



Determinants of Healthcare Utilisation Among Migrant Workers in India's Textile Industry: Challenges and Policy Perspectives

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Abstract

The present paper explores the factors influencing healthcare use among internal migrant workers in the textile industry, using Andersen's Behavioural Model. Such workers as migrant labourers are highly dependent on seasonal employment and often exploited by employers, and experience adverse conditions associated with migration. The current study aims to determine the predisposing, enabling, and need factors that influence healthcare access among migrant workers in the textile industry. The results of the present study revealed a significant number of private healthcare facilities used by participants despite their low socioeconomic status. Accordingly, the current results indicate that healthcare access among these workers remains insufficient despite the high level of need. The results contribute to an improved understanding of the phenomenon by recognising the gap in healthcare utilisation by migrant workers. Notably, the results highlight the importance of ensuring adequate healthcare access for this population group, a need that requires appropriate policies to provide affordable, accessible healthcare services.

Keywords: Healthcare Utilisation, Behavioural Model, Migrant Labour and Textile Industry

1. Introduction

Access to healthcare is a fundamental human right enshrined by the constitution, as every individual in India has a right to health under Article 21. Nonetheless, healthcare in India is characterised by inequity in access and utilisation due to social, gender, and regional disparities (Kisa et al., 2009). India's social and cultural heterogeneity is reflected in inequalities and disparities in healthcare access, with specific populations and demographics experiencing lower rates of access to healthcare services (CBGA, 2015; McMaughan et al., 2020; Sen et al., 2002).

Some of the issues in Indian healthcare that lead to low accessibility and utilisation of health services include supply-side barriers, such as a lack of infrastructural resources and a shortage of skilled personnel, and demand-side problems, such as high out-of-pocket payments and inflationary health expenditures (Johar et al., 2018). Healthcare in India is dominated by private providers, who account for 75% of health service provision, yet remain inaccessible to the poor (Kumar & Prakash, 2011). Also reported are inequalities with vulnerable groups such as women, the elderly, and the poor, who face barriers to accessing healthcare services, increasing their vulnerability to illnesses (Karkee & Kadariya,

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2013). Generally, healthcare utilisation in India is lower than in other low-income countries with weak institutional mechanisms.

Healthcare access has faced challenges due to the rise of the informal labour market and internal migration of workers, with most industries in India utilising cheap labour. Textile manufacturing employs major internal migrant workers, with their working conditions being characterised as unhealthy and unsafe (Maher & Haan, 2009). Migration is high in India, and most internal migrants work in the textile industry, which has been reported as having some of the worst working conditions in the world (Keerthiga & Selvam, 2017). The informal labour market largely constitutes India's textile industry, posing significant health risks to the migrants working in the sector. The health risks stem from working conditions, accommodation, and generally low living standards, which have been reported as key contributors to low accessibility and utilisation of health services among migrants in the textile industry (WHO, 2010; Wickramage et al., 2018).

The health issues facing the migrants are chronic illnesses, malnourishment, and communicable diseases, which are predisposed by personal behaviours such as drug abuse and unsafe sex among the workers (Tangcharoensathien et al., 2015). The vulnerability of the migrant workers to these health issues makes it imperative to address their unique healthcare needs to achieve universal health coverage set in the Sustainable Development Goals. However, there is limited research on the healthcare utilisation and access of textile migrant workers, as well as the factors influencing them. The study will be conducted in Tiruppur textile city, as it is a significant contributor to India's textile production and has a large proportion of the labour force utilising migrant workers. The study will examine the influence of several variables on healthcare access and utilisation among migrant workers in Tiruppur's textile industries. The Andersen behavioural model will serve as the theoretical framework for the study.

