive biological and epidemiological disparities.
- **Assess Nutritional and Digital Transitions:** Investigate the dual burden of malnutrition accelerated by ultra-processed foods alongside the youth mental health crisis induced by algorithmic cognitive extraction.
- **Propose a Structural Redesign:** Critique current technocratic health interventions and advocate for a state-funded redistribution of material, environmental, and nutritional resources.

3. Methodology

This study adopts a qualitative political-economy approach anchored within the Social Determinants of Health (SDH) framework and employs a critical interpretive synthesis of secondary datasets and interdisciplinary scholarship. The principal empirical sources include NFHS-5 (2019–21), NFHS-6 (2024–25, where available), reports from the Ministry of Health and Family Welfare, WHO databases, and peer-reviewed public health literature. The study employs purposive document selection based on three criteria: (1) national representativeness, (2) methodological transparency, and (3) direct relevance to health inequalities and social stratification.

The analytical strategy combines thematic synthesis with theory-guided interpretation. Empirical findings are interpreted through the lenses of Fundamental Cause Theory (Link & Phelan, 1995), Ambedkar's theory of graded inequality, Bourdieu's concept of embodied social reproduction, and contemporary political economy approaches to health. Rather than seeking causal estimation, the study aims to explain how structural arrangements shape the unequal distribution of health opportunities and vulnerabilities.

To enhance analytical rigor, data from multiple sources are triangulated wherever possible. This triangulation permits the identification of recurring patterns across caste, gender, nutritional transitions, environmental exposure, and digital transformations while acknowledging the limitations inherent in aggregate national datasets.

4. Limitations

A primary limitation of this study is its reliance on aggregated secondary data, such as NFHS-5, which may obscure localised, micro-regional healthcare disparities and real-time shifts within marginalised communities. Because the analysis relies heavily on historical and sociological frameworks, it lacks primary empirical field validation, clinical bio-markers, or direct longitudinal data to track the long-term metabolic impacts of recent ultra-processed food consumption. Furthermore, rapidly evolving digital and climatic landscapes outpace institutional data collection, potentially underestimating the immediate mental health and spatial penalties confronting highly volatile urban migrant populations.

Additionally, the study does not employ econometric techniques capable of establishing causal relationships between social determinants and health outcomes. Consequently, the analysis should be interpreted as explanatory rather than causal. Future research could integrate longitudinal panel data, geospatial techniques, and multilevel modelling to quantify the independent effects of caste, gender, environmental exposure, and digital behaviors on population health outcomes.

5. The Indian Epidemiological paradox

To ground the empirical data and illustrate how macro-level inequalities translate directly into micro-level biological deprivations, a structured conceptual map is required. The following matrix traces the pathways through which historical caste, class, and gender hierarchies manifest as tangible bodily crises across distinct structural tiers of the Indian state:

Structural Level	Operational Dynamic	Public Health Manifestation
Macro Level	State Capital Allocation & Political Economy (Brugger, 2025)	Structural entrenchment of Caste, Class, and Gender Hierarchies
Meso Level	Environmental & Social Spatialisation (Cowling et al., 2014)	Segregated Urban Slums, Rural Peripheries, and Food Deserts
Micro Level	Proximate Determinants of Bodily Deprivation (Link & Phelan, 1995)	High Maternal Anaemia, Stunting, and Algorithmic Cognitive Extraction

Table 1: The Indian Epidemiological Matrix

6. The Bio-politics of Caste Deprivation

Socio-economic identity remains the primary systemic mechanism driving developmental and biological inequities across the Indian subcontinent. Data from consecutive iterations of the National Family Health Survey (NFHS-5) illustrate that health indicators are distributed along a steep socio-economic gradient where historically oppressed groups specifically Scheduled Castes (SCs), Scheduled Tribes (STs), and multi-dimensionally poor rural households bear an extreme physiological penalty.

To fully comprehend the depth of this disparity, one must look beyond standard financial matrices to what French sociologist Pierre Bourdieu (1984) identified as the conversion of social and cultural capital into *bodily hexus* the physical embodiment of social class disposition. In the Indian subcontinent. This concept intersects directly with what B.R. Ambedkar (2014) identified in *Annihilation of Caste* as the physical and psychological manifestation of "graded inequality". Caste deprivation in modern India operates as an active form of bio-politics, where social status directly dictates bodily survival.

