8.1 Introduction

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. This draws our attention towards the healthcare sector (Ramanujam, 2009).

In assessing the country’s resources for economic development, the health of the people is considered as an important factor. A healthy individual is an asset to a community, while a sick person is a liability. Health of the individual is depending on the availability of health services and healthy environment. The right to health is the most basic of all human rights. The constitution of the World Health Organization asserts that, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. This means that every human being has the right to live in an environment with minimum health risks and have access to health services that can prevent or alleviate their suffering, treat disease and help maintain and promote good health throughout the individual’s life. Many people, living in India, are being denied this basic human right. The people of Coimbatore are not an exception to this situation. The vast majority of the country’s population still have no access to decent health care. Even though health care measures are available to some extent, the majority of population suffers due to inadequate health facilities, non availability of doctors and their services.

8.2 Industry and Health 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 220,000 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 percent 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 percent 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. 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. Pertaining to the above problems, the following issues are raised. What is the nature of health seeking behaviour of the industrial workers? To what extent various diseases affect the industrial workers? How the workers make the choice between private and
Government hospitals? What is the perception of people with regard to existing health insurance schemes? In this background, the present study seeks to achieve the following objectives. To analyze the socio economic status of the workers, to study the health seeking behaviour and choice of healthcare services, to explore the health care expenditure and sources of healthcare finance and to study the enrolment of health insurance schemes by the sample workers in the study area.

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.

8.3 Dimension

Coimbatore also known as Kovai is the second largest city in the state of Tamil Nadu. It is the administrative headquarters of Coimbatore District. Known as Manchester of Southern India, it is also a part of Kongu Nadu region of Tamil Nadu situated on the banks of the Noyyal River. Coimbatore is known for its textile factories, engineering firms, automobile parts manufacturers, healthcare facilities, educational institutions, pleasant weather, and hospitality and for its Kongu Tamil. Now there are over 5000 small, medium and large textile mills. The black soil, good rains and water resources had made this place a major agricultural centre. Cotton is grown in bulk and this made Coimbatore a Textile City. In spite of its prominence as a bustling industrial city,
Coimbatore still remains one of the most pollution free cities in India. There are more than 30,000 tiny small, medium and large industries and textile mills. The city is known for its entrepreneurship of its residents. The climate is comfortable round the year, so it is called Poor Man's Ooty.

Fast pace of industrialisation, spiraling population and the increase in the health awareness have led to the growth of the healthcare industry in Coimbatore. The city stands second to Chennai in the TamilNadu for highly affordable and quality healthcare deliveries of international standards. Coimbatore is also the preferred healthcare destination to the floating population from nearby towns and districts and also nearby districts of Kerala. The growth of the hospitals in the city can be attributed to the vision of the industrialists here to bridge the gap between growing health needs and the existing services. Many of the private hospitals in the city are promoted by industrialists as an extension of their business portfolio and their service to the society. The first healthcare centre started in 1909 later became the Coimbatore Medical College Hospital (CMCH) during 1960s. The history of large private players coming to the healthcare scenario started with the commencing of the G Kuppusamy Naidu Memorial Hospital (GKNMH). It was started 50 years ago by the Kuppusamy Naidu Memorial Trust primarily as a specialty hospital for gynecology and pediatrics. Over years, it developed into a multi specialty hospital with 300 beds. Notably, majority of the big private players in the city are registered as trust hospitals. The ushering in of the corporate multi specialty hospital a decade ago has intensified the competition among the private hospitals. This intense competition has necessitated advanced medical technology and better patient care. Few of the super specialty hospitals in the city have also slowly moved into specialties like cardiac care, cancer treatment and eye care. Amidst the super specialty and multi specialty hospitals also function wide range of specialty hospitals.

8.4 The Approach

The research design of the study includes the Area of the study, selection of sample, collection procedure and tools of analysis. Quantitative tool like Logistic Regression was used for statistical analysis. Variables, used in statistical analysis are respondent’s choice of medical and health facilities, gender, current age, nativity status,
community, educational status, monthly family income, consultation time, waiting time at health facility, quality of service, government health facility nearer to household, having a family doctor, enrolment in health insurance schemes and socio economic variables.

8.5 Summary of Conclusions

The findings of the study are highlighted below according to the objectives.