2. Theoretical Framework: Andersen's Behavioural Model of Healthcare Utilisation

Andersen's health behavioural model has been considered the study's theoretical background. The Health Behaviour Model (HBM) provides an integrated, multidimensional approach to individual and contextual factors, in contrast to existing models such as the Health Belief Model (Hochbaum, Rosenstock, & Kegels, 1952), Demand For Health (Grossman, 1972), and Young's model (Young, 1981). The HBM captures various factors, such as socio-demographics and healthcare necessities. The model is suitable for migrant workers because of their divergent healthcare choices. The variables specified in the HBM model comprise three factors. (i) Predisposing; (ii) Enabling; (iii) Need.

(i) **Predisposing factors** consist of (a) demographic features (gender, age, marital status, and past illness), (b) social factors (such as the level of education, occupation, household size, place of origin, religion, migration status (human mobility) (c) health beliefs (value concerning health and illness, knowledge about health conditions and illness, attitude towards healthcare services).

(ii) **Enabling factors** include household and community characteristics such as income, health insurance, wealth status, place of residence, and awareness of healthcare services, including distance, cost, and availability.

(iii) **Need factors** consist of individuals' perceived and evaluated health statuses, such as symptoms, nature and severity of the illness, type of morbidity, and diagnosis.

2.1. Predisposing Factors

Age is a significant factor in healthcare utilisation, though its impact varies across age groups. Blackwell et al. (2009) found that younger individuals are more likely to visit doctors than older individuals, while Singh, Patra, and Khan (2022) noted that older individuals are more likely to choose public health providers. Raj and Singh (2023) discovered that, apart from a lack of social support, the elderly also do not seek care early; rather, they choose to attend to their health needs at a later stage. However, the variables influencing healthcare utilisation among the aged consist of nativity, ethnicity, region, and geography (Andersen et al., 2002). In contrast, Dey and Mishra (2014) found that advancing age and education influenced healthcare utilisation, a claim that Agarwal and Bhattacharya (2021) echoed, noting that the urban-rural dichotomy and the state's health infrastructure are critical predictors.

In addition to age, education is another vital determinant of healthcare utilisation, has been at the centre of many studies, and has been shown to predict healthcare service use (Chen, Kazanjian, & Wong, 2008). Another crucial predictor of healthcare utilisation is an individual's marital status, with studies indicating that unmarried individuals are more likely to forgo healthcare services (Joung et al., 1995; Parslow et al., 2002). Sharma and Goli (2022) found that marital status also influences an individual's healthcare utilisation. The researchers Mishra and Das (2023) found that larger families, especially those with both parents working, are more likely to seek private healthcare services rather than government-run facilities because private services are readily available.

2.2. Enabling Factors

In terms of social factors, income level is closely linked with healthcare accessibility. People with low income are more inclined to use public health services, whereas high-income individuals prefer private hospitals (Blackwell et al., 2009; Chatterjee et al., 2019). Mishra and Mohanty (2022) have also argued that income level is a critical predictor of healthcare choice, with high-income individuals opting for private healthcare institutions to avoid public ones. Another factor that affects people's choice of healthcare is the place of residence. For example, people living in urban areas are more likely to use doctors because of easy access to healthcare facilities. Indeed, according to Rana et al. (2021), the probability of accessing formal healthcare services for urban residents is twice that of rural residents.

In addition to income level and place of residence, the length of time spent in a particular locality affects people's healthcare choices. Indeed, the longer a person resides in a given location, the more they are likely to use existing healthcare services (Chen et al., 2008). Another crucial aspect of healthcare accessibility is the distance between people and healthcare facilities. Indeed, the farther a person lives from a public

healthcare institution, the more likely they are to access private healthcare (Chauhan et al., 2015). Lastly, the mode of transportation is another critical predictor of healthcare accessibility. The lack of efficient transportation and long distances reduces access to public healthcare institutions (Srivastava & Kumar, 2020). The inaccessibility is especially acute for women and older people in peri-urban regions.