As Tripathi et al. (2024) observe, reimagining Dr. B.R. Ambedkar’s vision in the light of marginalised communities underscores how public health remains structurally inaccessible due to institutionalised social exclusion. The structural exclusion from secure land ownership, safe housing, and high-tier labour markets forces a massive segment of the SC and ST populations into hazardous environments characterised by high environmental exposure to toxins, heavy microbial loads, and poor baseline infrastructure. This social sorting manifests in stark epidemiological disparities:

- **The Continuum of Care (CoC) Deficit:** Marginalised women exhibit the lowest rates of completing the recommended four antenatal care (ANC) check-ups. Dandona, Majumder, and Kumar (2024) demonstrate that this gap is directly attributable to steep geographical and socio-economic inequalities, driven by systemic discrimination within rural primary health centres, long transit barriers, and financial precarity.
- **The Childhood Mortalities Inversion:** Neonatal, infant, and under-five mortality rates among SC and ST households remain significantly higher than the national average. This showcase how historical social exclusion converts directly into early-life biological mortality.

This caste gradient is further compounded by a profound sub-national geographical divide. The Indian federal structure features a stark divergence between the "Empowered Action Group" (EAG) states of northern and central India (such as Bihar, Uttar Pradesh, Jharkhand, and Madhya Pradesh) and the more industrialised, socially secure peninsular states of the south (Cowling, Dandona, & Dandona, 2014). In EAG states, the historical consolidation of feudal land relations and weak public investment have created an environment where public health facilities lack basic infrastructure, diagnostic equipment, and human resources. When a marginalised individual in these regions faces an illness, they are caught in a destructive choice: either endure untreated morbidity or enter an unregulated, highly predatory private healthcare market. This private exposure drives millions of low-income families into catastrophic health expenditures, solidifying a permanent intergenerational poverty trap.

7. Gendered Autonomy, Nutritional Transitions, and Micro-Regional Deprivation

Gender acts as a powerful non-medical social determinant that shapes the distribution of food, medical care, and bodily autonomy within the domestic sphere. The contemporary Indian gender landscape features a distinct paradox: educational attainment among young women has rose significantly, with national health registries confirming that the proportion of women completing ten or more years of schooling has reached 46.4 per cent (NFHS-6). According to classical human capital theory, this educational advancement should translate into increased economic security, lower maternal mortality, and enhanced household decision-making power. However, critical feminist economics reveals that this formal literacy has not triggered a corresponding rise in female labour force participation, nor has it dismantled deeply entrenched patriarchal domestic structures. This tension manifests as a structural "autonomy gap". Although a young woman may possess the literacy to understand nutritional or maternal health instructions, her capacity to execute these behaviours is heavily restricted by intra-household power dynamics and the domestic political economy.

Recent studies in India indicate that a substantial proportion of women encounter household, financial, and permission-

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related barriers when seeking healthcare, with more than half reporting logistical and economic constraints to accessing services. (Singh et al., 2025). This friction includes a persistent requirement for formal family permission, a lack of independent financial mobility, and severe restrictions on physical movement outside the domestic compound. Furthermore, Indian women bear a disproportionate burden of unpaid care work and domestic chores, creating a condition of chronic "time poverty". This temporal deprivation leaves women with little opportunity to manage their own physical wellness or attend preventative healthcare appointments. Consequently, maternal health programmes implemented by the state operate under a flawed, instrumentalist assumption. By focusing heavily on institutional delivery incentives (such as *Janani Suraksha Yojana*) without addressing the structural lack of female autonomy, domestic surveillance, and micro-regional delivery gaps, these programmes treat women merely as reproductive vessels rather than rights-bearing human agents. Furhter, the high prevalence of anaemia among women of reproductive age in India 57 per cent as reported in NFHS-5 (2019–21) reflects persistent structural gaps in nutrition, healthcare access, and gender equity (MoHFW & IIPS, 2021). Global estimates by WHO similarly identify anaemia as a continuing major public health burden among women, with India contributing significantly to this load (WHO, 2025). Subnational evidence also indicates stagnation in several regions. In the absence of NFHS-6 anaemia data, NFHS-5 remains the latest national benchmark, underscoring the continuing severity of the issue.

