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Addressing Popular Distress: The Role of Social Welfare and Populist Health Policies for Subaltern Communities

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Introduction

Subaltern communities historically marginalised groups based on caste, class, tribe, gender, or location face entrenched social and health disparities. These disparities manifest as limited access to healthcare, low socio-economic mobility, and persistent distress. Social welfare and health policies have emerged as key instruments for state intervention Social and economic distress among Subaltern communities remains a persistent challenge in developing societies, particularly in countries marked by deep structural inequalities such as India.

Subaltern groups comprising historically marginalised populations based on caste, class, gender, ethnicity, and geography experience disproportionate vulnerability to poverty, ill-health, and social exclusion. Limited to access to quality healthcare precarious livelihoods and systemic discrimination have contributed to cycles of deprivation that are reproduced across generations. In response, the state has increasingly relied on social welfare and health interventions as instruments to alleviate popular distress and promote inclusive development. Within this context, social welfare schemes and populist health policies have emerged as central strategies in addressing the immediate needs of marginalised populations while also serving broader political and governance objectives. Programmes aimed at income security, food distribution, and universal health coverage seeks to expand access and reduce inequalities, yet their effectiveness remains contested. While such policies have improved service outreach and visibility among Subaltern communities, questions persist regarding their sustainability, quality, and transformative potential.

This paper investigates the role and impact of social welfare and populist health policies on alleviating distress among Subaltern populations, with a focus on India as a case study. It argues that targeted welfare measures and progressive health policies can reduce inequalities, but their effectiveness depends on institutional accountability, resource adequacy, and the political will to prioritize equity.

Review of Literature

In the Indian context, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) has been widely studied as a flagship populist health intervention. Chatwal (2024) finds that PM-JAY has improved access to hospitalization for economically disadvantaged groups but continues to reproduce inequalities due to uneven implementation, lack of awareness among beneficiaries, and exclusion of informal and migrant populations. The study underscores that health insurance based models alone cannot adequately address the multidimensional distress experienced by subaltern communities.

Recent interdisciplinary research also connects social work practice with welfare policy outcomes. Studies published in *Social Work & Society* (2024) demonstrate that social welfare interventions are most effective when combined with grassroots engagement, advocacy, and intersectoral coordination. These findings reinforce that addressing popular distress requires

not only policy expansion but also institutional sensitivity to structural inequalities faced by subaltern communities

Scholars focusing on health equity emphasize the importance of integrating social welfare with community centered approaches. Kruk et al. (2021), through the Lancet Global Health Commission, argue that universal health coverage without quality and accountability disproportionately disadvantages marginalized groups. Their work demonstrates that poor-quality health systems in low and middle income countries exacerbate popular distress, leading to mistrust and underutilization of public health services among subaltern populations.

From a communication and cultural perspective, Dutta (2021) advances the culture centered approach to health, emphasizing that subaltern voices are often excluded from policy design. His work illustrates how top-down populist welfare schemes fail to capture lived experiences of distress, particularly among Dalits, Adivasis, urban poor, and informal workers. Dutta argues that meaningful participation and narrative inclusion are crucial for welfare and health policies to be emancipatory rather than merely populist.

Research Gap

Although recent studies have examined social welfare expansion, populist governance, and health policy reforms, there remains a significant gap in integrating these perspectives to understand how such interventions specifically address popular distress among Subaltern communities. Much of the post 2020 literature evaluates welfare and health schemes in terms of coverage, efficiency, or political intent, but offers limited insight into their structural and intersectional impacts on historically marginalized groups differentiated by caste, class, gender, and location. Moreover, existing research often treats populist health policies as either politically strategic or administratively effective, without adequately interrogating whether they contribute to long-term social and health equity or merely provide short-term relief. This gap underscores the need for a critical, subaltern centered analysis that situates welfare and health policies within broader frameworks of social justice, participation, and structural transformation.

This study addresses the following gaps:

Conceptual Gap: Limited integration of subaltern theory with analyses of welfare populism and health policy, particularly in understanding lived experiences of popular distress beyond aggregate indicators.

Empirical Gap: Insufficient disaggregated evidence on how contemporary welfare and populist health policies differentially impact Subaltern communities across caste, gender, and rural–urban divides.

Objectives

1. To assess how social welfare policies address economic distress among Subaltern communities.
2. To evaluate populist health policies in improving access and reducing health inequities.
3. To identify challenges and suggest policy reforms for equitable outcomes.

Methodology

This research uses a mixed-method approach:

- **Secondary data analysis** from government reports (NSSO, NFHS, Ministry of Health and Family Welfare, Ministry of Rural Development).
- **Qualitative interviews** with community leaders, policy practitioners, and beneficiaries (if primary data collection is feasible).

- **Comparative analysis** of different state initiatives(e.g., Telangana Vs Andhra Pradesh).

Data analysis includes thematic coding for qualitative insights and descriptive statistics for quantitative trends.

