INCOME EXPENDITURE PATTERN OF LABOUR CLASS IN ORGANISED AND UNORGANISED SECTORS WITH SPECIAL REFERENCE TO HEALTH CARE (A CASE STUDY OF DELHI)

(ABSTRACT)

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ABSTRACT

Health sector development in India in the past few years has shown a significant improvement in the rural health infrastructure. However, one of the problems has been the large inequality in health care facilities available within the urban areas of the country, which results in differences in the utilisation and spending pattern on health care by the population. The development experiences in India in the past five decades have resulted in significant improvement in the health conditions of labour in the organised sector. The work force in this sector has been protected through various health insurance and social security schemes such as the Employees State Insurance Scheme (ESIS) for industrial workers and Central Government Health Scheme (CGHS) for the employees of Central Government and its autonomous bodies. On the other hand, the unorganised sector, which constitutes a significant section of the population in urban areas, has remained outside the purview of health insurance schemes or various labour enactments. The population engaged in this sector in various cities and towns is growing quite faster due to continuous migration of workers far from rural areas in search of employment. The problem of health care of this population is acute in various cosmopolitan cities of the country and poses a big challenge.

The study is presented in seven chapters. The first chapter, Introduction deals with the purpose of the study in addition to the past and present health scenario in India, scope, objectives, hypotheses and limitations of the study. A brief explanation of various concepts used in the study is also given in this chapter.

Delhi is an urban State as 89.93 per cent of the population (1991 census) resides in urban areas. The population in this State has been steadily increasing due to the migration of people from neighboring States. Though Delhi has multiplicity of Government health care services, yet private clinics have become the major outlets for low-income households who are engaged in unorganised sector. Even workers in the organised sector bear considerable amount as out-of-pocket because of the use of private facilities by them. In Delhi, studies on health care utilisation and health care spending by the population engaged in organised and unorganised sectors is scantily available. The
present study, therefore, intends to look into the income and expenditure pattern of households engaged in organised and unorganised sectors with reference to their health care. Besides examining various factors influencing the health care expenditure of these households, the study also assessed the willingness to pay for quality health care by the labour households by way of user charges in public health care facilities and for a viable health insurance scheme.

In the second chapter, an attempt is made to review the existing literature on household health care expenditure. The available literature on these aspects are scanty in India and therefore literature available in other countries are extensively reviewed. The entire review is centered on the objectives of the study. The review is broadly divided into elasticity of household health expenditure, factors affecting utilisation and spending on health care by the households, the household’s willingness to pay user charges in public health care facilities and the concept of community health insurance scheme.

From the review of literature related to various aspects of this study, no major attempt seems to have been made in Delhi. Moreover, in Indian context, though a couple of studies have been conducted on household health expenditure, they have not gone into details of the indirect burden on the families. Further, in comparison to other developing countries, the studies relating to household’s willingness to pay user charges in public health care facilities or a health insurance scheme are scanty.

In the third chapter, an attempt is made to briefly examine the features of urban labour force in India as well as in Delhi. The employment scenario in urban Delhi for the past few years has changed tremendously with the continuous surge of rural population to cities. The composition of employment in the unorganised sector has increased in a larger proportion as compared to organised sector. The low capacity of both industry and services sectors in the urban areas to absorb the growing labour force resulted in seeking employment in the low productivity activities in unorganised sector. As a result the wage level in the unorganised sector is considerably lower than that in the organised sector.

The fourth chapter deals with the methodology, which consists of three sections. Various methodological issues in relation to the past studies in India and the ways in which they are used in the present study have been highlighted in the first section. The techniques and methods used to achieve the objectives of the study are presented in the
second section and the final section provides a brief discussion of the use of the data in achieving the said objectives.

The study used both descriptive and empirical analysis. As the study being a comparative analysis of households engaged in organised and unorganised sectors, the selection of households was made in such a way that they share some common characteristics. The study was conducted among the labour households living in JJ clusters in Delhi. A multi-stage sampling technique was used to select the sample population in the study. Through household listing all the households engaged in the organised sector in the selected areas were identified for the study. From the rest of households in the unorganised sector, 15 per cent was randomly selected. A structured interview schedule was used to collect data from the respondents. The questions of the schedule were formulated in such a way as to examine the objectives of the study.

In the fifth chapter, a brief account of the health status of population in Delhi and different type of medical facilities available for the population is presented. Besides examining various issues related to public health care services and amenities and how do they affect the health of the population also find place. There are obvious inequalities in the distribution of various amenities, facilities, services and resources in different parts of Delhi. While there is a large infrastructure available for provision of primary health care in Delhi, the urban poor living in various kinds of slums, especially in the JJ clusters are not effectively utilising the health care services and so the health status of these slum dwellers remain poor. However, with the constant efforts made by the Government both at the Centre and Delhi in the past few years, the inequalities have been reduced to some extent. Still a lot needs to be done to improve civic amenities. Above all, an iron political will also be required to enforce implementation of existing laws on pollution or promulgate new laws if they do not exist.

