REVIEW OF LITERATURE

CHAPTER - II

REVIEW OF LITERATURE

Women worldwide are underrepresented in higher income activities (positive jobs) and over represented in low income activities (negative jobs). The informal sector employs a large number of women throughout the developing nations. In India a majority of women work in the informal sector as informal labour. There is a growing body of evidence which suggest that waged work can have both positive and negative effects on women health. **(Chen, 2006).**

Health is an important asset of a society, and a healthy society is the foundation of a strong nation. Health is an important determinant of economic and social development because diseases create a vicious circle by depleting human energy, leading to low productivity and earning capacity, deteriorating quality and quantity of consumption standard of living. The literature for the present study, **"Health status of Working Women in Informal Sector"** is discussed under the following heads:

2.1 Health Problem in Work Place

2.2 Nutritional status of Working Women

2.3 Healthcare Services

2.4 Health Insurance

2.5 Related Studies

2.1 Health Problem in Work Place

Occupation al Health is one of the environmental health sciences, concerned broadly with the health effects of work and of working conditions. Physical, chemical, biological, organizational and social variables associated with occupation may affect the physical or psychological well-being of the worker adversely or positively. Until recently, the concept of occupational disease denoted a specific clinical and pathological syndrome by a hazard specific to a particular type of work or the work environment. Observation of the relation between occupational hazards poor health dates back several centuries, but a systematic description of diseases according to occupational causes was made only in the final years of

the 17th century by Bernardino Ramazzine, the acknowledged father of occupational medicine.

Dogra (1985) analyzed the important source of employment for industrial worker in India, and it has been estimated that nearly 1.5 million workers are employed in the textile mills. These mills have been the scenes of several working class struggles. Working conditions in most of the textile mills are known to be very bad. Dust, heat, noise, contact with dangerous chemicals ad high frequency of accidents are the most common occupational hazards.

A study on socio-economic and health conditions of women in Madras by **Miranda and Mahadevan (1988)** found that more than 50 per cent of the employed women were part time domestic workers and were employed in more than two houses. Stomach ailments, menstrual problems, anemia and general weakness were the common problems reported by the women domestic servants.

The problems of women in unorganized sector cannot be limited to the economic level only, but they also suffer from violence and their health was affected in specific ways, partly due to their role as child bearer and partly due to their social oppression as women. Omvedt had listed their problems relating to remuneration, conditions of work, health, safety, education, sexual exploitation, lack of access to property and caste discrimination. Remuneration was usually given into the hands of the men as head of the family. Women workers have to work for eleven to fifteen hours if domestic tasks are included. The problem relating to health, safety and education in the unorganized sector are the derivatives of poverty and exploitation in this sector (**Omvedt et.al, 1992).**

Nair (1997) analyzed the women's health in a coir yarn spinning industry in Kerala. The major objectives of the study was to understand the living and working conditions of coir workers, and to assess the influence of socio-economic factors with focus on perceptions and awareness of their problems, and to find their implications for health and well being of workers. A total of 150 workers were selected randomly from the village of Shertallai Taluk of Alleppey district. In the work place basic amenities like drinking water, sanitary facilities etc. were found lacking. Majority of the workers suffered from allergic problems affecting skin and respiratory organs followed by body aches and pains. The general health problems

are chest pain, headache, stomachache, vomiting, gynecological complaints etc. Due to the marginalized life pattern and the insufficient state support in the form of health services, the need of the coir workers for their occupational benefits had gone unrealized. Inspite of poor working conditions and still poorer living conditions, the attainment of the benefits for better health and well being is still a distant mirage.

WHO (1998) carried out a study on readymade garment workers in Bangladesh, on a sample size of 150 women who reported health problems like pain in the upper and lower limbs and other aches and pains. Around 80 per cent of the workers experienced this kind of illness quite often. This was followed by backache, which was reported by 47 per cent. The major reason was the posture adopted while working.

A study of the female labour force in agriculture sector in Thailand by **Archavanitkul (1998)** reported that most of the female labourers belonged to the age of 20-40 years. They were poor and had only elementary education. About 20 percent of these women had been exposed to the evil effect of pesticides which were due to the poor practices followed The health problems reported included headache, nausea, vomiting and skin rash. The study also found that young children were exposed to pesticides residues on their mother's clothes. The women workers were usually unaware of any minor symptoms and unlikely to seek treatment to change their behaviour.