8.5.1 Findings Related to the Socio Economic Status of the Sample Industrial Workers

In order to find out the socio economic status of workers, first the personal profile of respondents like sex, age, caste, education and occupation are considered important as they influence the family status. The socio economic analysis of the industrial workers reveals that the health needs of the people differ across age, sex, religion, community, marital status, native place, educational qualification and migration status. It is found in the study that a majority of respondents are in the age group of 15 to 29 years, mostly men. While the backward caste constitutes the majority, the scheduled caste workers are small in number and forward caste are almost negligible. Religion-wise distribution shows that the majority of the workers are Hindus followed by Christians and a small proportion of Muslims. Among the total population of sample respondents, 68 per cent were married. As far as the nativity is concerned, the majority of the workers belonged to rural areas and they speak Tamil language. Most of the workers are not well educated, most of whom with primary level and degree holders are deplorably low.

Most of the workers reported that they have discontinued their school education because of their family situation and poor economic conditions and also such they are forced to seek employment for supplementing in family income. It is interesting to note that almost all the workers had general education and workers with vocational education are almost negligible. In the sample a majority of the workers (81 per cent) belonged to low income categories. i.e, below Rs. 12,000 to above Rs.24,000 as a monthly family income. A majority of the workers (43.5 per cent) are having four members as their family size. This may be because in urban centers like Coimbatore nuclear families predominate which consists of the father, mother and children. The study on family structure and size reveals that the majority of the respondents belong to nuclear families having two to four members as their family size. It can be observed that nearly half of the respondents
(51.8 per cent) belong to foundry industry and the remaining 48.2 per cent of the workers came from textile industries. Nearly half of the respondents are living in their own house and most of them are migrants. While conducting the survey a majority of the respondents were reported that they migrated only for job purpose. When the researcher asked about the hospitalized details about the family members of the respondents during last one year, it is surprising to note that a majority of them were not hospitalized and most of them reported that they are not suffering from any chronic diseases.

### 8.5.2 Findings Related to the Health Seeking Behaviour and Choice of Health Care Services

Giving importance to the quality of services, patients consider various factors in the selection of hospital such as the availability of the competent specialists, reputation of the hospital, professional management, range of services offered, availability of latest technology and equipment, cost and convenience, proximity to home, courteous behaviour of staff and professionalized care. Consumer research has shown that patients have several alternatives available to them in the selection of hospital. Number of studies have shown that patients consider good patient care as a very important factor in the selection of hospital, which consists of specialists, wide range and quality of services, best technology and equipment and the overall reputation of the hospital. It was found in a number of studies that, though the patients are very much interested in cost and convenience, they do not always consider cost as the most important factor in selecting a hospital. It is interesting to note that when it comes to health, patients are psychologically ready to pay any amount. They never tend to be treated in low cost hospitals but prefer a hospital where good treatment and quality services are available. Studies have shown that personalized care given by courteous and dedicated staff is also considered as an important factor by the patients in their list of priorities. It is the confidence in the competence of the doctor, which is closely followed by the quality of service provided and the reputation of the hospital that is attracting more numbers of patients in the present days.

The common diseases affecting the people in the study area are Dysentery / Diarrhoea, Gastro-enteritis, Typhoid Fever, Chicken Pox, Diseases of Eyes, Food Poisoning, Accident & Violence, Cold & Cough, Skin Diseases and Other Unclassified Fever. Among the total
sample of respondents a majority of them (48 per cent) stated that their overall health status is good. Only negligible amount (42 per cent) of sample workers reported that they had been suffering from chronic ailment like asthma, tuberculosis, ulcer and heart problem, diabetes, cancer and hypertension. While conducting the survey 394 respondents reported about their duration of illness. A majority of them (49 per cent) reported that they were sick only for 2 days and 27 per cent of them reported that they are sick during last one month. Among the total respondents only 13 per cent reported that they were hospitalized during last one year. A majority of 56 per cent said that they have visited the hospital once during the last month. Of the respondents who fell ill, a majority of them (43.4 per cent) have taken treatment from the private hospital and 29 per cent from private doctor together constitute 72 per cent. It is surprising to note that among the total respondents a majority of them (78.4 per cent) do not have a family doctor. It may be observed from the analysis that a majority of the workers (46 per cent) stated that distance of hospital from their residence is below 3 km and 36 per cent reported that the distance of pharmacy from their residence is 0-2 km. On an average a majority (35.8 per cent) of workers stated that waiting time to meet the doctor is 30 minutes. An attempt has been made in the study to know the patients’ views about the distance of the hospital from their residence. A majority of the workers (60.4 per cent) reported that they do not have medical facilities nearby home.

