CHAPTER- I

INTRODUCTION

“We thus find ourselves at a crossroads: health care can be considered a commodity to be sold or it can be considered a basic social right. It cannot comfortably be considered both of these at the same time. This, I believe is the great drama of medicine at the start of this century. And this is the choice before all people of faith and good will in these dangerous times”.

- Paul Farmer

1.1 Introduction

The contribution of human capital to the overall economic growth has been universally accepted. The enhancement of this intangible form of capital through the enrichment of human capabilities has received considerable attention in recent times. Improvement of health status plays a vital role in the enhancement of human capabilities (Sen, 1987). The challenge before the developed countries is to maintain a higher level of health status than what they have already achieved. For the developing countries, the challenge is to attain a better health status. (Gangadharan K., 2005).

Health is one of the most important objectives of development-development means more than economic growth alone, it means the realization of human potential and the satisfaction of basic human needs. Good health is considered as a pre-requisite for economic development and social welfare. A healthy community is the infrastructure up to, which an economically viable society can be built up as unhealthy people can hardly be expected to make any valid contributions. Good health is an important factor for the provision of regular supply of labour as it avoids the disruptions caused by sickness and resulting absenteeism. Good health not only promotes high morale and labour productivity but also produces a positive environment of economic growth. Health has been declared as a fundamental human right. This implies that the state has a responsibility for the health of its people. National Governments all over the world are striving to expand and improve their health care services. Health care, as a right of every individual has been recognized in
many countries. Health of the people is really the foundation upon which all their happiness and well-being depends. Health is not only the starting point of all welfare but also a significant yardstick to measure the progress of a country. By now it is well known that the World Health Organization defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The definition has been modified later to include the ability to lead a ‘socially and economically productive life’. Researchers have identified health as a key determinant of the ability of an individual or group to benefit from a broader set of rights and entitlements.

1.2 Importance of Health

Good health is a pre-requisite to human productivity and development process. Charak, the ancient renowned Ayurvedic physician is known to have said, "Health is vital for ethical, artistic, material and spiritual development of man." Buddha has said that of all the gains, the gains of health are the highest and the best. Health has found an important place in the constitutions of all countries and the UN agencies. Of the thirty articles of the Universal Declaration of Human Rights, Article 25 is particularly concerned with the right to health. A healthy society is a strong society. Therefore, the progress of any nation depends on an efficient healthcare management system. Health has been proclaimed and declared a universal goal and public responsibility. Governments all over the world are responsible for preserving and protecting the human race from all possible hazards of health. Efforts in this direction vary from country to country, depending on their stage of development and on the magnitude of the problems to be tackled in the sphere of health. The common concern for human health and freedom from diseases provided purposeful focal point around which international cooperation has developed over the years.

It is now widely recognized that health is both an input and an outcome of broader social and economic development. It is also well known that achievements in health do not simply depend on the health sector, but arise out of improvements in standard of living, social stability, education, housing, water supply, sanitation and other environmental factors. These are amenable to change by actions taken by households, communities and governments and are usually outside the domain of the health system.
Good health also improves educational attainment and fosters economic growth and political participation. Yet unhealthy behavior, sickness, malnutrition and high fertility are also significant causes of poverty. Health and health services have a major influence on the well being of individuals and societies and are an important part of a nation’s politics and economy. Ill health and poor health services are increasingly recognized as major dimensions of poverty in their own right, so that efforts to combat poverty ought to consider the role of health. Good health is universally acknowledged to be of intrinsic value and, therefore, constitutes an integral element of development. One can be rich but sick enough to, not to enjoy any opportunities that wealth opens up and poor health may translate into worsening economic opportunities as well. There are numerous factors that influence health like hereditary factors, environmental factors, life style, adequate housing, basic sanitation and socio-economic conditions including income, education, availability and quality of health infrastructure and per capita health expenditure (Park K, 1994).

1.3 Why does Health Matter?

For an individual, health has a double function. On the one hand, perfect health represents a value of its own, target that needs to be reached as closely as possible. On the other hand, there are other aims in life as well e.g. good health gives good income in labour market (Zweifel and Breyer, 1997). World Development Report, 1993 explained good health as a crucial part of well-being. It further asserted that spending on health can also be justified on purely economic grounds. Improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in schools and makes them better able to learn; and it makes alternative uses of resources that would otherwise have to be spent on treatment (World Bank, 1993). A further elaboration may make the understanding better.

(i) **Gains in Worker Productivity:** The most obvious sources of gain from healthier workers are savings of workdays, increased productivity, greater better-paying job opportunities and longer working lives.
(ii) **Improved Utilization of Natural Resources:** Some health investments raise the productivity of land.

(iii) **Benefits to the next Generation through Education:** Poor health and nutrition reduces the benefits of schooling primarily in three areas: enrollment, ability to learn and participation by girls. Children who enjoy better health and nutrition during early childhood are better prepared for school and more likely to enroll.

(iv) **Reduced Costs of Medical Care:** The spending that reduces the incidence of disease can result in big savings in treatment costs. For some diseases, the expenditure pays for itself even when all the indirect benefits - such as higher labour productivity and reduced pain and suffering - are ignored. Polio is one such example.