The sixth chapter presents the details of data analysis and broad findings of the study. The findings of the study on the basis of the analysis of the data collected are presented in five sections: (1) the socio-economic profile of the selected households, (2) health profile, utilisation and expenditure of households, (3) the results of multiple regression on health care expenditures, (4) households view on willingness to pay user...
charges in public health care facilities, and (5) willingness to pay the proposed health insurance scheme.

The last chapter entitled ‘conclusion’ essentially sums up the entire study. It reports the findings of the study and then proceeds to make certain recommendations for improvement in the health as well as in living conditions of low-income workers engaged in the organised and unorganised sectors in Delhi.

The findings of the study are:

The mean monthly per capita income of households engaged in organised sector is nearly 50 per cent higher than the households engaged in unorganised sector. This difference has been mainly attributed to the relatively higher pay structure in the public services. The average income of an earning member in the unorganised sector is quite lower while comparing with the minimum wages recommended for the unorganised workers by the Government of the National Capital Territory of Delhi.

The household consumption expenditure pattern in the study revealed that households in the unorganised sector spent nearly 62.03 per cent of their consumption expenditure on food as compared to 58.39 per cent in the organised sector. The higher proportion of health care expenditure to consumption expenditure in unorganised sector results in a lower amount for purchasing both food and non-food items. Since the poor do not have purchasing power to buy enough food, they lack proper nourishment. As a result, they are more prone to illnesses. In this way a vicious circle operates. Due to lower purchasing power, the poor people tend to ignore minor illnesses.

The average expenditure incurred per illness treatment for households in unorganised sector is nearly 60 per cent higher than the households in organised sector. The direct-indirect cost ratio per illness treatment is worked out to approximately 6:4 for households in organised sector in comparison to 7:3 for the households in unorganised sector. However, the indirect costs associated with illness treatment including the loss of wage/income due to ill-health in the households in unorganised sector are quite higher as compared to the households in the organised sector. For hospitalised cases, the indirect costs constituted a major portion of health expenditure for households in both sectors.
Indirect costs associated with hospitalisation in public hospitals/insurance facilities were quite higher than in private hospitals. The average cost per maternity event (including delivery, abortion and cost of current pregnancies) was Rs. 1991 in households engaged in the organised sector while it was Rs. 1091 for households engaged in the unorganised sector. The average cost for child immunization per year for a household engaged in the former was worked out to Rs 77.50 as against Rs 43.02 in the latter.

When per capita health care expenditure is viewed in terms of income and consumption expenditure, the households in the unorganised sector has the highest proportion of health care expenditure. When the households in the organised sector spent 3.73 per cent of the consumption expenditure as out-of-pocket health care expenditure (including indirect expenditures related to illness treatment), the corresponding figure for households in the unorganised sector was 9.58 per cent. This constituted 3.23 per cent and 8.87 per cent of per capita income of households in the organised and unorganised sectors respectively. When monthly contributions to the health insurance scheme by the households in the organised sector are included, their share of health expenditure increased to 4.47 per cent of annual income.

In India, health care is a right of the people and as suggested in the directive principles of our constitution it should be provided free of charges to all. However, this study showed that the households in both the sectors have to bear considerable expenses to meet their health care needs. The services provided by the Governments both at the Centre and the State including health insurance facilities owned by the Government are inadequate both in quality and quantity.

In spite of low income, a substantial number of households do not utilise public health care facilities for treatment. The main reason has been the time spent in getting the treatment and a lack of faith in the efficacy of treatment provided in these facilities. Even quite a few illiterate respondents reported that due to their illiteracy and poor appearance, they were not received sympathetically by the doctors serving in public health care facilities. More often the patients had to buy medicines from the market hence the cost of treatment in public health care institutions becomes very high for them. Further, due to general rush in the outpatient departments of hospitals and dispensaries, low-income households preferred to visit private facilities for outpatient care. However, they utilised
to public hospitals for serious illnesses, which if treated by private doctors would be very costly for them.

The fall in the out-of-pocket health expenditure among the households in the organised sector is because of insurance coverage/specialised coverage available to the population. The utilisation of health care facilities by the population engaged in this sector is also relatively lower while comparing to the households in unorganised sector. This reflects the quality of services available to the population under insurance facilities. The study showed that number of visits per person per year in organised sector was only 4.02 as against 6.55 visits per person per year in unorganised sector.

The poor households engaged in the unorganised sector reported falling ill more often than their organised counterparts. The use of polluted water and the unhygienic conditions prevailing in the absence of a proper system of lavatories and drainage system in the JJ cluster has been the major cause of the common disease.