Outside the home women workers may face the risk of harassment. Furthermore they are likely than men to work in industries and in small enterprises with unsafe working conditions and poor regulation of such hazards as toxic chemicals, radiation, extreme temperatures, excessive noise and violence. Textile workers complain of pulmonary problems, dermatitis, hand injuries and chronic back pain **(Hovel, 1998).**

In a study by the **National Institute of Occupational Health (1998)**, the work stresses of 107 women engaged in sewing in small –scale garment manufacturing units found that 68 per cent of the women complained of back pain and this problem had persisted over a long duration for 35 per cent of the women.

Evaluation of numerous studies leads to the conclusion that prolonged exposure to different toxic substances, even at low concentration may cause a variety of adverse effects on health. This is illustrated over the proportion of cancers related to occupation which also

highlights the problem of interaction between multiple agents, either in the working environment or partly outside it. **(Lancet, 2000)**

Lalitha (2000) exhorted the various aspects of women's employment like types of work, working conditions, and problems faced among women working in Khadi sector and cotton textile mills in Dindigul District. The sample size consisted of 172 labourers engaged in production process out of which 122 were women (70.93%) engaged in blow-room weaving, dyeing, bleaching and printing, mixing, cleaning, cladding, drawing, reeling and packing. Some of the difficulties faced by the workers at workplace were poor ventilation, excessive heat, breathing problem, eyestrain, too much of noise from machine etc. she suggested winding the area for reducing the dust. Health check-up should be made frequently. All the health and safety measures in factories Act should be implemented.

Parikh et.al (2001) explores occupational health hazards among women workers in India. The study indicates that women are exposed to respiratory problems, eye and skin disorders, and noise induced hearing loss caused by dust, noise, heat and cold, etc. Women workers make frequent visits to the doctor.

Ngowi et.al (2001), reported the use of 41 different pesticides by small-scale farmers in Northern Tanzania and the use of Class Ia and Ib pesticides by women in the Tanzanian horticultural industry. Farmers reported that using Aldicarb, a Class Ia pesticide, is extremely hazardous to humans.

The incidence of cancer in the large cotton-manufacturing factory it Lithuania was studied by **Stukonis et.al (2002)**. The textile workers are mainly exposed to the textile-related cotton dusts and some other agents throughout the manufacturing process. The study includes the sample size of 10198 workers were employed. Among them only employees that worked atleast one year in the plant were included in the study. There were 1371 men and 4396 women. The cancer incidence of women was very close to expected in Lithuanian population. Among the women in spinning and wearing departments exposed to the cotton dust a total of 163 cancer cases were observed. The overall cancer risk in the cohort of female in the textile-manufacturing factory in Alytus was almost the same as the country general population. Among the women employed in the textile processing form $\geq$ 10 years group the overall cancer risk was 73 per cent higher than in other employment groups, and

some separate sites even higher: cervix urteri-166 per cent cancers, ovary-179 per cent and Kidney – 270 per cent.

Physical risks experienced by agricultural workers include extremes temperature, lifting and carrying of heavy loads, standing and walking long distances, exerting physical force, working in awkward positions, and vibration. Several women working in agriculture in developing countries located around the equator are exposed to high humidity and high temperatures. Agricultural workers exposed to extremely high temperatures commonly present with the effects of heat stress. Agricultural activities and physical risks such as tractor driving, ploughing and pesticide spraying, planting and weeding expose workers to whole body vibration, standing, walking and working in awkward postures for long periods of time. They are also involved in the carrying of heavy loads often in excess of 30 kg (**Holmberg et.al, 2003)**

Several jobs are inherently dangerous to both men and women workers, but some jobs are more dangerous for women because they have less physical strength and their special needs during maternity put them at risk **(Rethi, 2003).** Women work in industries like tanning, textiles, garments etc. In all industries, they toil long hours at low paid wages and in unskilled jobs. The health problems like T.B, allergies, abortions bronchial disorders, anemia, toxicity etc, are common phenomenon. Women in the last decade become exposed to new kinds of health hazards. The solution to combating the health risks of women at work is to prohibit women from working in potentially hazardous jobs.