7.1 The Nutritional Transition and the Dual-Burden Architecture

The Indian nutritional landscape is currently undergoing a chaotic structural shift that challenges traditional developmental paradigms. Historically, public health in India viewed nutritional failure almost exclusively through the lens of scarcity and caloric deprivation. While severe under nutrition remains a critical issue with childhood stunting affecting 31.8 per cent of children and wasting lingering at a stubbornly high 17.4 per cent, even during NFHS-6, reveal deep pockets of absolute food insecurity the country is simultaneously experiencing and an explosion in over nutrition and metabolic disorders. India is caught in a "double burden" of malnutrition, where communities face under nutrition and obesity within the same regions, and occasionally within the same households. This double burden is driven by the rapid, unregulated expansion of corporate food systems and the commercial determinants of health (Singar, 2026). In accordance with the revised dietary guidelines issued by the Indian Council of Medical Research and the National Institute of Nutrition (ICMR-NIN, 2024), scholars are documenting a massive rise in the consumption of ultra-processed foods (UPFs) across all socio-economic strata. UPFs defined by the NOVA classification system as industrial formulations consisting primarily of chemically altered substances extracted from foods, combined with stabilisers, flavour enhancers, and heavy chemical additives have achieved deep market penetration in India. Market analysis and industry reports indicate a rapid and sustained expansion in the consumption of ultra-processed foods across both urban and rural India, although precise growth estimates vary across datasets and product categories.

Category	Classification Profile	Market Penetration Dynamics (India)	Long-Term Metabolic Risk Profile
Category 1: Unprocessed / Minimally Processed Foods	Whole foods altered only through basic processes such as drying, grinding, fermentation, refrigeration, or pasteurisation, without addition of substances (ICMR-NIN, 2024). Examples: cereals, pulses, fresh vegetables, fruits, milk.	Remains central to rural and traditional dietary systems; however, affordability constraints, food inflation, and seasonal supply variability have reduced dietary diversity among low-income rural and urban populations.	Protective baseline dietary pattern; high fibre and micronutrient density supports metabolic regulation, improves glycaemic control, and reduces chronic disease risk.
Category 2: Processed Culinary Ingredients	Substances derived from foods or nature through pressing, refining, or milling. Used in cooking and food preparation. Examples: oils, sugar, salt, butter, ghee.	Deeply embedded in household cooking systems; however, consumption patterns are influenced by price volatility in edible oils and refined sugar markets.	Neutral in moderation; excessive intake particularly of refined oils, salt, and sugars contributes to cardiometabolic risk, including hypertension and visceral adiposity.
Category 3: Processed Foods	Relatively simple products made by adding salt, sugar, or oil to minimally processed foods to enhance preservation or palatability. Examples: pickles, cheese, salted nuts, simple bakery products.	Expanding in tier-2 and tier-3 urban centres as convenient semi-perishable foods, increasingly substituting freshly prepared meals in urbanising food environments.	Moderate risk profile; contributes to increased sodium and energy density, with potential impacts on long-term blood pressure and dietary quality when consumed frequently.
Category 4: Ultra-Processed Foods (UPFs)	Industrial formulations made primarily from refined substances and additives, with minimal or no intact whole foods. Includes	Rapidly expanding across urban, semi-urban, and rural markets, driven by retail penetration, aggressive	High-risk dietary pattern; epidemiological evidence associates high UPF intake with increased risk of obesity, type 2

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Category	Classification Profile	Market Penetration Dynamics (India)	Long-Term Metabolic Risk Profile
	flavour enhancers, emulsifiers, and stabilisers. Examples: instant noodles, packaged snacks, carbonated beverages, processed meats.	marketing strategies, and increasing affordability, reflecting a structural dietary transition.	diabetes, cardiovascular disease, and poor overall diet quality, particularly when displacing minimally processed foods.