The gross differentials in respondents’ choice of medical and health facility, by and large, would be inconclusive and findings drawn from such analysis have their own limitations. Hence, an attempt is made to identify the major factors that are likely to determine the respondents’ choice of health facility. In this case logistic regression analysis is carried out. Among the sample workers, it is striking to note that, controlling for all the variables used in the model, the odds of their choice of availing medical and health care services from private centres are more than 11 times and 8.5 times higher (OR = 11.435 and 8.523, respectively) among those who belonged to backward and forward communities and most backward communities, respectively as against to those who belonged to Scheduled Castes / Tribes (lower in socio-economic strata). These results are also turn out as highly significant (p<0.001 in each case). Another pertinent finding noticed here is that the role of quality of services existing in the health centres on workers’ choice of health care services.
Workers who ever perceived and availed the quality of services to an ‘excellent’ and ‘good’ extent have shown a greater tendency to choose private health care institutions during their illness to a large extent than their counterparts who felt such services are ‘poor’. These results also found to be statistically highly significant (p<0.001 in each case). Though such positive net effect is noticed in the case of those who stated that the quality of services at health centres at an ‘average’ level, the finding did not turn out statistically significant. The likelihood of availing health care services from private health facilities is significantly higher among those workers who stated that it is used to take 15 and 10 minutes time for consultation with the doctor than those who reported such time as just five minutes (p<0.001 and p<0.01, respectively). Likewise, the probability of visiting to private medical and health care centres is appears to be higher among those workers who earn a monthly personal income of Rs. 3001–6000 as compared to those who earn comparatively lower income (Rs. 3000 or less), and this finding is also turn out as highly significant (p<0.01). However, it is surprising to note that such probability is negative among those workers who earn comparatively higher income. Another expected finding noticed in this analysis is that the positive net effect of educational status on workers’ choice of health care services from private institutions. But the interesting fact noticed here is that though the odds of availing health care services from private health centres are noted to be higher in the case of all the levels of educational status of workers, the results turn out as statistically significant at a moderate level (p<0.05) only in the case of those workers who are educated up to primary school level as compared to their illiterate counterparts.

Some of the factors have shown negative net effects on the workers’ choice of health care services from private institutions. Among them the prominent one is waiting time at health facility to meet the doctor. This finding shows clearly that the workers, by and large, tend to avail the health care services to a quicker extent rather than waiting for a longer time. As noted in the case of bi-variate analysis, another pertinent finding observed here is that the likelihood of availing health care services by workers from private health facility is significantly (p<0.001) lower if a government health centre is available nearer to their household than those do not have such facility. Likewise, the probability of visiting private health facilities for medical and health care services is
much lower and significant \( (p<0.001) \) among those workers who used to have a family doctor than those who do not have such a doctor. The net effects of other three variables under consideration viz., gender, current age and nativity status on the choice of workers’ health care services though mostly on the expected direction, the results turn out as insignificant. Of course, such pattern is also true with regard to the first two factors in the case of bi-variate analysis.

A majority of the patients going to private hospitals select the hospital based on the performance of the doctors. This may be because many of the private hospitals are promoted by well-qualified and experienced doctors. These hospitals use the services of some of the best doctors in the state as well as in the country. These doctors are specialists and super specialists in specific health problems and have the expertise of using the most advanced technology and are exposed to the latest developments in medical and health care field through attending and participating in national and international workshops, seminars and conferences. Moreover, these doctors are generally referred to the patients by their friends, relatives and other doctors, especially in case of long-standing and complex health problems. When the researcher enquired about the reasons for choosing a particular health care system, around 26 per cent of the respondents stated that they select the health care system mainly for its timely attention.