2.3. Need Factors

The probability of choosing a particular health care service depends on the type and severity of the disease. According to the study by Jana and Basu (2017), any ailment that requires less than 15 days of treatment reduces the likelihood of selecting public healthcare institutions. On the other hand, the probability of choosing private healthcare providers is minimised as recovery increases. Chronic patients are more likely to select public health care options, whereas private healthcare facilities are preferred for surgeries by the Indian elderly population (Chatterjee et al., 2019). Ghosh (2014) demonstrated in his study that the likelihood of selecting private healthcare options decreases as illness severity increases.

3. Methodology

The primary data were collected from respondents who were internal migrant labourers working in textile units in Tiruppur. The study focused on the textile parks in the district. Convenience sampling was used to select the participants. The respondents were male migrants from other states who had been working in the Tiruppur textile industry for more than a year. The migrant workers were those who had faced illness in the past year. Since there was no information on the number of migrant workers, Krejcie and Morgan's (1970) formula was used to determine a sample size for a large, unknown population. Therefore, 400 migrant workers were selected as the sample size for the study. The strata were determined by the type of work performed by migrant workers across various textile units. The workers were categorised into seven occupation types, and the allocation of respondents was done proportionally.

4. Econometric Model: Multinomial Logistic Regression

Given that the response variable for healthcare utilisation is categorical (polytomous), Ordinary Least Squares (OLS) regression is not appropriate, as it is used for continuous response variables. The Logistic regression model is the most appropriate statistical method for estimating the relationship between a categorical response variable and a set of predictor variables. The type of logistic regression depends on the type of response variable. For nominal variables with more than two unordered categories, multinomial logistic regression (MLR) is most appropriate (Frost, 2019). MLR offers flexibility, as it does not require assumptions of linearity, normality, or homoscedasticity (Lahn & Ebenstein, 2009) and accommodates nonlinear relationships (Withers, 2009). In this study, MLR is employed to estimate the probabilities of each response category relative to a reference group based on a set of predictor variables (Kwak & Clayton-Matthews, 2002). Originating from binary logistic regression, MLR is conceptualised as a series of comparisons between multiple categories and a baseline (Ogunniran & Ademola, 2019). Prior research has identified MLR as the most appropriate model for analysing healthcare utilisation data.

4.1. Model specification

The response variable has three mutually exclusive categories (public healthcare, private healthcare, or self-medication) (Table 1). It intends to estimate those factors' impacts (on the response variable) using the Andersen Model, and we fit a suitable multinomial logistic regression model.

Table 1: Construction of Variables

Dependent Variables	Categorisation
<i>Healthcare</i>	<i>1=Public Healthcare; 2= Private Healthcare; 3= Self-medication</i>
Independent Variables	
<i>Predisposing Factors</i>	
<i>Region of Origin</i>	<i>1=North; 2 =East; 3 =Central; 4=North East</i>
<i>Place of Origin</i>	<i>1=Urban; 2=Rural</i>
<i>Age Group</i>	<i>1= (18-23); 2= (24-26); 3= (27 & above)</i>
<i>Marital Status</i>	<i>1=Unmarried; 2=Married</i>
<i>Educational Status</i>	<i>1=No formal education; 2= Formal education</i>
<i>Social Group</i>	<i>1=General; 2=OBC; 3=SC/ST</i>
<i>Religion</i>	<i>1=Hindu; 2=Muslim; 3=Christian & Others</i>
<i>Household size</i>	<i>1=Small (1-3); 2=Medium (4-6); 3=Large (7-8)</i>
<i>Smoking Habit</i>	<i>1=Yes; 2=No</i>
<i>Enabling Factors</i>	
<i>Place of Residence</i>	<i>1=Urban; 2=Rural</i>
<i>Income Group</i>	<i>1=11000-18500; 2=18800-23000; 3=23300-34000</i>
<i>Owning a House in Origin</i>	<i>1=Yes; 2=No</i>
<i>Years staying in the locality</i>	<i>1=Less than two years; 2 =Two to Four years; 3=More than four years</i>
<i>Accommodation Provided by the employer</i>	<i>1=Yes; 2=No</i>
<i>Awareness of hospital location</i>	<i>1=Yes; 2=No</i>
<i>Hospital Distance</i>	<i>1=Near (0-2 km); 2=Far (2-6 km); 3=Very far (6.5&Above)</i>
<i>Mode of travel</i>	<i>1 = Walk; 2 = Own Vehicle (Bike/Car); 3= Rented Vehicle (Auto/Rickshaw/ Cab); 4 = Public Transport (Bus)</i>
<i>Need Factors</i>	
<i>Severity of Illness</i>	<i>1=Not severe; 2=Severe</i>
<i>Type of the Illness</i>	<i>1= Occupational; 2= non-Occupational</i>
<i>Type of Morbidity</i>	<i>1=Short term; 2=Long Term</i>
<i>Treatment stage for Illness</i>	<i>1=Immediately; 2 =Wait and see the severity of the illness</i>