### 1.4 Health Status

Health status is multidimensional in nature and difficult to measure precisely. It is captured through a range of indicators such as mortality, morbidity, anthropometric measures, nutritional status or calorie intake and life expectancy at birth. Among these, mortality and life expectancy at birth are widely used to measure the health status of a population, as they are easily observed, objective and less prone to measurement errors. However, morbidity may be a more useful indicator than mortality, since it is related to the pain and sufferings of the people, while mortality is a terminal event. But the problem with morbidity is that it is difficult to measure without bias. Despite these well-recognized problems and difficulties of measurement, there can be little doubt that good information on morbidity is extremely useful (Sen, 1998).

Health status, in general and morbidity, in particular, are primarily influenced by the behavioral decisions of the individuals or family, besides genetically inherited health endowments and the health environment in which they reside. Thus, illness is not a random event, but one that is systematically related to the household- and community-level factors. In the event of an illness, a majority of individuals seek some form of treatment. The choice of curative health care (public, private, self-treatment and no treatment) depends upon the type of illness, access to service provider, information about the provider, economic status of the individual/household, among others.
1.5 Health and Economic Development

Health is an important determinant of economic and social development, because ill health creates vicious circle by depleting human energy, leading to low productivity and earning capacity; deteriorating quality and quality of consumption and standard of living. Therefore, a nation ought to give adequate attention to the health care of its people. Health is an important aspect of human resource development. Good health care facilities and services are essential for creating healthy citizens and society that can effectively contribute to social and economic development. Human health has come to be regarded as a prerequisite for optimum socio economic development. Human resource development, of which health is an important aspect, has been instrumental in accelerating economic development. Health of the people is really the foundation upon which all their happiness and all their powers as a state depend. Low income, poverty and illiteracy prevent many people in developing countries neglect giving due importance to the primitive and preventive aspects of health care.

Economic growth and development affect the health of the people by increasing their level of income and hence in the consumption - increasing goods and services. It means, there is a positive relationship between health and stages of economic growth and development but it is not always true. In this connection it is useful to note two important consequences of the improvement of health: As population become healthier, they also live long which is known as demographic transition. It occurs due to two reasons. Firstly, when health status of the individual improves, they live longer. Assuming given birth rate, the net addition to the population each year increases, increasing the share of older people in the total population. Secondly, the fertility rate (the average number of children born to a representative woman in her life) may tend to decline (which may not be always true) due to better health and greater economic security. Of course, this has more indirect effect of the change in health status. Secondly, as development proceeds, the pattern of diseases change which is known as epidemiological transition. This has also two effects. Firstly, when some diseases and ill-health are controlled or eliminated, the relative importance of other diseases increases as a matter of arithmetic. Secondly, as individuals live longer, diseases that only affect
older individuals increase in absolute term. Similarly, reduction in maternal mortality leads to larger number of older women and to a greater prevalence of postmenopausal health problems (Himanshu Sekhar Rout and Prasant Kumar Panda, 2007).

Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value. In instrumental terms, health impacts economic growth in a number of ways. For example, it reduces production losses due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children. Health also allows for the use of natural resources that used to be totally or partially inaccessible due to illnesses. Finally, it permits the different use of financial resources that might normally be destined for the treatment of ill health. Economic growth and development affect the health of the people by increasing their level of income and hence in the consumption- increasing goods and services. It, means, there is a positive relationship between health and stages of economic growth and development but it is not always true. In this connection it is useful to note important consequences of the improvement of health: demographic transition and epidemiological transition.

1.6 Determinants of Health

Health of a individual is complicated and multi-dimensional; and influenced by plethora of factors such as income of the person; pattern of educational attainment (schooling); population growth; density of population and age structure; abundance of natural resources; personal and government saving (investment rate); physical capital stock; economic policy, for example liberalization, globalization and privatization; the quality of public institutions; the geography, for example the location and climate of a country; food; housing; basic sanitation; social practices; measures to control environmental hazards; and communicable diseases positively or negatively.
Per capita income is highly correlated with indicators such as life expectancy and infant mortality (as health outcomes), not only in between but also within countries, which is known as income health linkage. This is because of two reasons. First, as income increases, it has become easier, or cheaper, to attain and maintain a given level of health over time. Second, individuals' preferences have been changed over time and that, for a given level of income, individuals have become more concerned about health. The close linkages between the two (income and health outcome) have not been fully appreciated (Mishra, Chatterjee and Rao, 2003).

The determinants of health constitute an issue of vital importance to health policy, in establishing the effects of various non-medical factors on health such as unemployment or income. The first economist to present a formal model on the determinants of health was Grossman (1972 a, b). Drawing on the theory of human capital by Becker (1965), Grossman constructed a model where individuals use medical care and their own time to produce health. Individuals were assumed to invest in health production until the marginal cost of health production equaled the marginal benefits of improved health status. The health status was assumed to affect utility both indirectly through raising labor income and directly by assuming that individuals value good health per se. Health is influenced by a number of factors such as adequate food, housing, sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases.

