INTRODUCTION

CHAPTER - I

INTRODUCTION

Health is a universal human aspiration and a basic human need. Health is a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. **(Raman Kutty, 1999)** 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 . Health is treated as a stock which degrades over time in the absence of "investments" in health, so that health is viewed as a sort of capital. **(Grossman, 1972)** Good health confers on a person or group's freedom from illness and the ability to realize one's potential. Health is therefore understood as the indispensable basis for defining a person's sense of wellbeing. Health is an indicator of well being that has direct implications not only for the quality of life but also indirect implication for the production of economic goods and services

Health is an essential input for the development of human resources and the quality of life and in turn the social and economic development of the nation. Health condition of the persons and economic development of the people go hand in hand, because better health conditions will lead to higher level of capabilities to develop the economy. Health is regarded as an important component for sustained development interventions at the individual, community and national levels. Improved health is a part of total socio-economic development and is regarded as an index of social development. Healthy diets and regular, adequate physical activity are major factors in the promotion and maintenance of good health throughout the entire life course. Healthy, well-nourished people are essential for national development**. (Srinivasan, 2006).**

Health and Economic Development

Health is a multi –dimensional phenomenon. It is both as end and means of development strategy. The relationship between health and development is mutually reinforcing. Health and development have a two way relationship while in the process of economic development health forms an important variables, the development spreads its

effect upon the health of the people. **(Mydral Gunnar, 1952)** Health is an essential input for the economic development of human resources and the quality of life and in turn the social and economic development of the nation.

Good health plays a substantial role in economic growth. 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 contributes to economic development which in turns tends to improve the health status of the population in a country. In developed countries, the health status is far higher than that of developing countries. Quality of life and health services are also different among these countries. India being a developing country health facilities are quite in adequate, both in rural and urban areas. Health has a critical role for economic development in low income countries better health translates into greater and more equitably distributed wealth by building human capital social capital and increasing productivity. **(WHO, 2000).**

Evolution of Unorganized Sector

Keith Hart was the first who 'discovered' the informal sector in the 1970s. The International Labour Organization (ILO) then embraced this. His view largely saw the informal sector as "covering marginal livelihoods and survival activity outside the regulatory reach of state and not yet able to be absorbed by industry (and) emphasized the role (or failure) of formal sector employment in defining the informal sector". The 1980s, however, saw the emergence of a more textured understanding of informality. Informal activity was then considered as much a rural or 'urban' phenomenon as it was an urban one.

World Employment Report by ILO (1998) characterized the informal sector in the following words: "Informal units comprise small enterprises with hired workers, household enterprises using mostly family labour, and the self-employed. Production processes involve relatively high levels of working capital as against fixed capital, which in turn reflects the relatively low level of technology and skills involved".

In the late 1960s and 1970s, a large section of the population in the developing countries was still suffering from poverty and still working outside the organized sector in activities that were later broadly termed as "informal". Economic growth was not percolating down to the masses fast enough. Due to population growth and urban migration, the active

labour force was growing at a much faster rate than the availability of jobs in the organized sector. The focus of development policies was gradually shifting from pure economic growth to growth with equity and the eradication of poverty. Interest was thus generated in sectors outside the organized economy that was providing a livelihood to a large section of the poor. Hence, the concept of the informal sector was born.

The past two decades, witnessed rapid growth of employment in the informal sector in all regions of the world. Until the recent Asian economic crisis, it was only the once rapidly- growing economies of East and Southeast Asia that experienced substantial growth of modern sector employment. However, in the wake of that crisis, most of these countries have experienced a decline in formal wage employment and a concomitant rise in informal employment. Even before the crisis, official statistics indicated that the informal sector accounted for over half of total non-agricultural employment in Latin America and the Caribbean, nearly half in East Asia, and as much as 80 percent in other parts of Asia and in Africa.

Informal Sector in Indian Economy

In India, the term informal sector has not been used in the official statistics or in the National Accounts Statistics (NAS). The terms used in the Indian NAS are 'organized' and 'unorganized' sectors. The organized sector comprises enterprises for which the statistics are available from the budget documents or reports etc. On the other hand the unorganized sector refers to those enterprises whose activities or collection of data is not regulated under any legal provision or do not maintain any regular accounts. In the unorganized sector, in addition to the unincorporated proprieties or partnership enterprises, enterprises run by cooperative societies, trust, private and limited companies are also covered. The informal sector can therefore, be considered as a sub-set of the unorganized sector.