Source: Calculated using primary survey data.

Moutinho and Hutcheson's (2007) general Multinomial Logistic Regression model is written as follows:

$$\text{Ln}[Pr(Y = k)/(Y = K)] = \beta_0 + \beta_1 X_{ik} + \beta_2 Y_{ik} + \beta_3 Z_{ik} + U_{ik} \quad (1)$$

The model of healthcare utilisation is denoted using two (i.e., $k - 1$) logit models:

$$\text{Ln}[Pr(Y = \text{Public})|(R = 1)/Pr(Y = \text{SM})|(R = 1)] = \beta_0 + \beta_1 X_{ik} + \beta_2 Y_{ik} + \beta_3 Z_{ik} + U_{ik} \quad (2)$$

$$\text{Ln}[Pr(Y = \text{Private})|(R = 1)/Pr(Y = \text{SM})|(R = 1)] = \beta_0 + \beta_1 X_{ik} + \beta_2 Y_{ik} + \beta_3 Z_{ik} + U_{ik} \quad (3)$$

Where $k=1, 2$, and 3 represent the three healthcare choices: public, private, and self-medication; $R=1$ represents those who reported illness during the last year and visited Outpatient Care for treatment. The response variable is the log probability that individual i will select healthcare alternative k ($k = 1, 2$) compared to alternative 3 . The third category, i.e., self-medication (Dispensary/Drugstore/Home Remedies), is the base group that reported being unwell but did not seek healthcare services. One is public healthcare (Public Hospital/PHC/CHC), with the help of trained professionals, and the other is private healthcare (Private Hospital/Clinic/Homoeopathy/Vaidya/Hakim), with the help of a trained professional.

The independent variables are divided into three clusters: predisposing, enabling, and need factors, illustrated by the vectors X , Y , and Z , respectively. The β s, the vector of coefficients, vary by the type of healthcare alternative and indicate the independent variables' net impact on the likelihood of choosing healthcare facility k . The unobserved variables of healthcare alternatives are called " U_{ik} ". The model also implies that every u_{ik} for every possible value of k is independently and identically distributed according to the extreme value distribution. The independent irrelevant alternative (IIA) features must be satisfied for the MNL model to work. Frequently, this presumption is not realistic. The nested logit model (NLM) is an alternative to MNL. However, in this model, all independent variables are migrant characteristics, whereas healthcare providers' characteristics are not included as independent variables.

The MNL and nested logit model results are similar (Sahoo and Madheswaran, 2014). Thus, when choices are not close substitutes, a multinomial model is appropriate (Kennedy, 1943). Intercept β_0 is the value of the response variable when all of the explanatory variables are equal to zero. Where β_1 , β_2 , and β_3 are the regression coefficients of X_{ik} , Y_{ik} and Z_{ik} . Each regression coefficient indicates the magnitude of the risk factor's contribution relative to the base category.