1.7 Health care

Healthcare has been defined by the World Health Organisation (WHO) as "A programme of services that should make available to the individual and thereby to the community, all facilities of medical and allied sciences necessary to promote and maintain health of mind and body." Healthcare remains one of the most important human endeavours to improve the quality of life. Healthcare services, life styles, culture, economic conditions and climate, influence the health conditions of the citizens in a country. Healthcare may be viewed as the provision of a range of healthcare services by professional, technical and supportive health workers, with in-patient, out-patient and home health facilities. The development of healthcare facilities is influenced not only by the opening of hospitals or healthcare centres, but more so by their proper administration.
and management. The main objective of any healthcare system is to facilitate the achievement of an optimal level of health to the people through the delivery of services of appropriate quality and quantity. Increasing availability and awareness about the technological advances for management of health problems, raising expectations of the people and the ever-escalating cost of healthcare are some of the challenges that the healthcare systems have to cope up with. Healthcare delivery systems will have to gear up to taking up necessary preventive, promotive, curative and rehabilitative healthcare for the population.

1.8 Demand for Health Care Services

Anything that increases the demand for health should increase the demand for health care, other things being equal. For instance, higher wages, which make health days more valuable, should increase the demand for health and health care (Johnson-Lans, 2006). An exception would be when the time price of health than the expected value of health care (Johnson- Lans, 2001). The demand for health care also depends on the particular function for health. Production functions are always constructed assuming a particular technology. Technological inputs in health care have increased the use of medical inputs in the production of health. They have also increased expectations about attainable health and therefore have increased the demand for health itself. This then increases the demand for health care. The effect of education on the demand for health care is not as predictable. If education makes a person more efficient in producing health, an increased awareness of the value of good nutrition and prevention of disease will reduce the quantity of health care required to produce a given stock of health. Education can also increase the demand more health, but less health care, if the effect of education on the productivity of inputs into health out weights the shift in the demand for health. Empirical research provides evidence of the ambiguity of education on the demand for health care (Wagstaff, 1986).

The effect of age on the demand for health care has been found to vary by type of health care required. For example, in an early study the demand for ambulatory care, such as seeing a physician during a given year, decreased significantly with age, but the demand for inpatient services and pharmaceuticals increased (Newhouse and Phelps, 1974).
However, when the health status is included in the estimation including age on the demand for health care, age is no longer significant. It appears that the deterioration in health status that accompanies age, rather than age itself, increases the demand for health care (Zweifel, 1985).

At face value, Grossman’s theory (1972) provides a reconciliation of these two views because people want health improvements and demand care that will produce these improvements. However, need is more complicated than that. Need implies that there is an imperative to have health care because it will address health problems. People have limited knowledge about health problems and the care that will resolve them. In contrast, the usual assumption of economics is that in making demands, people are the best judges of their own wants (Johnson- Lans, 2006). Demand simply implies the willingness and ability to pay for health care. Needs and demands can therefore be regarded as two very different ways of viewing matters, but considered together they give useful insights. Two extreme positions might arise. Sometimes there may be a demand with no need. People might be pessimistically mistaken about the possibilities for improving it. In practice, the more important case is that there might be need where there is no demand and if health services only responds to demand, then there is unmet need. Some of the unmet need will be due to deficiencies in information. Unmet needs may also be due to barriers to health care, such as supply factors (e.g, the availability of services to meet needs) and demand factors, such as prices and income levels which affect a person’s ability to access services (Morris et al., 2007) (Diane M. Dewar, 2010).

1.9 Health and Labour Market

The literature suggests that health has an effect on most outcomes of interest to labour market economists, including wages, earnings, labour force participation, hours worked, retirement, job turnover and benefit packages. For certain groups, such as single mothers and older persons, health is thought to be a major determinant of wages, hours and labour force participation. Certainly health is very important in retirement decisions, although there is no consensus about the magnitude of its impact or about its size relative to the effects of other variables. It is important to distinguish between health events that lead to an inability to explain retirement decisions fully and declining health status, which
leaves the option to stay in the labour market. To get an idea of the likelihood and timing of a retirement decision it is crucial to control for the health of an individual. An understanding of the effects of health on labour market activity is important for three other reasons: first, to assist in evaluating the cost-effectiveness of interventions designed to prevent or cure disease; second, to help assess the effectiveness and viability of such programmes, given that the relation between health and labour market participation is mediated by other social programmes and third, in the context of population ageing, more individuals will reach the age where health has the greatest impact on labour market outcomes.

It is a well recognized fact that the contribution of the informal sector to the Indian economy is enormous. It is estimated that about two-fifths of the country’s gross domestic product originates from and almost 90 per cent of families earn their livelihood from the informal sector. Despite this fact, a large number of workers engaged in the informal sector in both rural and urban areas are illiterate, poor and vulnerable. They live and work in unhygienic conditions and are susceptible to many infectious and chronic diseases. A vast majority of them neither have fixed employer–employee relationships nor do they get any statutory social security benefits. This implies that workers in the informal sector do not get health care benefits, paid leave for illness, maternity benefits, insurance, old age pension and other benefits. They receive very low wages; and, as own-account or self-employed workers, they obtain meager piece-rated earnings. At the same time, most workers of the unorganized sector have not formed their unions or associations. They thus remain without their representative organizations, which could otherwise help them, fight against the many injustices they face every day. They also do not have the bargaining power or collective strength to demand just policies and laws, including laws for social protection and social security. (Ahmad et al.,1991).