Tripathy (2003) opines about the risk involved in construction works, particularly for women workers, who have to climb great heights carrying heavy loads. Accidents involving simple injuries occur every day while fatal accidents were not uncommon. Collapse of ladder, falling from high roofs etc. were the major reasons for fatal accidents, as revealed from interviews and field notes. Long hours of work involving continuous handling of cement or other corrosive construction materials lead to the feet and hands being bruised, burnt and eaten away. Women workers who carry the cement mix and web bricks on their head suffer serious problems like headache and fever. Pregnant women who carry heavy loads run a high risk of abortion. There were no rules for safety in construction. Most of the women labourers belonged to the landless agricultural labourers and migrants.

Ram Lakhani (2004) made a study on "Occupational Health of Women Construction Workers in the Unorganised Sector". This study was undertaken to assess the occupational health status of women workers in the construction industry by evaluating incidences of occupational health disorders. One thousand and fifty-two workers were selected by stratified random sampling. Over three-fourths of the women and almost all men reported working for 10 to 12 hours daily. A majority of the women reported headaches and backaches, as well as pain in the limbs. Fifty-six per cent of women and 16 per cent of men reported injuries resulting in work loss. They had no social security or other workers' benefits. Most women and men said that they would prefer to do some other work. Respiratory, eye and skin disorders and noise-induced hearing loss (NIHL) were found to be prevalent amongst workers exposed to hazards like dust, noise, heat and cold, non-ionising radiation, and exposure to dry cement, glass and adhesives, tar and paint. About 76 per cent women reported gender-specific work stress factors, such as sex discrimination, and balancing work and family demands, above and beyond the impact of general job stressors such as job overload and skill underutilization. Discriminatory barriers to financial and career advancement were found to be linked to recurrent physical and psychological symptoms and more frequent visits to the doctor among women workers.

The **America Institute of Stress (2005)** found that US industry spends $ 300 million annually on job-related stress which causes absenteeism, diminished productivity, poor labour turnover, high medical cost, legal and insurance fees. The study by Queer and Roy (1989) reveals that same hazardous and dangerous tasks are given to unskilled contract and casual workers in developing countries. Both men and women work for 10 to 12 hours daily. Insecurity of jobs led not only to their economic exploitation but also exposes them to a variety of occupational diseases and accidents. Women as helpers form the lowest strata in the hierarchical construction industry. A majority of women reported headache, back pain and pain in the limbs. About 56 per cent of women and 16 per cent of men reported injuries resulting in work loss.

Singh (2005) analyzed the effect of work on health of workers in unorganized sector. Though there were no scientific and direct evidences to support that women worker in brick kilns contract occupational diseases but there can always be a probability of contracting a diseases due to their continuous exposure to dust, heat and unhygienic housing conditions in

brick kilns. It was noticed that some of the women who workers either as the carriers or the unloaders suffered from problems that they said were due to brick kiln work. The women who worked as moulders complained of pain in the back, shoulders, waist and joints. The carriers had roughening and blistering of hands and fingers. The unloaders complained about cough, chest pain and difficulty in breathing. Where women squat for more than 10 – 12 hours, they suffered from some gynecological problems like the miscarriage. Exhaustion to heat and cold are yet some other problems reported by the women of these kilns. There are episodic occurrences of cholera and typhoid at times, specially in children and women in these kilns. These women complained malnutrition in their children and it was observed that many of the children f brick kiln workers were underweight and suffered from digestive troubles and nutritional deficiencies. The diseases stated by them could be divided under seven broad heads. Women suffer from Bronchial and respiratory diseases like cough, cold, allergies and tuberculosis.

Ranjwan et.al (2007) in their study "Health Status of Women Employed in Unorganised and Self-Employed Sector" examined the physical fitness of 110 women engaged in unorganized and self employed sector such as construction work. Brick making, domestic work, tailoring and pottery were assessed by step-test method. It was found that physical fitness and Body Mass Index of the majority of subjects was below average in all occupational groups. Aerobic capacity of majority of workers was good but it was found to be decreased as per the age. Muscular skeletal complaints were highest among brick makers followed by pottery workers and construction workers. The attitude of women construction workers towards job was negative whereas other workers were in the state of neither liked nor disliked except tailors who had expressed favorableness at moderate level.