While a positive regression coefficient implies that the variable increases the likelihood of the outcome, a negative regression coefficient suggests that the independent variable decreases the likelihood of the outcome (Bhadra, 2010; Washington et al., 2003; Moutinho and Hutcheson, 2007). A near-zero regression coefficient indicates that the risk factor has minimal effect on the probability of that result. However, a significant regression coefficient

indicates that the risk factor substantially increases the likelihood of the outcome (Petrucci, 2009; Moutinho and Hutcheson, 2007).

4.2. Results from Multinomial Logistic Regression

The results have been interpreted using RRR (relative risk ratio) (Table 2).

Table 2: Multinomial Logistic Regression Results

Base Category (Self-Medication)	Public Hospital			Private Hospital		
Independent Variable	RRR	Std. Err.	P> z	RRR	Std. Err.	P> z
Predisposing Factors						
Region of Origin						
North	0.232	0.322	0.293	7.946	6.081	0.007***
East	1.567	1.944	0.717	3.62	2.643	0.078*
Central	3.442	4.49	0.343	5.214	4.549	0.058*
North East	(base)					
Place of Origin						
Rural	0.158	0.142	0.041**	0.644	0.358	0.428
Urban	(base)					
Age Group						
18-23	5.452	5.619	0.1*	2.227	1.372	0.194
24-26	6.309	6.286	0.065*	1.345	0.783	0.61
27 & above	(base)					
Marital Status						
Unmarried	1.042	0.84	0.959	2.169	1.197	0.161
Married	(base)					
Educational Status						
Formal education	5.428	4.345	0.035**	1.209	0.61	0.707
No formal education	(base)					
Social Group						
General	0.917	1.089	0.942	8.43	7.407	0.015**
OBC	0.174	0.163	0.062*	0.968	0.643	0.962
SC/ST	(base)					
Religion						
Hindu	0.007	0.009	0.000***	4.221	5.154	0.238
Muslim	0.02	0.03	0.007***	5.96	7.275	0.144
Christian & Others	(base)					
Household Size						
Medium (4-6)	2.892	2.768	0.267	10.79	7.352	0.000***
Large (7-8)	3.98	4.442	0.216	5.4	4.295	0.034**

Small (1-3)	(base)					
Owning a House in Origin						
Yes	0.054	0.056	0.005***	2.24	1.234	0.143
No	(base)					
Smoking Habit						
Yes	2.149	1.273	0.196	2.274	0.917	0.042**
No	(base)					
Enabling Factors						
Place of Residence						
Urban	0.228	0.147	0.022**	2.782	1.296	0.028**
Rural	(base)					
Income Group						
188 00-23000	6.825	5.927	0.027**	1.876	0.967	0.223
23300-34000	11.832	10.535	0.006***	5.531	3.441	0.006***
11000-18500	(base)					
Years of stay in the locality						
Two to Four years	7.24	7.262	0.048**	3.658	2.019	0.019**
More than four years	3.584	3.425	0.182	4.028	2.061	0.006***
Less than two years	(base)					
Accommodation Provided by the employer						
Yes	1.286	1.575	0.838	7.071	4.994	0.006***
No	(base)					
Awareness of hospital location						
Yes	7.973	7.246	0.022**	1.616	0.872	0.374
No	(base)					
Hospital Distance						
Far(2-6km)	5.562	3.791	0.012**	1.355	0.635	0.516
Very far (6.5 & Above)	4.487	5.446	0.216	4.752	3.558	0.037**
Near (0-2km)	(base)					
Mode of Travel						
Own Vehicle (Bike/Car)	0.067	0.085	0.033**	14.31	8.404	0.000***
Rented Vehicle (Auto/Rickshaw/ Cab)	0.029	0.046	0.028**	1.629	1.45	0.583
Public Transport (Bus)	0.211	0.223	0.142	3.282	2.219	0.079*
Walk	(base)					
Need Factors						
Severity of Illness						
Severe	5.099	4.15	0.045**	5.312	2.656	0.001***
Not severe	(base)					

Type of the Illness						
Occupational	3.04	2.052	0.1	1.734	0.673	0.156
Non- Occupational	(base)					
Type of Morbidity						
Long term	0.701	0.642	0.698	2.122	1.332	0.231
Short term	(base)					
Treatment stage for illness						
Immediately	4.167	3.893	0.127	4.453	3.083	0.031
Wait and see the severity of the illness	(base)					
Constant	0.203	0.592	0.585	3.15e-06	7.74e-06	0.000***

Source: Calculated using primary survey data.