1.10 Health Problems in Urban Areas

At the beginning of the 19th century only 3 per cent of the people in the world lived in urban areas. This figure risen to 10 per cent at the turn of the 20th century and increased to 25 per cent in 1950, 46.1 per cent in 1997 and is projected to about 54.4 per cent by the year 2015 (Govt. of Kerala 1997). In India urban population has been growing at a rate
of 3.8 per cent during 1971-81, which was higher than that of the 2.4 per cent national growth of population. Urban population, which was 77 million in 1961 (18 per cent), increased to 156 millions in 1981 (23.34 per cent). As per the 2001 census that accounts for 27.78 per cent of the total populations (Gangadharan K., 2005).

Generally, it is assumed that people in urban areas are well covered by health services saturated with large hospitals, innumerable dispensaries, nursing homes, specialists and general practitioners. In spite of such concentration of health facilities in the cities compared to rural areas and relative proximity of hospital and other facilities, standards of health care seem to have fallen far below reasonable minimum levels for those who live in slums. There is a phenomenon of an “inverse care law”, whereby those who are in greatest need of medical care have poorest access to it. While the principles of delivery of primary health care are equally applicable to urban health system as to the rural health, the slum population remains ignored on this account to this date. There also exists a vast discrepancy between the qualities of health care delivered by the private sector within the different sections of urban population. The health delivery system of an urban area, particularly that of large cities, consists of hospitals, dispensaries and maternal and child health and urban family welfare centers run by the Government, Municipal Corporation, Central Government Health Scheme and Employees State Insurance Scheme. The presence of large number of hospitals and outpatient departments had almost certainly a depressing effect upon the development of a more coherent health infrastructure in cities. Network of health centers and sub-centers such as those planned in rural areas do not exist in urban situations. In practice, many people inevitably lead to highly curative and irrational approach to health care. Emphasis on cure has been at the cost of preventive and public health measures. Health professionals and workers are not properly motivated to serve the weaker sections of the community. The urban poor live with or die from their burdens of disease and despair. Urban health problems are both easier and more difficult to manage than in the rural settings, easier because of access, greater readiness for change and more resources; more difficult because of social fragmentation, heavily contaminated environments and political instability.

Workers in poor countries of the so-called Third World are more likely to be affected by the dangers of high technology than their counterparts in wealthier countries.
Owing to their lack of education, most workers in the "developing" world are unaware of the hazards of their occupations. Moreover, their general backwardness in sanitation and nutrition and climatic proneness of their geographic region to epidemics cause diseases contracted from the work environment to be aggravated. Occupational diseases are often misconstrued as diseases resulting from the general environment. Since unemployment in underdeveloped countries is of a very high order, workers are prepared to accept any job, irrespective of the dangers involved. Labor is cheap and easily replaceable, so employers see no need for improving occupational safety and health. Labor unions are mostly controlled by full-time politicians who consider health a political issue, especially when their party controls the country's government. The seriousness of all these factors is heightened by the existing socioeconomic order in poor countries, in which national medievalism and multinational modernism play a crucial role. Unorganised labour which contributes about 90 per cent of the total workforce in the country remained a neglected lot especially for the lack of protection on safety and health.

1.11 Health and Safety of Workers

Work plays a central role in people's lives, since most workers spend at least eight hours a day in the workplace, whether it is on a plantation, in an office, factory, etc. Therefore, work environments should be safe and healthy. Yet this is not the case for many workers. Every day workers all over the world are faced with a multitude of health hazards, such as: dusts, gases, noise, vibration and extreme temperatures. Unfortunately some employers assume little responsibility for the protection of workers' health and safety. In fact, some employers do not even know that they have the moral and often legal responsibility to protect workers. As a result of the hazards and a lack of attention given to health and safety, work-related accidents and diseases are common in all parts of the world.

Health and safety of the workers is an important aspect of an industry’s smooth and successful functioning. A safe and healthy work environment is the basic right of every worker. However, the global situation falls far short of this right. The International Labor Organization (ILO) estimates that more than 125 million workers are victims of occupational accidents and disease in a single year. Of these approximately 2,20,000 workers die and about 10 million are seriously disabled. With world population increasing, the
above figures are expected to rise significantly if present conditions prevail. The situation is grim in the Third World. About 75 per cent of the global workforce lives and works in Third World countries which have so many serious problems like poverty and unemployment that the status of health and safety is very low. There are almost 820 million unemployed people in the Third World. South Asia. India has a very poor health and safety record. Much legislation exists to protect workers rights and health but they are not implemented properly and only an elite of workers enjoy the benefits. Of the total workforce only 8.8 per cent are organised. The workforce is abundant, low skilled and easily available and the high rate of unemployment makes them susceptible to exploitation. Getting work is more important than the hazards involved (M. Peer Mohamed Sardhar, 2011).

Poor working conditions of any type have the potential to affect a worker's health and safety. Unhealthy or unsafe working conditions are not limited to factories - they can be found anywhere, whether the workplace is indoors or outdoors. For many workers, such as agricultural workers or miners, the workplace is “outdoors” and can pose many health and safety hazards. Poor working conditions can also affect the environment workers live in, since the working and living environments are the same for many workers. This means that occupational hazards can have harmful effects on workers, their families and other people in the community, as well as on the physical environment around the workplace. Overall, efforts in occupational health and safety must aim to prevent industrial accidents and diseases and at the same time recognize the connection between worker health and safety, the workplace and the environment outside the workplace.