Numerous studies have shown that the major reasons for patients in preferring a government hospital are free treatment and low expenses. Against this background, an attempt has been made in the study to know the quality of treatment in government hospital. A majority of (42 per cent) of respondents reported that the quality is good. This may be because of the free treatment and medicines, low expenses, accessibility and convenience, reputation of the doctor and others. The researcher enquired about the reasons for rejecting government hospital. The important reasons considered for not preferring a government hospital are poor services, hospitals not easily accessible and not convenient, no specialist departments, poor hygiene, poor attention and many other disadvantages. The researcher also enquired about the reasons for selecting private hospital. The analysis shows that effective supervision to patients was ranked first. The other reasons are continuous treatment, quick diagnosis of diseases, availability of specialized doctors less waiting time, availability of blood bank, attending emergency cases and safe delivery.
An attempt is also made to analyse the differentials, if any, exist in workers’ choice of health care services across their selected background characteristics. The analysis is carried out with the help of cross-tabulations and chi-square test of significance keeping the choice of health care services as dependent variable, viz., from government health facilities and private health centres. It is evident from the analysis that the percentage of workers who have availed health care services from private health centres is much higher irrespective their gender background, but this is just one percentage point is higher among males as compared to females, whereas such pattern is reversed in the case of government health facilities. When the differentials in the choice of health care services examined across their age, it is observed that the percentage of visiting private health facilities appear to be higher among those belonged to higher age groups (79% and 77%, respectively among those whose age is 45 years & above and 30-44 years) than those who are younger in age (15-29 years). Bi-variate analysis in the case of choice of health care services by workers’ marital status reveal that the percentage of those availing health care services from private health facilities is marginally higher among those who are currently married as against those who are in other type of marital status. The chi-square results in all the case of all these three factors did not turn out as statistically significant. It is obvious to note that workers who are born and brought up in urban areas have shown higher tendency to avail private health care services (81%) than those workers whose nativity status is rural areas. Obviously, the reverse pattern is noticed among the sample workers in the case of government health services. Further, it is also interesting to note that the chi-square results between the nativity status and workers’ choice of health care services is found to be highly significant (p<0.001).

From our analysis it is clear that quality of health care services is playing a vital role in choosing the type of health facilities by the workers. For instance, the percentage of the workers who utilise the private health care services is relatively lower (57%) when they perceive and receive ‘poor’ health care services, which has increased consistently to 66.6 per cent, 77.7 per cent and then to as high as 90 percent with an increase in the level of quality of services received at the health centres to the extent of ‘average’, ‘good’ and ‘excellent’, respectively. Conversely, the percentage of workers visiting government health facilities has decreased with an increase in the level of quality of health care services.
Apparently, the chi-square results in this regard has turned out as highly significant indicating that there exists a strong association between the quality of health services and the choice of health care services (p<0.001).

8.5.3 Findings Related to the Cost Incurred for Illness and Source of Finance

The latest available National Health Accounts shows that in 2008-09 (provisional estimates), out of total healthcare expenditure in our country, only 26.7 per cent was public expenditure and 71.6 per cent was private expenditure with external assistance accounting for a very small share of 1.7 per cent. Out of the total private expenditure on healthcare, out-of-pocket expenditure accounts for a very large chunk as the healthcare expenditure financed by health insurance and expenditure done by other private bodies are very low (Sakti Golder, 2011).

In the present study, the respondents were asked to report the total cost incurred for their illness during lost one month. Most of them (82 per cent) stated that they spent below Rs.500 as total medical expenditure, 86.8 per cent stated that they have spent below Rs.200 as doctor fees and 90.5 per cent spent below Rs.300 as medicinal expenses. For diagnostic charges 50 per cent of them spent below Rs.100 and 71.4 per cent spent below Rs.50 as transport charges, for other expenses 40.8 per cent spent below Rs.100. While the researcher asked about the loss of wages, a majority of (66.2 per cent) of workers stated that they lost wages worth of below Rs. 500 because of their illness during last one month. Around 28 per cent of the sample respondents reported that they spent between Rs.201 to Rs.400 for their caretakers.