Note:*** $p < .01$, ** $p < .05$, * $p < .1$

4.2.1. Predisposing Factors

Here, self-medication (dependent variable) is considered the base category. The preference for private healthcare services among respondents from the North is likely to be 7.9 times that of those from the Northeast. Similarly, the respondents' preference for East and Central is expected to increase by factors of 3.6 and 5.2, respectively. This means that respondents' origin plays a vital role in accessing healthcare services. It may be due to several factors, such as attitude towards healthcare, healthcare practices, cultural practices and treatment practices (Chen et al., 2008; Lin, Wang, & Zhu, 2021). The multinomial results indicate that respondents from rural areas are more likely to prefer self-medication. The RRR value is 0.158.

The preference for public healthcare services among respondents in the 18-23 age group is likely to be 5.4 times higher than that of the 27 and above age group. Similarly, the preference for public healthcare services of respondents in the 24-26 age group is expected to increase by 6.3 compared to the 27 and above age group.⁴ Age is the most important indicator for determining healthcare use because the elderly population has a higher chance of health problems than the young population (Affairs, 2016; Blackwell et al., 2009; Brown, Barner, Bohman, & Richards, 2009; Chen et al., 2008; Hochhausen, Le, & Perry, 2011; Masiye & Kaonga, 2016; Ogunniran, Ademola, & Onyeka-Ubaka, 2014; Surood & Lai, 2010).

The preference for public healthcare services among respondents with formal education is likely to be 5.4 times higher than among those without formal education. Respondents with higher levels of education are more likely to receive advanced care. Individuals with a low level of education are more likely to seek primary care, self-care (Drugstore or Dispensary), or no care (Alguwaihes and Shah, 2009; Banerjee, 2021). Respondents' preference for private healthcare services by general category is expected to be 8.4 times higher than in the SC/ST category. The choice of public healthcare services of respondents with formal education is less likely to increase than in the SC/ST category.

Social group (Caste) discrimination is also found in healthcare utilisation (Adhikary et al., 2020; Baru, Acharya, Acharya, Shiva Kumar, & Nagaraj, 2010). The multinomial results show that the Hindu and Muslim respondents are likely to prefer self-medication. The RRR value is 0.007 and 0.02, respectively. Religion impacts healthcare utilisation (Surood & Lai, 2010). The preference for private healthcare services

among respondents with medium household size (4-6 members) is likely to be 10.7 times higher than among those with small households (1-3 members). Similarly, the respondents' preference for a medium household size (7 or more members) is expected to increase by a factor of 5.4. The household with children or older people and a more extensive household size influence healthcare utilisation (Chatterjee et al., 2019; Su, Pokhrel, Gbangou, & Flessa, 2006). The preference for private healthcare services of the respondents who have smoking habits is likely to increase by 2.2 times that of those who do not.

4.2.2. Enabling Factors

The respondents' preference for public healthcare services, with an income range of |18,800- |23,000, is expected to be 6.8 times higher than that for the income range of |11,000- |18,500. The preference for public healthcare services of respondents having an income range of |23,300- |34,000 is likely to increase by 2.14 ((public/ private) 11.8/5.5) times that of those income ranges of |11,000- |18,500 (Blackwell et al., 2009; Sahoo & Madheswaran, 2014; Su et al., 2006). The multinomial results show that respondents who own a house (origin) are expected to prefer self-medication. The RRR value is 0.054.