In terms of numbers and statistics, the informal economy is large in India, accounting for 370 million workers in 1999-2002 and constituting nearly 93 per cent of the total workforce and 83 per cent of the non-agricultural work force. Women account for 32 per cent of the workforce in the informal economy, including agriculture and 20 per cent of the non-agricultural workforce. It is estimated that around 118 million women workers are engaged in the unorganized sector in India, constituting 97 per cent of the total workers in India.

According to the National Accounts Statistics, the workers in the unorganized sector contribute over 62 per cent to the NDP. The sector also contributes over 50 per cent of the total household savings thus dispelling the myth that poor do not save. A substantial 39.3 per cent (₹ 46 thousand crores) is the contribution of the informal sector to India's total exports (NHRC, 2006).Notwithstanding the attempts of the government to provide social security in the form of pensions and other benefits, the problems of minuscule coverage and paltry amounts of benefits were often noticed. Among the major categories of unorganized workers, the construction workers are dispersed and have mobility and to a larger extent unorganized.

Women Employment in Unorganized Sector

Amongst those who are left out of any social protection system in India, and amongst those who are poor, women form a major group. Women dominate those forms of work that are unregulated and unregistered, found most in the so-called 'informal economy.

During the second half of this century, as a result of globalization of economy, there are new trends, which have created new opportunities for employment for women the world over. In many regions, women's participation in remunerated work in the formal and non-formal labour market has increased significantly and has changed during the past decade. While women continue to work in agriculture and fisheries, they have also become increasingly involved in micro, small and medium sized enterprises. Women's share in the labour force continues to rise and almost everywhere women are working more outside the households. In India, the sharing of economic activity by women is nothing new. From time immemorial women have been working both in the home and outside, though not in strict sense of earning wages.

Although fewer women than men worldwide are in the overall labour force, in some countries, such as Zambia, Honduras and Jamaica, the informal sector employs more females than, males, while in a number of other countries, women make up 40 per cent or more of the informal sector. The significance of the informal sector, in relation to overall production and labour force, varies from country to country but is thought to be greatest in Africa.

The table 1.1 attempts to give the distribution female work force in the rural and urban informal sector in comparison to their male counterparts.

Table – 1.1

Number of Workers in Informal Sector (in millions)

Sector	Male	Female	Total
Rural	196.74 (71.86)	104.02 (84.58)	300.76 (75.80)
Urban	77.05 (28.14)	18.96 (15.42)	96.01 (24.20)
Total	**273.79 (100.00)**	**122.98 (100.00)**	**396.77 (100.00)**

Source: Report of the Expert Group on Informal Sector, May 2006.

The total female workforce in informal sector was 122.98 million (31 per cent) in 2006, their share in urban was only 18.96 million while in rural it was 104.02 million. The male workforce in the rural informal sector is quite lower than the female, which is 84.58 per cent of women participated in informal sector but male participation is 71.86 per cent.

Women are over-represented in the informal sector worldwide. This basic fact has several dimensions. Firstly, the informal sector is the primary source of employment for women in most developing countries. Existing data suggest that the majority of economically active women in developing countries are engaged in the informal sector.

Health Problems of Women Workers in Unorganized Sector

Women's occupations are fluid and multi-dimensional. The first problem is to learn what those activities are really involved in different situation and cultures: a simple occupational category is seldom sufficient as a basic for establishing specific health risk. Agriculture workers may dig and hoe and apply fertilizers and pesticides, but not all the workers will perform all of those tasks and where the tasks are segregated by gender the health implications for men and women may be very different. The tasks which men and women undertake vary from culture to culture and at different times in different places. While most cultures assign particular tasks to women and in some women's roles are more

regulated and their economic activities restricted, there are in general very few activities which can universally be described as women's work. Occupational health risks are seldom confined to one sex alone. The risks are only likely to fully understood, and confronted, in the context of a gender specific analysis of occupational health.

Research into women's and men's occupational health also requires recognition of extent of intra-sex variations and careful controls for biological and social characteristics which may affect health outcomes. Poor nutrition (for example) may be a more important factor in some types of occupational health impairment than simply being female. The effects of potential occupational hazards on women's reproductive health have been, probably, the major focus of concern which has increased in recent years as more environmental hazards are identified and as more women enter the paid workforce. A range of occupational reproductive hazards has been documented but a large number of possible risks still require further examination.