Among the total respondents 182 workers (83.5 per cent) paid the amount fully for taking treatment and the remaining 16.5 per cent underwent treatment free of cost. For medicinal expenses, a majority of 37 per cent of respondents spent 1001-2000 rupees and for diagnostic charges, a majority of 47.8 per cent spent an amount below Rs.500. While calculating the total expenditure incurred during their hospitalization days, 32 per cent of respondents reported that they have spent a total amount of Rs.4001-6000 and to meet their transport expenses, a majority of 38 per cent sample workers reported that they spent between Rs.401-600 at the time of their stay in the hospital. A majority of 32 per cent respondents spent Rs.401-600 for their caretakers stay in the hospital.
When the researcher enquired about the source of finance for treating illness, 30.2 per cent respondents stated that they made use of the savings amount to defray the expenses. Some studies have also found that treatment is not free at public health facilities; in fact, in many cases it is only slightly cheaper than private health care. For instance, Banerjee, Deaton and Duflo (2004) found that in spite of the Government stipulation that medicines be supplied free when available, more often than not rations had to be bought from the market. The survey in rural Udaipur found that visiting a public facility cost the poor about Rs 71 compared to Rs 84 in the case of a private doctor and Rs 61 in the case of a traditional healer. Hence, treatment costs at public facilities are only marginally economical than if they were to go to private health care providers. The economic burden of the treatment cannot be ignored. Even the poorest 20 per cent in rural areas spent about Rs 4,291 on one hospitalization case. Similar patterns are apparent in urban areas. Further, hospitalization frequently results in financial catastrophe, especially in the absence of risk pooling mechanisms; only 10 per cent of Indians have some form of insurance and most of these are inadequately. On an average, those who are hospitalized spent about 58 per cent of their total annual expenditure on health care and more than 40 per cent have to borrow money or sell assets to cover expenses (Peters et al., 2002).

### 8.5.4 Findings Related to the Enrolment of Health Insurance Schemes by the Sample Industrial Workers

The health insurance is a vital method of financing the spiraling costs of medical care. The high cost of hospital services coupled with the unpredictability of health needs and the inadequacy of personal savings is the primary reason for the growing importance of insurance as a means of financing health services. In spite of the growing importance of health insurance schemes the number of people covered by health insurance is very less in India. It has been found that one of the major reasons for low health insurance coverage in India is the lack of awareness of the health schemes by the people. Currently in India, only 2 million people (0.2 per cent of the total population of 1 billion) are covered under Mediclaim, the most popular health insurance scheme in India, whereas in developed nations like U.S., about 75 per cent of the total population are covered under one or the other insurance scheme. In this background, an attempt has been made to know whether the industrial workers are aware of health insurance schemes.
The present analysis shows that a major portion of workers 66 per cent are not aware of any of the health insurance policies. Regarding the enrolment, 77.5 per cent of the respondents are not enrolled in any of health insurance schemes. Among the respondents who have enrolled, a majority of them (36.3 per cent) prefer private health insurance schemes and around 29 per cent took accidents policy and 28 per cent took Kalaignar Kaapitu Thittam. An interesting finding is that a majority of (23 per cent) respondents reported that they were motivated by their employers to join in the health insurance schemes. Among the total respondents most of them (71.5 per cent) have taken the Mediclaim policy.

The gross differentials in respondents’ enrolment of health insurance have been analysed across their selected background characteristics. However, such gross differentials are less conclusive and generalizations drawn from such analysis have their own limitations. Therefore, an attempt is made to find out the principle factors that are likely to affect the respondents’ enrolment of health insurance by adopting the logistic regression. The findings clearly establish the fact that educational status of the respondents plays a vital role in respondents enrolling for health insurance. Greater awareness about the importance of health insurance and the demand for the health insurance would be higher among educated respondents, especially among those who go beyond secondary school and above and thereby, large number of such persons enroll themselves for health insurance.

Next to educational status, current age of the respondents appear to be the major deciding factor whether the respondents got enrolling themselves for health insurance or not. For instance, compared to those younger at age (15-29 years), respondents who ever at their most prime working ages (30-44 years) have shown greater tendency to take a health insurance policy. This result is also turn out as highly significant (p<0.001). It is also conspicuous to note that respondents whose family monthly income is better have higher likelihood of enrolling themselves for health insurance as compared to those who belong to families in which monthly income is low (Rs. 3000 or less). Another interesting point noted based on the logistic regression analysis is that the odds of enrolling for health insurance are found to be higher and significant at a moderate level (OR = 1.5; p<0.05) among the females as compared to their male counterparts. Finally, though the
elderly who reside in urban areas as well as in nuclear families and working in jobs related to foundry industry have shown higher odds of enrolling themselves for health insurance than their counterparts, the results did not turn out to be statistically significant.