Kalyani et al (2008) made a study on "Occupational Health Hazards of Farm Women in Tobacco Cultivation". The respondents expressed the health hazards by the farm women in all the operations of tobacco cultivation. The Study had shown that farm workers suffer from increased rates of respiratory diseases, skin disorders, certain cancers, chemical toxicity, and heat-related illnesses. Low back pain, Pain in joints of arms, Body ache due to Bending constantly for hours, in bent posture and Cuts, Wounds, Body pain & Fatigue due to Lack of proper safe equipment.

The 'papad-making' industries of India had provided ample opportunity of employment for the women workers of low socio-economic class although their problems were not much explored. In this study an attempt had been made by **Roy and Dasgupta (2008).** To find out the health status of the women, the working conditions, influencing their health status, to find out the factors, to assess their felt needs. A cross-sectional, descriptive type of observational study was made. The slum was chosen by random sampling method. Following this, complete enumeration method was adopted. Data were collected by interview and clinical examination of the women engaged in this occupation with a pre-designed and pretested schedule. For Statistical Analysis, Proportions and Chi-square test were used. The findings of the study revealed that 77.5 per cent were in the reproductive age group and none were below 14 years. Most of them belonged to poor socioeconomic status. Sixty per cent were in this occupation for more than 10 years and they spent 5 hours for this work daily over and above their household job. Musculoskeletal problem was their commonest health problem. Angular stomatitis, pedal edema, chronic energy deficiency was found on examination. Personal hygienic measures taken were far from satisfactory. A focus group discussion revealed their health and family problems, dissatisfaction about their working conditions and wage. Other needs identified were home visits for their health care, free medicines and health education.

Balasubramaiyan (2011) analysed the major trends in Healthcare, occupational safety and medical expenditure in India. The study reveals that as many as 22 occupational diseases generally affects the health of the workers in India. These diseases can cause vomiting, joint pain, loss of appetite, wrist drop, body ache, etc. The ever increasing industrialization, chemicalisation and sophistication have made industrial jobs more and more complex and intricate. This has led to dangers to human life in industries through accidents.

A study on "Women Work and Health Problems in Backward Region" was conducted by **Porapur (2011)**. A sample of 450 women respondents from rural area and 450 from urban area making the total of 900 women respondents were covered. The working women had been asked whether they were suffering from any health problem due to working outside. The study pointed out that 53.78 per cent women respondents suffer from health problem and 46.22 per cent women respondents did not support this. Even in urban areas 56.22 per cent

women respondents in the sample suffered from health due to working outside. The most important reason for health problems classified during the study are dust/environment problem, continuous sitting, continuous standing, due to long distance, long working hours and excess burden of work. Thus, it was clear that majority of the women respondents in the study were faced with the problem of health due to their working outside the home.

A Study on the Health Problems of Women Working in a Textile Unit in Coimbatore by **Thomas (2011)** revealed that 50 women (31.65 per cent) used to get head ache frequently and 15 women (9.49 per cent) were affected by fever once a month. Forty two women (26.58 per cent) suffered from backache due to the long hours of work in standing position. Many women had certain ailments, very often. Nineteen women (12.03 per cent) suffered from cough, 20 women (12.66 per cent) had knee pain, nine women (5.91 per cent) had stomach pain and three women (1.9 per cent) suffered from the blood pressure.

Govindappa (2012), made a analysis on the occupational health problems and sanitary facilities of "Women Workers in Garment Factories in Karnataka". From the analysis the author found that 210 respondents complained no bathroom facility, 190 respondents reported no proper urinal facility, 170 respondents claimed no toilet facility, 230 respondents forming majority (92 per cent) claimed no cloakroom facility. Only 30 per cent i.e., 78 respondents reported about satisfactory drinking water facility. Sixty per cent of the respondents carry food and other 40 respondents depended upon canteen facility. Sixty one respondents suffered from breathing difficulties, 43 from allergic squeezing coming out of cotton dust. According to the survey conducted by the Associated Chambers of Commerce and Industry (Ass Ocham), 68 per cent of working women in the age bracket of 21-52 years were found to be afflicted with life style ailments such as obesity, depression, chronic backache, diabetes and hypertension. It is very unfortunate that after one and half decade since supreme court pronounced a land mark judgment in 1997, mandatory creation of gender committees at all work place to deal sexual abuses and harassment and this direction is being ignored.