1.12 Healthcare Insurance

People buy insurance because they are risk-averse. Buying insurance allows a person to pay a certain known amount in order to transfer the risk of a much larger expenditure (in the case of an adverse event) to an insurer, known as a third party payer. Firms sell insurance because they are paid to assume a risk that can be managed by spreading it over a large pool of the insured. Insurance markets exist where consumers are willing to pay enough to transfer risk to induce insurance companies to assume the risk. (Johnson-Lans, 2006). There are a number of types of risk associated with health.
There is the risk to one’s health and life associated with illness or disease. There is the additional risk that if one undertakes treatment, it may or may not cure or alleviate symptoms of disease. There are also the costs associated with the treatments of illness and disease. A person can take action to reduce the risk of illness and disease. A person can take action to reduce the risk of illness such as getting vaccines, avoiding unhealthy environments and leading a healthy lifestyle. One cannot insure against bad health outcomes, though. However, people can insure themselves against some or all of the financial loss associated with the treatment of illness by buying health insurance policies (Johnson-Lans, 2006).

People do not generally self-insure by saving money when well to use in times of illness. Much of this is due to the fact that people cannot save enough for catastrophic illnesses. Even people with extensive wealth buy insurance due to the fact that most people are “risk-averse”. Economists define risk aversion as a characteristic of people’s utility functions. Consumers’ attitudes toward risk depends on the marginal utility of an extra dollar that may be different in different ranges of wealth. If the marginal utility of wealth decreases as wealth increases, there is a small probability of a smaller amount of wealth when the probability weighted or expected value of the alternatives is equal. That is a situation of risk aversion. Risk loving people gamble when gambling involves an unfair bet. Betting on lotteries would be rational behaviour in a range of wealth when the marginal utility of an extra dollar is increasing. In general, it is assumed that people are more likely to buy insurance to cover low probability events involving large losses than high-probability events that are associated with small losses and they are more likely to buy lottery tickets when there is a low probability of winning a large amount (Johnson-Lans, 2006).

- **Moral Hazard**

Moral hazard refers to the phenomenon of a person’s behaviour being affected by his or her insurance coverage. Moral hazard is known to exist in all types of insurance markets. For example, people may be more careless with property that is insured. The main way that moral hazard comes into play in the health insurance market is through an increase in demand for healthcare services utilized.
• **Adverse Selection**

Adverse Selection exists when people with different health related characteristics than the average person increase the amount of health insurance purchased. People know more about their own health status than insurers and this inequality of information is the basis for risk to insurers due to adverse selection. In the health insurance market, high risk people are those with more severe health problems than the average person. These people would be overrepresented in the insurance markets, particularly those markets with more inclusive policies. This would drive up the premium because the high risk persons would use more health care and drive off those with better health from buying the insurance policies. The existence of adverse selection is an argument for a single payer plan because those with higher risk would not be able to pick their insurance plan and everyone would be in the same insurance pool (Johnson-Lans, 2006).

1.13 **Statement of the Problem and Need for the Study**

People constitute the valuable human resources needed for the development of any country. It is needless to say that the development of the national economy rests on the health, ability and well being of the people. The promotion and protection of health of the people is essential for sustained economic and social development. In fact, health is an important input in any process of development. In assessing a country's resources for economic development, the health of the people should be reckoned with. In a country like India, the problem of health is an enormous one, where the majority of poor is outside the effective medical network. The government hospitals have not failed to equip poor to become customers in basic medical services nor have they provided them free effective medical services. In the Indian environment, where majority of the government hospitals are found in a deplorable condition, it is need of the hour that charitable trusts, voluntary agencies, private hospitals and corporate sector come ahead and carry forward the task of making available to the society the best possible health services.

A direct consequence of inadequate official attention to health matters is that, the Indian population continues to be exposed to a high incidence of communicable diseases and readily preventable illnesses. Communicable diseases are seen to be responsible for more than half of the burden of disease in India (Murray and Lopez 1996). Many basic illnesses that have radically declined in large parts of the developing world in recent
decades (such as tetanus, measles, pneumonia, leprosy, malaria, hepatitis and tuberculosis etc.) continue to be common in India. To illustrate, India’s share of worldwide leprosy cases is estimated to be as high as 68 per cent (Antia.W.H.,1999). It is worth noting that the burden of disease falls very unevenly on different sections of the population. Indeed, health inequalities are very sharp in India, in comparison with many of the other countries, even of the poor ones (Antonovsky and Aaron, 1967).

It is obvious that the vast majority of our populations still have no access to decent health care. There is a general feeling among people that Government-run health services are not up to their satisfaction. This is both in terms of quality and coverage. All does not interpret the term health care uniformly. Some use it comprehensively to include both medical treatment of diseases and promotion of health status. Others, however, equate it with the medical and curative services only. In practice, Government health care services are unfortunately, curative with only little public health component. The Government has been spending quite a lot of money for setting up Primary Health Centers, Sub-Centers, Community Health Centers and hospitals, yet a large population has no access to health care services at all and what they received does not alleviate their problems. It was a widely shared view that the Government hospitals were not able to make significant dent on the health status of the population. They fell short of expectations because they did not meet the laid down objectives adequately.