When the researcher enquired about the source of finance for paying the premium 59 per cent of the respondents told income is the main source of finance to pay the premium and around half of the respondents (59 per cent) reported that they took the policy only for themselves. When they were asked about the reasons for not subscribing health insurance scheme a majority of them told (22 per cent) that they were unaware of the schemes and around 25.9 per cent of the respondents reported to the researcher that in their health insurance schemes not all illness are covered. While getting the insurance benefit 41.9 per cent respondents reported that so for they did not get any claim. The researcher enquired about the factors influencing to take subscription of new health insurance plans, a majority of 25 per cent respondents reported that it must be cheaper and most of the respondents (57.9 per cent) prefer less than 100 rupee per month as premium. Around 39 per cent of respondents stated that they want all their family members to be covered in the plan. It is interesting to note that 22 per cent of the respondents prefer private hospital based insurance scheme and again 21 per cent of respondents prefer Government insurance plans.

An interesting fact is, when the researcher after explaining the benefits of health insurance schemes to the respondents, a majority of them (80 per cent) reported that they are willing to join in health insurance schemes. When the researcher asked the respondents whether they would participate in health insurance schemes, if it is available for Rs.100 per months, 73.7 per cent agreed to join. Among the total respondents, a majority of (91 per cent) said that they did not join in ESIS health insurance schemes and again 91 per cent did not get the insurance card, may be because of the temporary nature of employments. Around 92.8 per cent of the workers are not using the ESIS facility because of the fact that they are working as a temporary worker. Among the respondents who have availed services from ESI, most of them (39 per cent) have used the hospital service. When the question is about the impression about the recent health insurance schemes, a majority (45.4 per cent) the respondents reported that they are partially satisfied. Among them 33.3 per cent said that long distance and inconvenient location is
the reason for dissatisfaction. The other reasons are low coverage, poor quality of services by medical and paramedical staff, high cost in terms of travel expenses, wage loss, bribes, long distances and inconvenient locations, cumbersome administration procedures in obtaining cash compensation.

8.6 Conclusion

Despite considerable progress since independence, not only do health outcomes for Indians still fall short of other, similarly placed countries, they are also unevenly distributed across the population and across states. Health outcomes are especially poor for individuals and households at the lower end of the socio-economic ladder. Indians are also extremely vulnerable to financial risks from illness, as indicated by high levels of out-of-pocket spending, and this vulnerability appears to be increasing over time. Finally, by most accounts, satisfaction with publicly-provided health care service is low. Though there is hope that this may change as the National Rural Health Mission (NRHM) matures, and with the implementation of the National Urban Health Mission (NUHM), we do not have enough evidence to support this as yet. The private sector has its own problems and is generally poorly regulated and of variable quality, ranging from high-end institutions to unqualified providers. These outcomes are reflected in India’s slow progress towards achieving several of the Millennium Development Goals (MDG) to which it is committed. In any assessment of progress towards the MDGs, India performs relatively well on the poverty reduction and education–related goals, but not as well on goals related to health (Bibek Debroy et al., 2010).

The heavy reliance on private providers, even among the poor, via out-of-pocket payments reflects a general lack of service quality in public sector provision, and the fact that public facilities lack drugs that people have to pay out-of-pocket. The lack of risk pooling and a heavy reliance on out-of-pocket spending based on fee-for-service, inadequate linkages between primary care and hospital-based care, and organizational deficiencies in public spending are seemingly the major drivers of inefficient resource use in India’s health sector. Many of these issues have been flagged before. It is remarkable that, since the Bhore Committee of 1946, there have been 21 committees and commissions with a health focus. The point is that the multifarious issues and solution are well known
and, in many cases, have been repeated by successive committees since independence. (Bibek Debroy et al 2010). And the recommendations of these committees and commissions helped fashion India’s healthcare infrastructure, policy and regulation. They also highlighted deficiencies in the system, many of which are even relevant today.