2.2 Nutritional status of Working Women

The health of Indian women is intrinsically linked to their status in society. Despites many exceptions, studies on women's status have found that the contributions Indian women used to make to families are often overlooked in so many cases, and instead they are taken as economic burdens. The majority of Indian women have low levels of both education and formal labor force participation. Poor health has repercussions not only for women but also for their infants and other members of family. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be capable to provide food and adequate care to their children. Finally, a women's health affects the household economic well-being. As a result of poor health, women will be less productive in the labor force.

Poor health has repercussions not only for women but also their families. Women with poor health and nutrition are more likely to give birth to low weight infants. They are also less likely to be able to provide food and adequate care for their children. Finally, a women's health affects the household economic well being, and as a women with poor health will be less productive in the labour force. While malnutrition is prevalent among all segments of the population, poor nutrition among women begins at infancy and continues throughout their lifetime. **(Chatterjee 1990; Desai 1994).**

The physical fitness and Body Mass Index of the subjects were studied by **Ranjwan and Zend (2007).** It can be noticed from that 71.8 per cent of the subjects were in below average category of physical fitness whereas 28.18 per cent respondents were in high average category. None of the subjects have projected good or excellent physical fitness. Majority of tailors (95%) and domestic workers (60%) were falling in high average category with respect to their physical fitness. Distribution of the sample frequency against BMI, projected that on an average, more than 70 per cent subjects belonged to mesomorph category.

Basu and Sidh (2008) examined the net effect of work status on women's health and whether the effect persists after controlling for the influence of socio-economic factors. Their hypothesis was that working women face a greater risk of morbidity and mortality, given that most would be expected to shoulder dual responsibilities: market and household. They also examined the risk across regions. In particular, they examined whether the work status-health relationship differs between the southern and northern regions of India, which

were known to be distinct in female autonomy. This analysis focuses on only two issues: nutritional status (as measured by body mass index and prevalence of anemia) and reproductive health (as assessed by the presence of reproductive health problems) of women from villages in the study area. Results showed that though both work status and socio-economic factors influence health status, the latter are more important; most of the gross effect of work status is due to socio-economic conditions rather than work participation. This calls for policy intervention in providing better health facilities, female education and supplementary nutrition programs for poor women.

Bajaj (2008) in her study on "Women Construction workers in Delhi" finds that among the women surveyed at construction sites, 52 per cent were suffering from chronic energy deficiency. While 24 per cent of these workers has normal body weight index, seven per cent were overweight.

A study made on "Diet and Nutritional Status of Women in India" by **Rao et.al (2010)** revealed that the health of women is linked to their status in the society. The demographic consequence of the women has formed expression in various forms, such as female infanticide, higher death rate, lower sex ratio, low literacy level and lower level of employment of women in the non-agricultural sector as compared to men. Generally, at household level, cultural norms and practices and socio-economic factors determine the extent of nutritional status among women. National Nutrition Monitoring Bureau (NNMB) has been carrying out regular surveys on diet and nutritional status of different population groups since 1972. They made use of, the data collected during 1998-99 and 2005-06 on diet and nutritional status of tribal and rural population respectively in nine States of India. The intake of all the foods except for other vegetables and roots and tubers was lower than the suggested level among rural as well as tribal women. The study revealed inadequate dietary intake, especially micronutrient deficiency (hidden hunger) during pregnancy and lactation. The prevalence of goiter was relatively higher with 4.9 per cent among tribal women compared to their rural counterparts 0.8 per cent. Tribal women were particularly vulnerable to under nutrition compared to women in rural areas. The prevalence of chronic energy deficiency was higher with 56 per cent among tribal women compared to rural women which were only 36 per cent.