Workers in every occupation are faced with a multitude of hazards in the work place. Occupational health and safety addresses the broad range of workplace hazards from accident prevention to the more insidious hazards including toxic fumes, dust, noise, heat, stress, etc. The occupational health service is a link in the work organization.

Ronald Blake (2006) has classified occupational hazards into the following four categories:

- *Biological Hazards:* these hazards are manifested by diseases caused by bacteria, fungi, viruses, insects, dietary deficiencies, drinking, allergy, brain fever, imbalances, tetanus, stress and strain, infectious waste and infestations.
- *Environmental hazards or physical hazards:* these include noise pollution, vibration and stocks, unsatisfactory lighting, radiation, extreme temperature, illumination, heat, ventilation, air and water pollution. These hazards cause redness of eyes, genetic disorders, cancer, sterility, hearing, loss nerve injury, etc. to workers.
- *Phychological hazards:* industrial/job stress caused by various stressors, such as and role demands, organizational leadership, lack of group co-herion, inter-group and inter-personal conflicts, life and career changes, etc. lead to

emotional disturbances which in turn lead to fatigue and exhaustion. All these affect health of employees.

Every year, in all industries, 1.5 million workers suffer from ill health caused or made worse by work. In the food and drink industries in unorganized sector, an estimated 29,000 workers (48 per cent of the workforce) suffered from ill health caused or made worse by work during 2001/02, according to the Self-reported Work related Illness (SWI) Survey for those years **(Gowri and Devi, 2011).**

Health and Nutrition

Women's health is of utmost importance as it reflects the health of the family; she plays a pivotal role in the family not only as a home maker and care taker of children but also bearer of children. In the recent years, there has been a remarkable upsurge of interest in India regarding health of women. India being a developing country, vast section of its population suffers from malnutrition, unemployment and poor health care. This is more severe in case of two main weaker sections of the society namely women and children.

The other important aspect of Health is Nutrition. Without nutritious food there will be no health. So nutrition also plays an important role in a country's economic development. The subject of nutrition is not only of theoretical interest but it has tremendous importance in practical life. It may, however, be remembered that this problem is not a new one. It is infact as old as the civilization itself. The quantity and the quality of food available determine in an important way, the physical and mental health and well-being of the nation.

The problem of under nutrition and malnutrition has to be studied in its distributive perspective. By under nutrition we mean calorie deficiency, which signifies a corresponding degree of hunger. In other words, it expresses quantity aspects of nutrition deficiency. On the other hand malnutrition the quality aspects, deals with deficiency of other nutrients. Malnutrition resulting form deficiencies in calories and protein is widespread throughout the developing world. This protein energy malnutrition results in stunting or low height for a given age.

Malnutrition in women and men can result in reduced productivity, slow recovery from illnesses, increased susceptibility to infections, and a heightened risk of adverse

pregnancy outcomes. A woman's nutritional status has important implications for her health as well as the health of her children. A woman with poor nutritional status, as indicated by a low body mass index (BMI), short stature, anemia, or other micronutrient deficiencies, has a greater risk of obstructed labour, having a baby with a low birth weight, having adverse pregnancy outcomes, producing lower quality breast milk, death due to postpartum hemorrhage, and illness for herself and her baby.

Nutritional Status of Rural Women in Tamil Nadu

India has exceptionally high rates of child malnutrition, because tradition in India requires that women eat least throughout their lives even when pregnant and lactating Malnourished women gives birth to malnourished children, perpetuating the cycle.

Table 1.2

Nutritional Status of Women in India in 2005 – 06 (Selected States)

States	Anaemia		Underweight (< 18.5)	
	Women	Men	Women	Men
India	24.2	55.3	34.2	35.6
Andhra Pradesh	23.3	62.9	30.8	33.5
Karnataka	19.1	51.5	33.9	35.5
Kerala	8.0	32.8	21.5	18.0
Tamil Nadu	**16.5**	**53.2**	**27.1**	**28.4**

Source: HFHS – 3 (2005-06)

Generally, health status includes a set of indicators used to provide important health and health related data regarding incidence and prevalence of disease, health risks and performance of health systems. Health status provides a broad overview of reproductive and child health as well as disability prevailing in the country.