The workers in the unorganized sector constitute about 93 per cent of the total workforce in the country. The Government has been implementing some social security measures for certain occupational groups but the coverage is miniscule. Majority of the workers are still without any social security coverage. One of the major insecurities for workers in the unorganized sector is the frequent incidences of illness and need for medical care and hospitalization of such workers and their family members. Despite the expansion in the health facilities, illness remains one of the most prevalent causes of human deprivation in India. It has been clearly recognized that health insurance is one way of providing protection to poor households against the risk of health spending leading to poverty. However, most efforts to provide health insurance in the past have faced difficulties in both design and implementation. The poor are unable or unwilling to take up health insurance because of its cost, or lack of perceived benefits. It is evident from the analysis that the percentage of workers who have availed health care services from private health centres is much higher irrespective their gender background. When the differentials in the choice of health care services examined across their age, it is observed that the percentage of visiting private health facilities appear to be higher among those belonged to higher age groups. It is obvious to note that workers who are born and brought up in urban areas have shown higher tendency to avail private health care services (81%) than those workers whose nativity status is rural areas. Obviously, the reverse pattern is noticed among the sample workers in the case of government health services.

From our analysis it is clear that quality of health care services is playing a vital role in choosing the type of health facilities by the workers. The percentage of workers visiting government health facilities has decreased with an increase in the level of quality of health care services. There exists a strong association between the quality of health services and the choice of health care services. The findings clearly establish the fact that educational status of the respondents plays a vital role in respondents enrolling for health insurance. Greater awareness about the importance of health insurance and the demand
for the health insurance would be higher among educated respondents, especially among those who go beyond secondary school and above and thereby, large number of such persons enroll themselves for health insurance.

Next to educational status, current age of the respondents appear to be the major deciding factor whether the respondents got enrolling themselves for health insurance or not. It is also conspicuous to note that respondents whose family monthly income is better have higher likelihood of enrolling themselves for health insurance as compared to those who belong to families in which monthly income is low. Enrolling for health insurance are found to be higher and significant at a moderate level among the females as compared to their male counterparts. An interesting fact is, when the researcher after explaining the benefits of health insurance schemes to the respondents, a majority of them (80 per cent) reported that they are willing to join in health insurance schemes.

Most of the workers reported that they are not covered by any health insurance plans or medical claim packages. Workers must pay most of their medical bills, though they reported that their employees will pay medical cost in the event that injuries are sustained as a result of an accident in the work place. While government hospitals exists more than 70 per cent interviewed reported that they would rather consult with more expensive private doctors, demonstrating a lack of faith in the quality of care the public facilities provided. Access to medical care in the work place is also severely limited. Most of the textile units and all the foundries connected to those interviewed for this study do not have a permanent doctor working on-sight. Doctors and nurses never these visits these companies. Other than injuries sustained from accident, the industrial units do not take responsibility for any other health problems that workers might suffer due to their poor working conditions. Most of the units studied did not even have first aid kits to help workers in case of emergency. Levels of income and expenditure for workers as documented to through interviews showed that those who earned little are spending a great deal on medical expenses. During this research the view that something must be done to improve the health conditions was found to be wide spread among the workers (S.M.Prithiviraj).
Doctors in this region view as one of the reasons for growing alcoholism and depression among workers. In addition to fatigue, poor sanitation and water facilities in the region contribute to the worker’s susceptibility to diseases. The workers do not have enough knowledge to make a casual relationship between their health problems and their working and living conditions. Most of the workers in both industries are reported to have been suffering from body pain, frequent cold and headache. Some workers reported having skin diseases and problems such as eye irritation. Workers in dying and bleaching units reported as suffering from severe headache. They also believed they had more frequent cold and less sense of smell, since they began working with chemicals. This suggests that a serious impact on workers health. All categories of workers interviewed reported that they needed higher wages to cover their basic expenses.

The demanding work schedule as well as irregular working hours in these industries take a toll on their health. The working hours of skilled and unskilled workers in this region are more than of the legal maximum of 60 hours per week and on average reach 72 per hours per work. These working hours surpass national and international standards these long working hours affect the food consumption and sleeping patterns of workers. Apart from the objectives, this study found that in many of the textile, foundry units covered in this study, had no emergency exists, while some factories, that did have emergency exit doors had blocked them with instruments and boxes. Clearly, if fire were to breakout, massive loss of life would be the result. Many workers carried out their work in small congested halls and hall ways in this region, which possess safety risks. None of the workers interviewed said that safety policies were posted at their work places and very few said that their company provided training in fire safety.