Regarding expenditure pattern, an average Indian household spends Rs. 250 per capita per annum on the use of health services (Shariff et al., 1999). For the urban households the figure is about 40 per cent higher than their rural counterparts. As for health insurance, most Indians are not covered by any insurance schemes, but the small minority that are covered, mostly belong to the organised urban sector; the rural population has almost no insurance coverage at all, formal or informal (Ellis et al., 2000, Gumber and Kulkarni, 2000). It is estimated that a small fraction of less than 9 per cent of the Indian workforce is covered by some form of health insurance, through Central Government Health Scheme, Employee State Insurance Scheme and Mediclaim (Gumber and Kulkarni, 2000).
It is by now well established that most Indians pay large amounts out-of-pocket for covering their health costs: three quarters of health spending in India comes from households’ out-of-pocket disbursements (Berman 1998, Ellis et al., 2000). If one takes only primary curative care, household spending forms the majority of this expenditure in India. In addition to just expenditure, the elaborate government health care system belies the fact that the private health care sector has grown at a phenomenal rate and today form an equally significant part of the health system in India. About 57 per cent of hospitals and 32 per cent hospital-beds are in the private sector (Bhat 1999). It has been observed that with the growth in income, high purchasing power and the expansion of the middle class urban India has witnessed a tremendous growth in the private health care system (Sundar 1992, World Bank 1993).

Data from National Sample Survey Organization (NSSO) have shown that all income groups spend their savings, borrow money or sell assets to meet hospitalizations cost. It is also indicated that health care cost is one of the reasons for indebtedness not only among the poor but also in the middle-income group. It is therefore, necessary to share the cost of severe illness and hospitalizations among individuals, organizations and the state. Shortage of qualified health personnel, inadequate and irregular supply of medicines, inadequate training facilities for the different categories of staff required are some of the other factors which discourage the people from utilizing fully the health care services provided by the Government.

The health status of urban population is peculiar in character as majority of them are floating population and the awareness of urban industrial workers about various health problems like curative, maternal and child health differ widely due to differences in their socio-economic set up. The vulnerable sections in the urban areas are suffering from morbidity problems especially diseases of poverty and are not having enough access to health care services. Due to the low income, they provide first priority to food and later only for treatment. Since income being low, they first usually approach the public hospitals, but the poor and inadequate services rendered by them compelled to go for private health functionaries competent enough to handle the user’s problem is also crucial. Laboratory facilities and supply of drugs needed for diagnosis and treatment often play a vital role in determining access to health care services. Access to health care
Financial barrier is still a dominant problem for access to necessary healthcare for majority of the Indians. To ensure universal and comprehensive healthcare to its citizens, alternative healthcare financing strategies like health insurance are being widely accepted. However, despite health insurance being an equitable and efficient solution, the health insurance coverage still remains at an infant stage in our country.

It has to be recalled that India does not have a history of a high level of health insurance coverage at once upon a time and the coverage falling to the present level so that we have enough lessons to list out why the health insurance coverage is at very low level. In fact, so far there have been no significant studies that have addressed this particular issue. From a demand side perspective, several studies indicate that people are willing to pay for health insurance (Dror et al., 2007; Gumber and Kulkarni 2000; Mathiyazhagan 1998; Sodani 2001). Moreover, the existence of a partially subsidized public healthcare system, absence of proper awareness on risk pooling forms of health insurance, poor trust in insurance companies and the inability of the people in the informal sector to deal with insurance companies are some of the other plausible reasons for the low level of health insurance intake in India (Vellakkal, 2008).

Industrialization is necessary for prosperity and at times for the survival of a nation. The production is the real wealth of a Nation. Only industrialization is not enough, real benefit is brought by continuous top performance of the worker which is only possible by their good health. Industrial workers constitute only a segment of general population and the factors that influence the health of the population also apply equally to industrial workers. Health seeking behaviour of industrial workers is undoubtedly an issue that calls for more research by experts and activists. Respiratory problem is one of the major health threats to textile workers. It leads to some systemic symptoms in exposed workers, along with a number of other physical problem like, hearing loss or noise problem, low back pain respiratory symptoms and pulmonary functions.

Despite a large and extensive public health care system there has always been some criticism regarding its quality and accessibility, especially in the recent past (World Bank, 1997). With regard to the direct provision of public services, the entire
system is grossly overloaded and under-funded. Problems like crowded outpatient departments, poor physical conditions of the infrastructure and primitive health information continue to remain in the public health care system. On the other hand the private sector which is easily accessible and is seen as delivering better quality services is much more expensive and is largely supported by direct out-of-pocket payments. This discrepancy in the cost of treatment in the private sector is much higher in the urban areas than in the rural areas. For instance, according to the NSS survey, the average cost of treatment involving hospitalisation in the private sector was 350 per cent higher than the public sector in urban areas; whereas for the rural areas the figure was 150 per cent high (Gumber and Berman, 1995).