2.3 Healthcare Services

Realizing the importance of health, National, State and Voluntary agencies all over the world are striving hard to expand and improve health care service. The purpose of health care services is to improve health status of population. Health status of people depends on provisions of basic sanitation, safe drinking water and clean surroundings which can be included in primitive health care, in addition to preventive and curative health care. Health delivery system is an important subset of health care services. Success of health care service depends on the extent and utilization of health care services by the people.

Baru et.al (2000) throws light on the efficiency of the private sector in providing health services to the people. Study says that though it is assumed that private sector is more efficient and provides better quality care, it does not stand up to empirical scrutiny. According to the study, Delhi's private hospitals follow questionable management practices with regard to workers as well as patient care. Expenditure on wages in these hospitals are kept low through contractualisation of fourth class employees and by gradually undermining the established rights of permanent workers due to which over worked, ill trained and insecure workers are likely to make more mistakes and hide them too. Thus these private hospitals are having many loopholes like more emphasis on profit motive leading to cutting of costs which has a direct bearing on the quality of care, practice of discharging patients early in order to ensure quick turnover and increased intervention. The study concludes that, it is imperative for these hospitals to ensure certain minimum working conditions expected in all industries for the employees. State should have effective administrative mechanisms that will ensure that these private hospitals comply with conditionality's for receiving subsidies like quality and equity in the provision of services. Regulatory framework for medical care would certainly help in improving the performance or medical industry in health services delivery

Duraisamy (2001) attempted to analyse the utilization and expenditure on medical services in Tamil Nadu using the NSS 42nd round survey data. The average hospital fees in a private hospital was about 19 and 100 times higher than the public hospital charges in rural and urban sectors respectively. The majority of the population relied on the allopathic system

of medicine. The results indicated that as the level of education and per capita income increases the utilization of public healthcare services reduced significantly.

Rao (2001) explained the cost and distance influence on the poor and rural population. Big hospitals with modern equipment and highly specialized medical personnel do not substantially contribute to the healthcare of rural and urban poor. The treatment available in sophisticated hospitals is out of reach of these people because of the cost involved in the treatment. Barrier of distance between villages and the city hospitals also prevents them from seeking specialized medical treatment. As a matter of fact it was impossible for the emperies to reach out to the vast majority of the rural population.

David Sahn et.al (2003) in their study "The Demand for Healthcare Services in Rural Tanzania", examined the pattern of healthcare demand in rural Tanzania. The data from the 1993 Human Resources Development Survey (HRDS) was used to model the healthcare choices that individuals in Tanzania, make when sick or injured. A nested multi nominal logit model was used. The most important finding was that the own price elasticties were quite variable, being far greater than unity for private clinics, private hospitals, and public hospitals. Specifically it was found an uncompensated elasticity of demand for private services with respect to the price of public clinics and dispensaries to be a surprisingly high 0.64. Regarding the quality on healthcare demand there was a greater demand for public clinics and dispensaries in those clusters with higher quality of medical staff.

Anand (2003) highlighted the use of social choice and welfare theory in health economics by developing and applying the integration of claims framework to health-care rationing. Related to Sen's critique of neo-classical welfare economics, the integration of claims framework recognizes three primitive sources of claims-consequences, deontology and procedure. Taxonomy was presented with the aid of which it is shown that social welfare functions reflecting these claims individually or together, can be specified. Some of the resulting social choice rules can be regarded as generalizations of health-maximization and all have normative justifications, through the justification may not be universally acceptable. The study shows how non-linear programming can be used to operationalise such choice rules and illustrates their differential impacts on the optimal provision of health-care. Study concludes that the integration of claims provides a viable framework for modeling health-

care rationing that is technically rigorous, general and tractable, as well as being consistent with relevant moral considerations and citizen preferences.

To analyze the performance of rural public health systems of 16 major states in India in improving the health indicators of their population **Sankar and Kathuria in 2004** made a study. In order to measure performance, the study used techniques from the stochastic production function and panel data estimation using data for the period 1986-97. Study found that not all states with better health indicators have efficient health system. Relative efficiencies differ across states and this is due to differences not only in the health sector endowment, but also its efficient use. It shows that states should not only increase their investment in the health sector endowment, but also its efficient management and use is required.