8.7 Policy Suggestions

Based on the findings from interviews with workers, trade union leaders, concerned government officials along with the researcher perspective in the issue, several recommendations have been compiled for addressing these problems. Workers must be provided with gloves to use while handling toxic chemicals. Protection masks must be provided to all the workers inside the factory and their use should be mandatory. There should be health and safety training provided for the workers. Safety measures to be taken
should include the installation and regular inspection of fire extinguishers, regular fire drills (every six months), and accessible emergency exit doors. Workers in each section must be trained in fire safety measures. Gloves and masks must be provided to all the workers.

Free medical checkups with a permanent on-site doctor should be provided to workers in the workplace. First aid kits should be made available in all work places. Employers should provide compensation for all medical bills, not just accident-related medical costs. All the workers must be immediately enrolled in the Employees State Insurance Scheme irrespective of period of service. Again, international campaigns should put pressure on multinational garments corporations to support these demands.

Strict enforcement of legislation regarding control of noise pollution at the workplace and implementation of maximum working hours should be monitored. Conduction of Yoga and meditation classes for promotion of positive health and recreational facilities to the workers like sports and clubs may be provided for relaxation. The un-organized sectors should be brought Under Coverage of Employees’ State Insurance Scheme for the promotion and protection of health of these workers. Textile industries involve diverse operations including fiber synthesis, weaving, manufacturing, dyeing and finishing. The prime health and safety concern in the processing of textiles is the exposure to toxic chemicals and physical hazards, such as accidents with machinery. Not only can the exposure to toxic chemicals cause immediate and long term health and safety problems at the production site, negative publicity on health aspects or issues of labour conditions during production proved to have a high impact on sales.

The health insurance companies should come out with clear cut policy details, as many of the respondents had vague ideas about the various benefits and risks involved in a policy. The middle and low socio-economic groups are a potential market to be tapped as they are ready to spend a reasonable amount as premium payable per annum rather than huge medical expenses in case of any adversities. If the private insurance players want to venture in the market, they should try to imbibe trust in the people as most of the respondents preferred government health insurance schemes, the reason being guarantee for their capital. To develop a viable health insurance scheme, it is important to understand people’s perceptions and develop a package that is accessible, available,
affordable and acceptable to all sections of the society. Most of the respondents were of
the opinion that government should come out with a clear cut policy, where the public can be
made to contribute compulsorily to a health insurance scheme to ensure unnecessary out-of-
pocket expenditures and also better utilization of their health care facilities.

- There is an urgent need to raise health sector spending both by the central and state
  Governments, as it is quite low at present. Funds allocated must flow to desired
  channels through good governance and effective implementation.

- There is an immediate need to reform the public sector healthcare system. Programmes
  initiated by governments must be regularly monitored for efficiency and quality. There is
  need to plug financial leakages and wastages. To improve the efficiency of public sector
  healthcare there is need to improve the issues of doctor absenteeism, lack of storage
  facilities for drugs, attitudes of hospital staff, etc.

- As private sector presence in the health sector has grown over the last decade and a
  half there is need to regulate them. The easy availability of private sector facilities
  and their profit-making must be balanced by equity and efficiency considerations. There
  is need to ensure the quality of private sector health care provision.

- There has been steep rise in medical care costs recently. The Government should devise some
  ways to make our health system less expensive and accessible to majority of the population
  especially to poor. There is also the need to remove rural-urban gaps that exist in most health
  care provision. Access to health services must be improved in quantity and quality.

- Universal access to basic infrastructure facilities (i.e. access to safe water and
  improved sanitation facilities) should be encouraged along with public partnerships to
  deliver specific services.

- Various socio economic, demographic, psychological and programme factors and
  which have shown differential influence on the health status of the industrial workers
  across different groups indicate the necessity for initiating appropriate and realistic
  intervention of social security measures based on proper stratification of the industrial
  workers in the community.
The physicians dealing with the industrial workers not only have to deal with specific health problems, but also the social and psychological health needs of the industrial workers.

8.8 Future Research in the Area of Study

There is a huge scope for further study in this area. The health problems faced by the industrial workers in India is emerging as a big challenge to society as well as policy makers because the health status of industrial workers is not much improved in our country as in the case of developed countries. The scope for further research is as follows: How the occupational hazard affect the health status of industrial worker? What are the barriers that affect their health seeking behaviour? Why there is a need for gender related studies for industrial workers? Why most of the workers neglect government hospitals and what are the reasons to prefer private hospitals? Why most of the industrial workers are not having much awareness about health insurance schemes? Why most of them are not utilising the health insurance schemes?