The present study adopts a mixed-method research design to examine the role of social welfare and populist health policies in addressing popular distress among Subaltern communities in India. A mixed-method approach is considered appropriate as it enables a comprehensive understanding of the issue by combining quantitative trends with qualitative insights. This approach helps capture both the structural dimensions of welfare and health policies and the lived experiences of marginalized populations, which are often overlooked in purely statistical analyses.

Research Design and Data Sources

The study primarily relies on secondary data, supplemented by qualitative insights. Secondary data were collected from credible government and institutional sources such as the National Sample Survey Office (NSSO), National Family Health Survey (NFHS-5), reports of the Ministry of Health and Family Welfare, Ministry of Rural Development, and policy documents related to major welfare schemes like MGNREGA, Public Distribution System (PDS), and the National Health Mission (NHM). These sources provide reliable information on coverage, access, and outcomes of welfare and health programmes among socially disadvantaged groups.

To enrich the analysis, the study also draws on qualitative evidence from existing field studies, social work reports, and published interviews with beneficiaries, community leaders, ASHA workers, and policy practitioners. The feasible informal discussions and observations from field experiences were used to contextualize secondary findings, particularly in understanding barriers such as exclusion discrimination lack of awareness and service quality.

Sampling and Comparative Approach

The study uses a purposive and comparative approach, focusing on Subaltern communities including Scheduled Castes, Scheduled Tribes, women, and informal workers. A comparative perspective is adopted by examining welfare and health policy implementation across selected Indian states, such as Telangana and Andhra Pradesh, to highlight regional variations in governance, outreach, and outcomes. This comparison helps identify best practices as well as systemic gaps in policy delivery.

Data Analysis Techniques

Quantitative data from secondary sources were analyzed using descriptive statistical methods, including percentages, trends, and comparative indicators related to employment, food security, maternal health, and healthcare access. Qualitative data were analyzed through thematic analysis, where recurring themes such as economic distress, access barriers, intersectional marginalization, governance challenges, and community participation were identified and interpreted. This thematic coding allowed the study to link empirical observations with theoretical perspectives from subaltern studies, social justice theory, and health equity frameworks.

Ethical Considerations and Limitations

As the study primarily uses secondary data and published qualitative sources, no direct ethical risks to participants were involved. However, the research maintains ethical sensitivity by accurately representing marginalized voices and avoiding generalizations. The study acknowledges limitations such as dependence on secondary data, lack of large-scale primary

fieldwork, and possible regional bias. Despite these limitations, triangulation of multiple data sources strengthens the validity and credibility of the findings.

Findings

1. **Social Welfare and Economic Distress:** Programmes like MNREGA have improved rural incomes temporarily but face challenges such as delayed payments, inadequate workdays, and exclusion errors. PDS has reduced hunger but suffers from leakage and corruption.
2. **Health Policies and Access:** NHM and its sub-programmes (ASHA workers, Janani Suraksha Yojana) increased institutional deliveries and immunisation coverage. Yet quality of care, infrastructure deficits, and urban–rural divides remain pressing issues.
3. **Intersectional Disparities:** Caste and gender intersect to exacerbate marginalisation. Dalit and Adivasi populations, especially women, report lower health outcomes and limited welfare access due to discrimination, mobility constraints, and information gaps.

The findings of the study also reveal that social welfare and populist health policies have played a meaningful but uneven role in alleviating popular distress among Subaltern communities. Welfare programmes such as MGNREGA and the Public Distribution System have contributed to short-term income security and food access, particularly for rural and informal workers; however, their impact is constrained by delayed payments, administrative exclusions, and governance deficits. Similarly, health initiatives under the National Health Mission, including ASHA led outreach and maternal health schemes, have improved institutional deliveries and basic service utilization, yet persistent gaps in infrastructure, quality of care, and regional disparities continue to undermine health equity.

Discussion

The evidence suggests that welfare and health policies have *potential* to mitigate distress but are often undermined by weak governance and socio cultural barriers. Effective implementation requires:

- Decentralised planning with community participation.
- Transparent grievance redress mechanisms.
- Targeted funding to underserved areas.
- Capacity building of frontline workers.

The distinction between **populist** (broad, politically driven) and **equity oriented** (structurally transformative) policies is crucial: populist policies may deliver short term gains, but deep equity requires structural change. The discussion highlights that these limitations are not merely technical but deeply structural, shaped by caste-based discrimination, gendered vulnerabilities, and unequal power relations that marginalize Dalit, Adivasi, and informal-sector populations. While populist health policies enhance visibility and political legitimacy, they often prioritize numerical coverage over substantive inclusion, thereby offering symptomatic relief rather than addressing the root causes of distress. This underscores the critical distinction between welfare as political appeasement and welfare as a transformative instrument of social justice.

A deeper examination of the findings indicates that the effectiveness of social welfare and populist health policies is closely tied to the nature of state–society relations and the extent to which Subaltern communities are treated as active stakeholders rather than passive beneficiaries. While welfare schemes such as MGNREGA, PDS, and NHM have expanded

institutional reach, their top-down design often fails to engage with the everyday realities of caste-based exclusion, gendered care burdens, and informal labour conditions.