The preference for private healthcare services of respondents living in urban areas is likely to increase by 12.2 ((private/ public) 2.7/0.2) times more than in rural areas. The destination's geographic area is also important in determining access to healthcare. Mainly, respondents moving from rural to urban areas are considered aliens in urban areas; this will lead to a barrier to access, resulting in unqualified medical practitioners or self-medication (buying medicine from a dispensary or drug store or practising home remedy) (Baru et al., 2010; Masiye & Kaonga, 2016; Sahoo & Madheswaran, 2014; Su et al., 2006).

The preference for public healthcare services of respondents staying two to four years is likely to increase by 2.06 ((public/ private) 7.24/3.5) times that of those staying less than two years. The preference for private healthcare services among respondents staying more than four years is likely to be four times that of those staying less than two years. Years of staying in the destination lead to becoming part of the community, and familiarising oneself with different healthcare services will remove barriers to accessing healthcare. More years of staying influences healthcare services (Chen et al., 2008; Dang, Zou, Peng, & Ling, 2018; Hochhausen et al., 2011; Surood & Lai, 2010). The respondent's employer's preference for private healthcare services is likely to increase by seven times that of employers who do not. The preference for public healthcare services among respondents aware of the hospital location is likely to be 7.9 times higher than among those unaware (Surood & Lai, 2010; Mishra et al., 2015).

The preference for public healthcare services among respondents, by hospital distance, is far more likely to increase by 5.5 times than for those near the hospital. The preference for private healthcare services among respondents with very far hospital distance is expected to increase by 4.7 times that of those with a near hospital distance (Mishra et al., 2015). Respondents' preference for private healthcare services with their vehicle is expected to be 14.3 times that for walking. Similarly, respondents' preference for private healthcare services among bus users is expected to increase by a factor of 3.2. There are several barriers to accessing healthcare, including the distance to the healthcare facility and the mode of transport (Klein & Von Dem Knesebeck, 2018; Surood & Lai, 2010).

4.2.3. Need Factors

The probability of choosing a specific healthcare service depends on the type of illness and its severity. The study by Jana and Basu (2017) has shown that any ailment that lasts less than 15 days reduces the likelihood of choosing public healthcare. In contrast, increased recovery time minimises the probability of choosing private healthcare. Chronic patients have higher odds of choosing public healthcare providers, while private healthcare is preferred for surgeries among the elderly population in India (Chatterjee et al., 2019). The study by Ghosh (2014) showed that the likelihood of choosing private healthcare decreases with increased illness severity. More recently, Sharma and Sekher (2020) found that individuals with non-communicable diseases (NCDs) in urban India were more likely to utilise private healthcare, while rural patients with similar conditions opted for public facilities due to cost concerns. Additionally, Jain and Awasthi (2021) reported that the perceived severity of illness significantly influenced the choice of healthcare provider, with private facilities preferred for acute episodes and public care for chronic management, especially among lower-income groups.

5. Conclusion

The study finds an imbalance in the use of healthcare resources among internal migrants working in India's textile industry. These people rely mostly on private healthcare services, despite the financial risks. Socioeconomic factors have been shown to influence migrants' ability to access healthcare significantly. The study's results can guide policymakers in addressing the issue. Healthcare access for migrant workers can be improved through a comprehensive approach. It includes ensuring the provision of appropriate care by expanding access to public facilities and promoting health schemes. Another recommended measure is to improve migrants' awareness of the benefits of these programs. Authorities should push employers to provide more occupational health services for migrant workers and appropriate insurance coverage. Moreover, a strategy to integrate migrants' needs into the universal healthcare system should be developed. Policies should make care more affordable and accessible to migrants by offering subsidies and alternative routes, such as mobile clinics. In addition, the development of regulations aimed at eliminating exploitative working environments will also contribute to making healthcare more accessible to internal migrants in India.

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