Table 2: NOVA Classification of Foods and Their Market and Health Profiles in India

The political economy of this transition reveals that UPFs function as cheap, highly accessible caloric substitutes within urban food deserts and low-income neighbourhoods. For a working-class household surviving on less than Rupees 15,000 per month, mass-produced packaged foods offer an affordable option that requires zero cooking fuel, possesses an extended shelf life, and delivers high immediate satiety due to elevated levels of free sugars, saturated fats, and sodium. However, this transition introduces a severe long-term health penalty. Extensive epidemiological studies show that high UPF intake triggers a graded, dose-response relationship with the Cardiovascular-Kidney-Metabolic (CKM) syndrome continuum. As Singar (2026) demonstrates, each 10 per cent increase in the share of total daily energy derived from UPFs correlates with a 12 per cent higher relative risk of developing Type 2 diabetes and incident cardiovascular events. Consequently, India's poor are facing a destructive health intersection: they remain exposed to childhood infectious diseases and micronutrient deficiencies, while simultaneously developing early-onset chronic non-communicable diseases (NCDs) without the financial resources or institutional healthcare access required for long-term chronic disease management.

7.2 Countervailing Trends and Areas of Progress

A balanced assessment of India's health landscape requires acknowledging several areas of significant progress. Successive rounds of the National Family Health Survey demonstrate improvements in institutional deliveries, immunisation coverage, sanitation access, and female educational attainment. Certain southern and western states have achieved health indicators comparable to middle-income countries despite modest economic resources. Programmes such as Ayushman Bharat and expanded digital health infrastructure have increased access to healthcare services among previously underserved populations. Nevertheless, these achievements do not invalidate the central argument of this paper. Rather, they illustrate that policy interventions can mitigate inequalities when accompanied by sustained public investment and institutional capacity. The persistence of substantial inter-state and intra-state disparities indicates that improvements remain uneven and continue to be mediated by underlying social hierarchies. The concept of algorithmic cognitive extraction refers to the systematic capture and monetisation of human attention through digital architectures designed to maximise user engagement. By continuously manipulating behavioural feedback loops, these systems transform attention into an economic resource while generating unintended consequences for mental health, sleep patterns, social relationships, and dietary behaviours.

8. Spatial Precarity, Environmental Degradation, and the Digital Frontier

In the era of the Anthropocene, physical geography and built environments have emerged as primary structural determinants of health and economic survival. In India, this spatial inequality is magnified by climate change and uneven urban development. The concept of spatial equity assumes that all citizens, regardless of their location, should enjoy equal access to clean air, potable water, and protection from environmental hazards. However, the expansion of Indian metropolitan areas has occurred through a pattern of systematic spatial segregation, where low-income populations and marginalized migrant workforces are systematically pushed into informal settlements, industrial peripheries, and low-lying urban slums. Under the National Clean Air Programme (NCAP), monitoring networks consistently record dangerous concentrations of ambient particulate matter (PM 2.5) that far exceed safe international thresholds. Crucially, this toxic air exposure is not distributed equally. While affluent urban neighbourhoods possess the financial resources to install indoor air purification systems and maintain green spaces, slum environments feature high population densities, adjacent industrial units, and zero environmental insulation. This exposure leads to high rates of chronic obstructive pulmonary disease (COPD) and cardiovascular inflammation among working-class communities.

This structural risk is further intensified by escalating climate instability. Prolonged heat waves and shifting monsoon patterns have converted weather events into structural economic shocks. In substandard housing units lacking thermal insulation or consistent electricity, extreme summer temperatures cause severe heat stress, dehydration, and increased mortality among outdoor labourers and elderly residents. Concurrently, the degradation of rural agricultural ecosystems driven by topsoil erosion, falling water tables, and unpredictable weather forces millions of smallholder farmers into cyclical distress migration. When these rural labourers arrive in urban centres, they exist in a state of administrative invisibility. Lacking portable social security cards, official address verification, and formal employment contracts, they are excluded from local welfare registries. This exclusion leaves them highly vulnerable to hazardous working conditions and sudden health crises.