Individuals who utilise private health care providers incur substantial higher costs than those who use public health care providers. The low income-group in the unorganised sector do not consume enough health services to meet their enormous health needs. Apart from their inability to consume private health services, they also fail to utilise the freely or heavily subsidized public health services because they fail to perceive the need to seek health care services for many health problems. Moreover, their poor income and daily wage occupation are still barriers to consume public health care services. Therefore, any health programme, which attempts to bring forth equality should bear in mind these factors and formulate a plan which would overcome these handicaps of low-income groups to utilise health services.

The study also revealed that irrespective of the sector engaged, certain socio-demographic, economic and health related factors influence the out-of-pocket health care expenditure of households in both sectors. A comparison of the results of multiple regression analysis of out-of-pocket health care expenditure of households in the organised and unorganised sectors reveal that certain socio-demographic, economic and health related factors influenced the out-of-pocket health expenditure. Among the socio-demographic variables, age of the head of households, sex of the head of households, caste of the households, number of children in the households (below five years of age),
and years of schooling of the head of households are the significant factors influencing the out-of-pocket health expenditure of households in the organised sector. On the other hand, the age of the head of household is the only significant factor influencing out-of-pocket health expenditure of households in the unorganised sector. Moreover, unlike that in organised sector, the young head of households in unorganised sector spent a higher amount as out-of-pocket health care expenditure.

Among the economic factors, household income is highly significant factor influencing the out-of-pocket expenditure of households in the unorganised sector. However, the out-of-pocket expenditure is less influenced by economic factors in the organised sector. This does not support the hypothesis in this study.

As far as the health related factors are concerned, regardless of the sectors involved, presence of chronic illness in the family in the reference period is a significant factor influencing out-of-pocket health care expenditure. Besides the above factors, the use of private health care facilities also influenced the out-of-pocket health care expenditure of households in the organised sector. However, in unorganised sector, number of illnes episodes and the use of quality health care by the households also emerged as important factors influencing out-of-pocket health care expenditure. Results of regression analysis suggest that besides socio-demographic and economic factors, the health related factors also equally influence the health care expenditure of households engaged in the unorganised sector.

There are inter-sectoral differences in the factors influencing the out-of-pocket health care expenditure of households. For instance, most of the selected socio-demographic variables influence the out-of-pocket health care expenditure of households in the organised sector, whereas, except the age of the head of households, other factors have not emerged as influencing factors of out-of-pocket health expenditure in the unorganised sector. When household income is a significant factor influencing the out-of-pocket health expenditure in unorganised sector, the same is not a significantly influencing factor in organised sector. It may be noted that certain factors related with the employment in organised sector such as education and level of knowledge about health problems may also influence the health expenditure. Similarly, the influence of caste on health care expenditure may be due to employment in organised sector.
A broad conclusion may be difficult to draw from the results of multiple regression analysis. Apart from the selected variables, other variables, which are not covered in the study such as psychological and cultural factors, availability of and accessibility to health care facilities and factors related to organisation of health care facilities may have influence on out-of-pocket health care expenditure of households in both organised and unorganised sectors.

The out-of-pocket health care expenditure of households in both organised and unorganised sectors is income inelastic. This means proportionate increase in the health care expenditure of households is lesser than proportionate increase in income. The analysis also revealed that variation in household income alone would not explain the variation in out-of-pocket health care expenditure of households in both organised and unorganised sectors. Along with income, socio-demographic and health related factors also play an important role.

From the information and facts that came to light regarding introduction of user charges in public health facilities it may be concluded that people prefer the private health care facilities for its prompt and non-differential service and accessibility. Households in organised and unorganised sectors are willing to pay user charges irrespective of their socio-economic status. However, people utilised public health care services because of better infrastructure and availability of specialists' doctors, especially in the case of emergencies and complicated illnesses.

Only 54.60 per cent of the households in organised sector were willing to pay for outpatient visits, as against 61.4 per cent by households in unorganised sector. 79.28 per cent of households were willing to pay for inpatient care in the former, while 60 per cent in the latter. Good quality care, less waiting time and improvement of physical facilities are the major conditions for paying user charges by the households in both the sectors. The households in the organised sector are willing to pay an average of Rs. 30.78 and Rs. 80 per each out-patient visit and inpatient day respectively in public health care facilities as against Rs. 22.09 and Rs. 71.64 per outpatient visit and inpatient day by the households in the unorganised sector. Nearly 90 per cent of households who were willing to pay user charges reported that they would pay only if improvements in its quality of care were brought about.
A majority of households in both sectors are willing to pay the proposed health insurance scheme. About 62 per cent of the households engaged in the unorganised sector are willing to prepay the proposed health insurance scheme in comparison to 55 per cent in the organised sector. The households engaged in the organised sector on an average are willing to pay Rs.796 per year for the proposed health insurance scheme as against Rs.515 by the households in the unorganised sector. The households in the organised sector were willing to pay a higher premium partly due to their higher annual earnings and knowledge about such scheme than their unorganised counterparts. The average amount of premium willing to pay forms nearly 1.4 per cent and 1.5 per cent respectively of annual household income in the organised and unorganised sectors. This indicates that households are willing to pay much lower amount than what they actually spent. This seems to be the minimum affordable share the households are expected to pay for health care. This information may be of relevance in deciding user charge or fixing the premium on community health insurance, especially with reference to public health care facilities.