The study reveals that bureaucratic complexity, digital dependence, and inadequate grievance redress mechanisms disproportionately affect Dalits, Adivasis, migrant workers, and women, reinforcing existing hierarchies of access. From a subaltern studies perspective, this exclusion reflects a broader silencing of marginalised voices in policy formulation and evaluation. Consequently, welfare and health interventions, when implemented without meaningful participation and accountability, risk functioning as managerial tools of governance rather than instruments of social transformation. This discussion reinforces the argument that addressing popular distress requires not only policy expansion but also a democratic reorientation of welfare and health systems that centres equity, dignity, and community agency.

Policy Implications

- **Reform welfare delivery** using digital transparency tools to reduce leakage.
- **Invest in primary health infrastructure** with quality standards and accountability.
- **Strengthen community health worker networks** with adequate remuneration and training.
- **Institutionalise participatory governance** at village and district levels.

From a policy perspective, the study suggests that addressing popular distress among Subaltern communities requires moving beyond fragmented and populist interventions toward integrated, equity-oriented governance frameworks. Policy implications include strengthening decentralized and participatory welfare delivery systems, investing in high-quality public health infrastructure, and institutionalizing accountability mechanisms that ensure inclusion of marginalized voices in policy design and implementation. Enhancing the working conditions, training, and remuneration of frontline health and welfare workers is essential for bridging state community gaps.

An important policy implication emerging from this study is the need to reorient social welfare and health policies from narrowly targeted, scheme-based interventions toward a comprehensive and rights-based social protection framework. Welfare delivery systems must prioritize inclusion by addressing structural barriers such as caste discrimination, gendered access constraints, digital exclusion, and geographic remoteness that continue to marginalize Subaltern communities. Strengthening decentralized governance through empowered Panchayati Raj institutions, urban local bodies, and community-based organizations can enhance local accountability and responsiveness. In the health sector, policy emphasis should shift toward robust public health infrastructure, especially at the primary care level, rather than excessive reliance on insurance-driven or private-sector models. Integrating welfare schemes with health, nutrition, education, housing, and livelihood programmes can better address the multidimensional nature of popular distress. Additionally, institutionalizing social audits, community monitoring, and participatory policy feedback mechanisms will ensure that Subaltern voices inform both policy design and implementation, thereby transforming welfare from a populist promise into a sustainable instrument of social justice and equity.

Conclusion

This study has examined the role of social welfare and populist health policies in addressing popular distress among Subaltern communities in India, situating these interventions within broader frameworks of social justice, health equity, and subaltern studies. The analysis demonstrates that welfare schemes and health initiatives have contributed to

improving access to income support, food security, and basic healthcare services, particularly for historically marginalized groups such as Dalits, Adivasis, women, and informal workers. However, the findings also reveal that the benefits of these policies remain uneven and fragile, constrained by structural inequalities, administrative exclusions, and socio-cultural barriers. Populist health and welfare policies, while politically visible and symbolically inclusive, often prioritize short-term relief and numerical coverage over substantive inclusion, quality of services, and long-term empowerment. As a result, popular distress is alleviated only partially, without fundamentally altering the conditions that produce vulnerability and exclusion.

The study concludes that meaningful and sustainable reduction of popular distress among Subaltern communities requires a shift from welfare as political populism to welfare as a rights-based and transformative project. Such a shift demands stronger public institutions, participatory governance, and policy frameworks that explicitly address caste, gender, and class-based inequities. Integrating redistribution with recognition and participation is essential to ensure that Subaltern communities are not merely recipients of welfare but active agents in shaping policy outcomes. By foregrounding subaltern voices and emphasizing equity-oriented governance, this research contributes to ongoing debates on social welfare and health policy in developing societies. It underscores that addressing popular distress is not solely a matter of policy expansion, but of democratic deepening, institutional accountability, and a sustained commitment to social justice and human dignity.

References

1. Fraser, N. (2003). *Social Justice in the Age of Identity Politics*. Cambridge: Polity Press.
2. Lahariya, C. (2018). "Universal Health Coverage in India." *Indian Journal of Public Health*.
3. Marmot, M. (2010). *Fair Society, Healthy Lives*. UCL Institute of Health Equity.
4. Patel, V., et al. (2015). "Health inequities in India." *Lancet*.
5. Sen, A. (2002). *Health Equity and Social Justice*. Oxford University Press.
6. Khera, R. (2020). Dignity and Daily Wages: The Case for Employment Guarantee in India. Oxford University Press.
7. Dreze, J., & Sen, A. (2022). India: Inequality and Social Justice. Penguin Random House India.
8. Béland, D., & Waddan, A. (2021). "Populism, Social Policy, and the Welfare State." Policy & Politics, 49(2), 169–187.
9. World Health Organization (2021). Social Determinants of Health and Health Equity. WHO.
10. Gupta, A., & Vegelin, C. (2016; updated relevance post-2020). "Sustainable Development Goals and Inclusive Development." Third World Quarterly, 37(3), 433–448.