Healthcare insurance system has been in vague in India for the past several decades. These are, once dominated by government run insurance agencies like General Insurance and Oriental Insurance is now open for other organisations too. Now the healthcare market is witnessing several players offering health insurance schemes to mitigate the expenditure that may arise due to unforeseen disturbance in the health of individuals. Varieties of policies exist in the market that suits the differing needs of persons seeking to insure their health. But are the workers really aware of such kinds of policies that are in force? How do they come to know about such policies? Is it true that those who have become aware of such insurance programmes have taken up policies to ensure that they incur less when they become sick? If no, what has forbidden them? Has price of insurance remained a prohibitive factor? If yes, are the workers prepared to come under an insurance cover the cost of which is the least? In order to seek solutions to these questions, the present study has to be undertaken. India’s under funded public sector and its extensively used but largely unaccountable private sector cannot hope to meet the country’s enormous, growing and shifting health needs. If India continues on its present path, the mismatch between its health system and its health problems will became only more severe. The present moment is a decisive one because the government of India is now seeking to define a better health system for the country, one that can take better advantage of the capacity of the private sector and deliver better service and outcomes for all regions and socioeconomic groups. Over the years, though the researchers, academicians and governments have tried to find ways and means to this, many issues and aspects of
health, viz. provision of quality services and an effective delivery system, managing health expenditure and its financing and adequate expansion of service network to rural and tribal areas to achieve equity in access to health care are yet to be completely resolved. Little attention has been paid to the micro aspects of health economics by the researchers, government, policy makers and the development planners. In the process of urbanization, the cities are swelling due to population growth. This has resulted in further deterioration of physical environment in these cities not backed by adequate expansion of civic amenities as well as health and other service. Though all types of health facilities are available in our cities, not all sections of the society are benefited by these facilities. The worst sufferers in the urban areas are the people belonging to the economically weaker sections of the society.

The above stated problems have direct impact on the workers of textile and foundry (engineering) sectors. Hence, an attempt is made in this study to bring to light the actual problems faced by these workers in availing the health care services either from government or private hospitals. The availability of both Government and private hospitals in the delivery of health care services vis-a-vis the perception of the target population of these services can be effectively evaluated on the basis of the result of the study. Hence, it was thought important to study the choice of health care services and enrolment of health insurance schemes among industrial workers.

1.14 Objectives of the Study

The main purpose of the study is to examine the choice of health care services and to analyse the enrolment of health insurance among industrial workers in Coimbatore city. Keeping this in view the following specific objectives have been set for the study:

- To examine the Socio economic background of the sample industrial workers.
- To analyse the Health Seeking Behaviour and Choice of Health care Services by the Sample Respondents.
- To examine the Cost incurred for Illness and Source of Finance for the Industrial Workers
- To study the Enrolment of Health Insurance Schemes for the Industrial Workers.
1.15 Scope of the Study

The interaction between man and his working environment may lead to betterment of health, when work is fully adapted to human needs and factors or to ill health, if work stresses are beyond human tolerance. Occupational diseases and injuries result from specific exposures at work. In addition, work exposures may aggravate certain illnesses or be a factor of varying importance in causing diseases. As both industries are in the forefront of the industrial growth and accommodate the major chunk of the work force of the country, concerted and concrete efforts for enhancement of better health status and the impact of health insurance among them would do a lot to improve the morale and motivation of the employees and as a result there would be improvement in the health of our Indian industry.

The study attempts to examine the choice of health care services and the details about the enrolment of health insurance among workers of selected industries in Coimbatore. The main reason for selecting textiles and foundry industries for the study is that, these industries are prime industries in Coimbatore. Coimbatore has been selected for the study because it is the capital of the district in terms of business development, industrial and population growth. Coming to healthcare services, while many cities have witnessed growth of public and private limited enterprises, Coimbatore has witnessed an unprecedented growth. In fact, it has been described as a 'medi-city' since it has the largest number of corporate hospitals compared to many other cities in India. People from all over the state and some parts of the country come to these hospitals for quality treatment. Therefore, in view of these positive factors, the textiles and foundry industries in Coimbatore are chosen for the study to obtain the required information and necessary insights.

The results of any study in health economics will be useful in the field of Human Resources Development as health is an important factor of human resources. The study would be useful for estimating the choice of health care services in future. The number of people, affected by various diseases is on the increase. The present study would bring out the availability and adequacy of health facilities in the study area. Therefore, the study of the people's perception of health care services would
indicate the line of improvement to be made in the health care services in future. The study will be much useful to the Government, health administration and planners. The students of health economics would find this study useful, as it would add it to their knowledge.

1.16 Research Methodology

The various aspects of research methodology adopted for the present study relates to the research instrument, population profile and sampling, coverage, collection of data, coverage and data analysis and limitations are presented below:

(a) Research Instrument

A structured, interview schedule was prepared for the purpose of collecting the data. The enrolment of health insurance schemes, choice of medical facilities and cost incurred for illness were drawn out from the related studies and the statements of the schedule were framed representing these factors. These were given a shape in consultation with the field experts.