David Lawson (2004) investigated the determinants of health seeking behavior in Uganda, keeping in mind the income and user fees being the main factors which influenced healthcare demand in Uganda. When analyzing healthcare demand in Uganda there were several rich data sources upon which micro econometric analysis could be used. However, the most useful of these was the 1992/2000 Uganda National Household Survey (UNHS), which was particularly rich in community and healthcare data. Multi nominal logit approach was adopted which not only focused on the most important decision but also on what type of medical care was demanded. Overall, the demand analysis showed that income was strongly associated with increased healthcare usage, across all age ranges. Furthermore, they found significant differences in health seeking behavior to be related to Age and gender, and that increased levels of education are consistently associated with a transfer away from government provided healthcare, possibility indicated that people regard its quality as inferior.

Santosh et.al (2004) in their study has examined the health status of migrant workers in North India. Health status of these women have improved after migration, they have not started using modern Health facilities either for child birth or general illnesses.

The study by **Majumber (2006)** on "Utilization of healthcare in India: An empirical study based on National Family Health Survey – 2" made an analysis on healthcare economy in India. The major objective to examine how demand for public as well as private healthcare

service were affected by various socio-economic and demographic characteristics and other health service system related factors. It covered a representative sample of about 95,000 women in the 15-49 age groups from 26 states in India. Methodologically the exercise was carried out by estimating binary multivariate logistic pattern. The study revealed that utilization of public health facilities varied sharply according to individual, household and social characteristic and institutional factors. On an average in India, 58.91 per cent of the respondents utilized private and 41.09 per cent of the respondents utilized public health facilities. When they concentrated on quality of care they stated that private health facilities remained far ahead of their public counterparts.

Jain et.al (2006) made a study on "Qualitative Assessment of Health Seeking Behaviour and perceptions Regarding Quality of Healthcare Services among Rural Community of District Agra". Eighteen villages of three rural community development blocks of district Agra (Uttar Pradesh) was selected on the basis of performance for achievement of RCH indicators. Multistage stratified Random Sampling Technique was adopted for selection of villages to be included in the study. The responses of community members were free listed and semi-qualified using standard qualifiers. The results indicated that the community members first discussed their health problems with the community members. Majority of people tried some home treatment first and then only opted for approaching any other provider. Choice of the health provider was in fact dependant on decision-makers which would be elder male family members or some other person from the community. Literacy status, socio economic status, past experience and perceived quality of healthcare services played a pivotal role in the selection of provider. Quality of available healthcare services was poor in the opinion of respondents as a result of which rural community preferred to approach private providers ranging from indigenous medical practitioners, rural medical practioner's and qualified doctors.

2.4 Health Insurance

The studies and literature reviews of health insurance schemes targeting rural or informal sector populations in developing countries (often called "community insurance schemes") frequently conclude that schemes have weaknesses, yet do not explore in detail the effect of design features on performance. This paper presents a conceptualization of how performance in the areas of risk protection and resource mobilization is determined by the interaction of design features with institutional and technical factors. Design features refer to scheme specifications (e.g., required contribution) and to operating modalities (e.g., procedures for enrolment or obtaining benefits. Performance, with respect to risk protection and resource mobilization, of several potential "high population schemes" for the informal sector in Africa, is assessed. The outcome suggests that the design of community health insurance schemes may be improved by: (1) design specifications that utilize data on willingness to pay (WTP) of the target population and projected health care costs; (2) incorporating modalities of operations that facilitate cost effective exchange between a formal organization and individuals acting in an informal environment.

The effectiveness and efficiency with selected health insurance schemes for the informal sector population have achieved resource mobilization and risk protection. The evidence is presented mainly from schemes judged to have the necessary— though often insufficient—design and/or implementation features that would permit expansion to achieve high primary or secondary participation rates. Logically these features exist because, at the minimum, the calculation of contribution levels reflects the ability and willingness to pay (economic demand) of the target population. The proposed scheme is described to potential buyers in terms of benefit package and management structure, and the demand is the ability and willingness to pay (WTP) the annual contribution in the required installments. **(Dyna Arhin and Tenkorang, 2001).**

Santerre (2006) in his study "Examining the marginal access of private health insurance", a relatively simple model was developed to incorporate a broader measure of marginal access value into the demand for health insurance. The conceptual model incorporated assessed value by treating the demand for health insurance as being derived from the demand for good health. This study used national data (1960-2002) and multiple

regression analysis to track and explain changes in the marginal access value of private health insurance over time at the national level in the United States. Based upon multiple regression analysis, marginal access value was shown to have increased over time in response to rising income, more generous benefit coverage, and new medical technologies. In addition, expansions in the Medicaid programme have shown to have slowed the growth of the marginal access value of private insurance.