8.1 The Digital Frontier: Cognitive Extraction and Youth Mental Health

As the Indian state transitions toward digital-first governance models evidenced by the implementation of the Ayushman Bharat Digital Mission the digital ecosystem itself has transformed into an unregulated social determinant of health. India

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currently possesses the world's largest and most hyper-connected youth population, with over 600 million individuals under the age of 25, and a mobile internet user base exceeding 750 million. While public policy celebrates this rapid connectivity as a triumph of democratisation, interdisciplinary research across digital sociology and public health reveals a major behavioural and psychiatric crisis among Indian youth. The rapid spread of cheap smartphones and low-cost mobile data has exposed vulnerable demographics to attention-extraction algorithms designed to maximize screen time. Extensive clinical research led by the Centre for Advanced Research on Addictive Behaviours documents a substantial rise in problematic technology use, with pooled prevalence estimates for internet and social media addiction ranging between 14 per cent and 27 per cent among school and college populations (Balhara, 2025). This digital over-saturation operates through specific psychological and social mechanisms:

- **The Syndrome of Relative Deprivation:** Young people from rural or low-income backgrounds are exposed to the highly curated lifestyles of urban digital influencers. As Rani (2024) notes, this constant exposure creates intense internal stress, severe body image anxieties, and a persistent "fear of missing out" (FOMO) within school and college cohorts.
- **The Pathogenesis of Screen-Induced Isolation:** Jonathan Haidt (2024) in *The Anxious Generation* argues that the systematic "great rewiring of childhood" via screen-centric interaction replaces physical, offline community participation, leading to a sharp decline in real-world social capital and an escalation in clinical anxiety and depressive symptoms. Importantly, this digital precarity intersects directly with the nutritional transitions occurring across urban environments. Emerging empirical research reveals a high correlation between excessive screen time, late-night algorithmic scrolling, and the compulsive consumption of ultra-processed foods. Emerging studies indicate a significant positive association between prolonged screen exposure sleep disruption, and increased consumption of ultra-processed foods among adolescents and young adults. The blue light emitted by mobile devices disrupts circadian rhythms, suppresses melatonin production, and induces chronic "sleep debt," which alters metabolic signaling and triggers acute sugar cravings.

Consequently, young people frequently consume hyper-palatable, ultra-processed snacks while isolated in front of screens, accelerating a dual cycle of physiological and psychological deterioration. By treating youth mental health purely as an individual psychological issue rather than a structural consequence of cognitive extraction, state planners fail to build the offline social infrastructure, community youth spaces and digital regulatory frameworks required to protect the mental well-being of the population. A genuinely transformative public health strategy must move beyond the biomedical management of disease and embrace a social investment model centred upon equity. Such a model would require universal primary healthcare, nutritional security, environmental justice, gender-sensitive labour policies, portable social protection for migrant populations, and regulatory frameworks governing digital platforms and commercial food systems. Health inequalities should therefore be understood not as unfortunate outcomes of development but as politically produced distributions of life chances.

9. Epilogue: Shifting from Technocratic Interventions to Structural Redesign

The intersections of these diverse social and structural determinants confirm that India's contemporary health and development crises cannot be solved through fragmented, technocratic interventions. Providing isolated sanitation access through *Swachh Bharat* or deploying localised digital medical portals does not alter the underlying caste, class, and gender hierarchies that dictate a citizen's baseline biological vulnerability. When public health strategies treat health as a series of disconnected, apolitical biological events, they protect the economic and political systems that generate these inequalities. As Nancy Fraser (2003) argues in *Redistribution or Recognition?* a just social framework requires moving beyond mere symbolic recognition or surface-level adjustments toward a fundamental restructuring of political economy and resource allocation. To build an equitable society, India must shift from incremental, market-aligned policies toward a comprehensive structural redesign. This approach requires shifting focus from data collection to rigorous data accountability and from nominal legal recognition to a robust, state-funded redistribution of environmental, material, and nutritional resources. True developmental transformation occurs only when a state reconstructs its daily socio-political and economic environments, ensuring that physical well-being and human capability are treated as fundamental democratic rights rather than structural luxuries.

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