Though these indicators are satisfactory, anaemia and underweight rates in Tamil Nadu are alarming in comparison with states like Kerala and it also affects adversely its image of a progressive state in a country. The above table shows the anaemia levels and

underweight for both men and women in selected states in India. In this table anaemia was more prevalent for women. All over the India totally half of the women are anaemic and in the case of men it is only 24.2 per cent. In Kerala only 32.8 per cent of women and 8.0 per cent of the men were anaemic. But in Tamil Nadu more than fifty percent (53.2 %) of the women and 16.5 per cent of men which is double the percent of men in Kerala are anaemic. In Kerala 18 per cent of women are underweight (<18.5 kg) and in Tamil Nadu it is 28.4 per cent. While comparing percentage of underweight for men, Tamil Nadu is quite higher than Kerala which is 27.1 per cent.

Health Insurance

India is one of the most under-insured countries in the world. The health-care sector is recognized as an industry, hence long-term funding is possible, through financial institutions. Health awareness among people in India of late is increasing and people are going for regular health check-ups. Health insurance has a potential of around ₹ 10,000 crores. Currently insurance companies collect around ₹ 1000 crores as premium from selling health insurance (mediclaim) products, which is estimated to increase to ₹ 45,000 crores in the next ten years. Most of the new life insurance entrants are providing health insurance benefits as riders to their base products **(Murthy, 2011).**

Significance of Health Insurance in India

Health insurance assumes significance in India as the public cost of financing health care in the country has been significantly increasing due to several factors such as population size, improvement in medical technology and challenges of simultaneously tackling communicable and non-communicable diseases. With limited public budget the government is unable to cope with rising costs and is therefore, encouraging alternative sources for financing the expanding health care system, which currently is financed mainly from private out-of-pocket payments. Out of the 5 per cent of GDP spent on health care, three quarters is financed by the private sector, which is mostly out-of-pocket. The failure of the public sector to respond to client needs (non-availability of functionaries, shortages of drugs consumables, etc.) leaves little option for both the rich and the poor but to seek private care. With almost one-third of the population living below the poverty line and inability of the public sector to cater to the needs of everyone, it becomes important for funds to be organised in some other

ways, such as community financing, social insurance or private insurance. Insurance could enable the individuals to cover the costs of treatments for those events that would otherwise be difficult to afford at the time of need. It is presumed that larger the number of people utilizing the health services of the private sector (through health insurance), the lesser the burden will be on government resources to finance secondary and territory care.

Health insurance assumes significance as demand for health care is irregular and unpredictable. Health expenditures are known to follow a positively skewed distribution where expenditure are very small, or zero, for most people and large for very few people. Pooling is considered a way of realizing social justice because it is based on solidarity and co-operation between the well and ill, the rich and the poor. Pooling helps to avoid large financial risks and helps people gain access to health care that would otherwise be unaffordable. Thus, health insurance provides financial protection against the high cost of medical treatment and unpredictable health events. In the case of India, the important question is whether insurance should cover catastrophic costs and prevent people from going into absolute poverty, or should health insurance cover all types of treatment. Furthermore, it is important to consider the feasibility of raising resources through insurance and estimate the target group that can be covered under insurance **(Garg, 2006).**

Health Insurance for Unorganized Sector

India has a huge working population of about 400 million. Nearly 90 per cent of this work force is in the unorganized sector. There are numerous occupational groups in economic activities, passed on from generation to generation, scattered all over the country with differing employer-employee relationship. Those in the organized sector of the economy, whether in the public or private sector, have access to some of health service coverage. While the unorganized sector workers have no access. The National Commission for Enterprises in the Unorganized Sector (NCEUS) has recommended a specific scheme of health insurance in case of incidences of illness and hospitalization for workers and their families. The Eleventh Five Year Plan introduce a new scheme based on cashless transaction with the objectives of improving access to health care and protecting the individual and her family from exorbitant out of pocket expenses. Under the scheme, coverage will be given to the beneficiary and her family of five members. Providers will be both public and private still

this new based health insurance scheme is working and achieve the good progress among the below poverty people.

With this back ground a study on the "**Health Status of Working Women in Informal Sector**" is undertaken with the following objectives

1. To study the socio-economic profile of the women workers in informal sector
2. To analyze the food consumption pattern of those workers and to measure the nutritional status of the respondents
3. To identify the job related physical health problems of women workers in informal sector and
4. To measure the awareness level of Health Insurance Scheme