The National Health Insurance (NHI) scheme, first introduced in Ghana in 2004 as a pro-poor financing strategy aimed at removing financial barriers to health care and protecting all citizens from catastrophic health expenditures, which currently arise due to user fees and other direct payments. A comprehensive assessment of the financing and benefit incidence of health services in Ghana was undertaken. A study by **Akazili et.al (2012)** drew on secondary data from the Ghana Living Standards Survey (2005/2006) and from an additional household survey which collected data in 2008 in six districts covering the three main ecological zones of Ghana. Findings show that Ghana's health care financing system is progressive, driven largely by the progressivity of taxes. The national health insurance levy (which is part of VAT) is mildly progressive while NHI contributions by the informal sector are regressive. The distribution of total benefits from both public and private health services is pro-rich. However, public sector district-level hospital inpatient care is pro-poor and benefits of primary-level health care services are relatively evenly distributed. For Ghana to attain an equitable health system and fully achieve universal coverage, it must ensure that the poor, most of who are not currently covered by the NHI, are financially protected, and it must address the many access barriers to health care.

It is true that the insurance companies in India at present have been operating in a competitive environment. In order to woo the customers the companies in the private sector have started introducing attractive health insurance schemes. However the insurance companies in public sector are well established while the new companies in the private sector have yet to establish their identify in the market, while the stigma of "poor customer service" is evident among the insurance companies in the public sector the private sector insurance companies should find this as an opportunity to serve the customers with good service. There is also a feeling among the sector insurance companies are neither attractive nor flexible

while the product mix of the private insurance companies is attractive but expensive, **Murthy (2011).**

Gumber et.al (2000), made a study on "Health Insurance for Informal Sector A Case Study of Gujarat". This pilot study explores the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system, and the likely constraints in extending current health insurance benefits to workers in the informal sector. The ESIS has substantial scope for improvement of its services, particularly better utilization of its facilities. The survey shows that the poor prefer public sector management of health care facilities.

2.5 Related Studies

Among the 1013 women whose health data were analyzed only 23 were in good health, while the rest had some health problems. It follows that women rarely go for preventive health checkups and often "lives" with their health problems, without seeking medical help. The lack of awareness as well as indifferences contributes to their myriad problems **(Sinha, 1993).**

Mathiyazhagan (1996) analyzed the choice of healthcare in India. He examined the people's choice of healthcare provider in rural India. The people's choice of healthcare provider was estimated through Logit Model by using rural household survey on health in Karnataka state in India. The study also explores the heuristic approach through observation and informal discussions with rural people about their opinion on existing healthcare services. The analysis showed that the private healthcare provider has emerged as the people's choice. However, the choice was significantly linked with socio-economic conditions of the rural people. The discussion suggested that policy makers in India should take serious note of the growing popularity of the private sector in providing healthcare services in India, and that it would be advisable to opt for regulatory and supportive policy interventions.

Gowri and Devi (2011) conducted a survey on "Creating Awareness about Occupational health and safety of women in informal food sectors" with the objectives of to assessing socio-economic background information of the respondents, to examine their nutritional profile and to provide occupational hazard free environment to the respondents.

The study found out that majority of them are residing in rural areas and were illiterate and seventy per cent of them were Hindus. While looking the nutritional status 32 per cent of them were normal in weight, only 16.5 per cent were obese. Majority (67 per cent) were anemic. It was clear that most of them were affected either by mild to moderate or severe forms of anemia and had back pain, depression, asthma and dermatitis. They are not aware of the occupational health and safety. Forty three per cent of the respondents opined lack of income as the cause of occupational diseases and 91 per cent never had knowledge about preventive measures of occupational diseases. From this study it was clear that the respondents need occupation health and safety education.