(b) Population Profile and Sampling

The study was confined to Coimbatore City of Tamil Nadu. This city was selected, keeping in mind that it is well endowed with human resources. The decision to select foundry and textile industries is due to the fact that the industrial activity in Coimbatore region depends more on these units and the workers of these units are prone to health hazards due to pollution. It is essential for them to know their choice of treatment, sources of finance and health insurance facilities. Questions relating to personal profile of the respondents demand for healthcare services, healthcare seeking behaviour, factors related to healthcare choice, extent of healthcare expenditure and enrolment of health insurance schemes among industrial workers are included in the schedule. The present study relates to the health care services in urban Coimbatore. It was decided to collect the necessary information from approximately 1500 employees of both the industries by providing equal representation. However, while collecting data from these workers, 41 workers did not respond and 12 workers were not available. Thus a total of 1447 employees were selected for the final study.
(c) Coverage

Coimbatore is the third largest city in Tamil Nadu-India, it has more than 40,000 small, medium and large-scale industries, which serve the engineering needs of the major parts of the country. The city is known for its dynamic people and excellent infrastructure. The entrepreneurial spirit of the business community here is renowned across the country. Besides Textiles, the city today has evolved itself into a diversified economy with Engineering, Auto Components, Pumps and Motors (Out of every two water pumps produced in the country one is from Coimbatore), Foundries (One among the six major centers in India) and the educational institutions (the highest density in the country: 84 in 75 Square Km) which produce about 40,000 graduates of various disciplines a year. The city is the second largest software producer in Tamil Nadu, next only to Chennai. It has been decided to confine the study area to Coimbatore city as it has all the necessary characteristics for conducting a study of this kind. Coimbatore is one of the most industrially developed Districts in Tamil Nadu and has the pride of being called the “Manchester of South India”. Different types of Industries are in operation here. However, Textile and Foundry (Engineering Industry) are the prime Industries that exist in Coimbatore.

(d) Collection of Data

For collecting the data, the respondents were contacted individually and given a brief description about the nature and purpose of the study. For the convenience of the respondents the statements were translated into vernacular language so that the respondents could respond with ease. Data required for the study are to be collected through interview schedule which will be administered among the workers of foundry (engineering) and textiles industries in Coimbatore. Apart from this, secondary data relating to textile industries were collected from South Indian Mills Owners Association (SIMA), South Indian Textile Research Association (SITRA) and Small Spinners Association (SSA). Foundry industries data are collected from Coimbatore District Small Scale Industries Association (CODISSIA), The South Indian Engineering Manufacturing Association (SIEMA), Coimbatore and District Industrial Center (DIC), Coimbatore. At the first stage, the name and the addresses of the Industrial units will be identified.
In the next stage number of workers employed in textile and foundry units would be identified based on the number of units and the total workers have been chosen at random depending on the number of employees on the roll at the time of the study.

Primary data forms the basis for the study. Data required are collected through interview schedule. Convenient Sampling method was adopted and it is proposed to take around 1500 samples from the above said unorganized industrial workers. Questions relating to personal profile of the respondents, health seeking behaviour of the workers, demand for healthcare services, extent of healthcare expenditure and source used to meet-out such expenditure and the problems/benefits availed from health insurance schemes was included in the schedule.

(e) Data Analysis

Both descriptive and quantitative tools were used for the analysis of data. Descriptive methods of analysis like simple averages and percentages were in addition to Graphs and diagrams were used in this study for easy understanding. Appropriate statistical tools were used to draw inferences from the data collected. Health Insurance enrolment and choice of healthcare services of the respondents were analyzed through Logistic Regression techniques.

1.17 Limitations of the Study

The study suffers from the following limitations.

1. Since the health status is sensitive to seasonal factors, this raises the issue of reliability of rates reported from the present study based on a single time point. Hence the rates and pattern of illness captured by this study pertains to only a specific period of the year namely the end of summer and starting of monsoon. So the chances of infectious illness may be slight less compared to the monsoon period.

2. Measurements of illness are based on self-perceived basis, most of the deprived sections neglects fever of short duration (i.e. one or two days) as acute illness. If it is also included then morbidity rate would have been much higher.

3. The researcher have not discussed the comparative study of the workers in foundry and textile industries.
4. This study is not focused on the gender discrimination in the reference to differentiation in wages of the workers in both the industries.

5. Health department officials claim that they have no information about workplace accidents because employers, attempting to avoid media attention or enquiry by the police, seek treatment for most injured workers at private hospitals. Mainly for this reason the researcher is not very successful in documenting specific cases of work-related accidents in Coimbatore foundry industry.

1.18 Chapterisation

The research work is divided into nine chapters.

The first chapter presents a vivid picture of the need for human resource development and Health Economics. The link between health and economic development are elaborated. The significance of public health care services is highlighted. Objectives, methodology and limitations of the study are presented.

The second chapter deals with the review of literature of the study. Concepts and terms used in the study are explained. The theoretical aspects of the concepts and a detailed analysis of earlier studies are also discussed in this chapter.

The third chapter highlights the health profile of India, Tamil Nadu State and Coimbatore.

The fourth chapter gives a general description about the socio economic background of the sample workers in the study area.

The fifth chapter elaborates the analysis of health seeking behaviour and choice of hospitals of the sample workers in Coimbatore city

The sixth chapter explains the health care expenditure and sources of finance by the industrial workers against illness.

The seventh chapter analyses the details about enrolment of health insurance among the industrial workers.

The Eighth chapter summarizes the findings, the conclusions and the suggestions for further study.