Among the households in unorganised sector the amount of premium willing to pay varies with household income and occupation. The self-employed are willing to pay on average Rs.687 as against Rs.447 by the household engaged in manual work. The results from the logistic regression analysis revealed that the willingness to pay the proposed health insurance scheme by the households in the organised sector is significantly influenced by the socio-economic factors such as age of the head of households, family size, number of children in the family, education of the head of households and monthly household income. Besides these variables, the presence of illness in the family and source of health care facilities utilised also influenced the decision to pay the proposed health insurance scheme. On the other hand, the willingness to pay the proposed health insurance scheme by the households in the unorganised sector is appeared to be positively influenced by the variables such as family size, monthly household income, number of times doctors consulted and number of working days lost due to ill-health. These results have been supported by studies in other developing countries.

In the light of the findings of the present study, the Government may be able to redefine its role in providing health care services and tap the potential of households in
bearing health care costs. Once the conditions are feasible for a health insurance scheme, care must be taken in designing a scheme that is affordable, has an easy mechanism for collecting premiums and transparent in terms of the distribution of benefits. Improving awareness of the people about the scheme is also an important step before its implementation.

On the basis of the findings of our study, the following recommendations have been made:

1. The public distribution system of the Government in low and poor income areas should be streamlined and all essential commodities should be provided in good qualities and in sufficient quantities at the minimum prescribed prices. This would protect their already eroding purchasing power.

2. The earnings of a majority of workers in unorganised sector are lower than the minimum wage recommended for unorganised sector workers by the Government of Delhi. It is therefore, necessary to implement the minimum wage regulation in all activities in unorganised sector, including the casual labour.

3. Improvement of the health of the poor depends mainly on preventing diseases and providing maternal and child health services. The private sector does not take much interest in this area of health services, preferring to concentrate on curative services. The Municipal Corporation of Delhi should therefore create more health centers and strengthen the existing ones in slum areas. The services available within each health facility should be improved to reduce waiting time and increase contact time with the doctor.

4. Apart from providing curative services, more attention should be given to improve various public health activities such as provision of safe drinking water, environmental sanitation, drainage and safe garbage disposal in slum
areas as these activities will prevent most of the communicable diseases from spreading and reduce the financial burden of treatment.

5. Private participation in some of the health care facilities situated in non-poor areas may be encouraged.

6. The non-profit and voluntary agencies owned hospitals should be encouraged. Necessary initiatives should be taken to bring all non-profit health facilities under the public health system. These hospitals may be encouraged to provide all types of care, including primary care, perhaps by subsidy.

7. Avenues for earnings lie more in secondary and tertiary hospitals than in the primary health care facilities. The additional revenues earned through user charges should be made available to hospitals and not be transferred to the Government consolidated funds so that the main deficiency of lack of funds for expenditure on the maintenance of service could be resolved.

8. This study showed that regardless of socio-economic category, households are paying for their health care. As free services would dampen the health care system, it is necessary to charge at least a minimum amount from every one, irrespective of socio-economic class so that every one may be made conscious of the use of services. The study revealed that the low-income group engaged in organised and unorganised sectors could afford to spend only a lower proportion of their income on health care services whereas middle and high-income groups could afford more than this proportion. Therefore progressive charges according to economic capacity of people may be preferred against uniform charges.

9. Numerous studies including the present one showed that facilities owned by ESIS and CGHS suffer from low morale, under-staffing and shortage of equipments. Allowing these facilities to charge fees for their services, even if
the fees are paid by the Government on the basis of each patient treated might help to improve the quality of services provided by them. It is suggested for charging for extra conveniences like visiting a patient after visiting hours, consulting after regular hours or on holidays.

10. Before planning a health insurance scheme for workers in unorganised sector, it is a formidable task to make people aware of the risk pooling concept and the role of health insurance in easing out the future financial burden on the households. Above all, strong political will and Government initiatives are the two major elements lacking for introducing a health insurance scheme for unorganised sector. A clear policy framework is needed to publicize and guide the development of insurance schemes for low-income workers in unorganised sector. A policy framework might be a valuable tool to support the scheme which complement and reinforce overall national health policy objectives.

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