CHAPTER I

INTRODUCTION

Human resource development is considered as an integral part of economic development. With the increased realization of the role of 'human capital' in the development of an economy, investment in human capital has gained momentum in almost all countries in the world. Health is directly linked with the productivity and efficiency of human capital. Economists have long back realized the importance of health in the human capital formation. Thomas Robert Malthus believed that sound health and controlled population could solve the problem of under consumption and over production in an economy.\(^1\) Dalton's canon of maximum social benefit implies that the Government should incur expenditure in such a way as to promote the greatest good for the greatest number. One such expenditure is the investment in health promotion of the entire population because it is important for the maintenance of human capital.\(^2\) Gunnar Myrdal (1968) asserted that the quality of population can be increased through various public health and medical care measures of the entire population.\(^3\) Good health, not only raises quality of life of the people by increasing productivity, but also reduces losses caused by absenteeism, saves resources otherwise spent on treatment of illness and enables more optimum use of resources. Recognizing the importance of investment in the health of the people, the World Bank emphasised investing in the health of the poor as an economically efficient and politically acceptable strategy for reducing poverty and alleviating its consequences in low-income countries.\(^4\)

There are a multitude of factors that influence health of people in a country. The quantum of expenditure incurred on health care services by both Government as well as private sector is crucial among them. Government policies profoundly influence health of the population by spending on public health services and providing care directly through various health facilities. If expenditures are equally distributed throughout the population, there is potential to improve health for all. The role of Government in providing health care of its population is justified on three grounds. Firstly, the poor can not always afford health care that would improve their productivity and well being. The public expenditure
on health of the poor can reduce their suffering from ill-health, poverty and alleviate its consequences. Secondly, some activities that promote health of the people are ‘pure public goods’ that create large positive externalities. Private markets would not provide them at all or would produce too little. Thirdly, market failures in health care and health insurance mean that Government intervention can raise welfare by improving how these markets function.

Developed countries in the world are spending more on the health of their people and tend to have the significantly high level of life expectancy and the lowest level of infant mortality. Whereas, developing countries are spending only a small proportion of their Gross Domestic Product (GDP) and are also the ones having miserably low level of these health indicators. The range of expenditure of the GDP on public health among developed and developing countries show a large variation of above 15 per cent to below one per cent respectively.

1.1 Purpose of the Study

Health sector development in India in the past few years shows a significant improvement in the rural health infrastructure. However, one of the problems today is the large inequality in health care facilities within the urban areas of the country, which results in differences in the health care utilisation and health care spending 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. On the other hand, the unorganised sector, which constitutes a significant section of population in the urban areas, has remained outside the purview of health insurance schemes or various labour enactments. This population 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.

Delhi is considered typically an urban state as 89.93 per cent of the population reside in urban areas. The population in this state has been increasing rapidly with the migration of people from other states in the country. According to 1991 census, the population in Delhi is 94.20 lakhs with the growth rate of 4.15 per cent per annum, one of
the highest among various states in the country. The population density in Delhi is 6352 per sq km, which is quite high compared with the national average of 273. Of the total population in Delhi the working population constitutes 29.80 lakhs. The Directorate of Employment, Government of national capital territory of Delhi estimates 8.52 lakhs are in the organised sector and the majority of 21.60 lakhs, are engaged in unorganised sector. A strong disparity in the health care infrastructure and utilisation by the population in organised and unorganised sector is visible in Delhi. Despite the multiplicity of Government health services in Delhi, private clinics become the major outlets for low-income households who are engaged in unorganised activities. Even workers in the organised sector bear considerable amount as out-of-pocket because of the use of private facilities and extra payments paid for services, which are provided by Government health facilities.

In Delhi, as in other parts of the country, studies emphasising the nature, size, working and living conditions of labour class engaged in organised and unorganised sectors are available. However, a comparative study emphasising the health care utilisation and spending by the population engaged in these sectors is scanty. Considering these fact and background in view, a study on labour households in Delhi may represent a workable model for other cities and towns in the country. The present study, therefore, intends to look into the income-expenditure pattern of labour class engaged in the organised and unorganised sectors in Delhi with an emphasis on their household health care expenditure. Besides examining various factors influencing health expenditure of these households, the study also assesses the willingness to pay for quality health care by the labour households by way of user charges in public health facilities and a viable community health insurance scheme.

1.1.1 Health Scenario in India: Past and Present

In India, the Bhore Committee (1946) set up by the Government had proposed a comprehensive public sector health programme with the State guaranteeing that no one should be denied needed health care for want of the ability to pay. Since then the Government of India and States started spending a considerable amount on the health care of the people. The investment in health sector has further increased rapidly since the seventies particularly after the Alma-Ata declaration of "Health For All by 2000 A D "
The per capita public expenditure on health has now increased by more than 50 times as compared to 1951. The plan outlay on health has increased from Rs 65.2 crores in the First Five Year Plan to Rs. 757.92 crores in the Eighth Plan. Besides the absolute financial allocation much improvement has also been recorded in the health infrastructure and facilities in both rural and urban areas. Number of medical colleges in the country has increased from barely 28 in 1951 to 128 in 1991. Number of Primary Health Centres (PHCs) has increased from 725 in 1951 to 22,243 in 1991. Similarly, a tremendous increase in number of doctors, nurses and other health functionaries has also been recorded. Number of hospitals for one lakh population has increased from 7 in 1951 to 14 in 1991. Number of doctors from 18 to 48 in 1992. Number of hospital beds from 32 in 1951 to 97 in 1992.

The enhancement of financial allocation and increase in health care infrastructure has resulted in the improvement of health status of people. The crude death rate is declined from 23 per thousand population in 1951 to 8.9 in 1997. Infant mortality rate has shown a decline from 146 in 1951 to 71 in 1997. The life expectancy of an average Indian has increased to 60.6 years (1991-96) from 41.2 years in 1951-60. Particularly there is a relative improvement in the expectancy of life for females.

However, the health system in India discriminates between the labour-households in the organised sector and the labour-households in the unorganised sector. The former constitutes only a small proportion of labour force, yet utilise health facilities disproportionately. The work force of this sector has mainly been protected through two major health insurance schemes such as Employees State Insurance Scheme (ESIS) for industrial workers and Central Government Health Scheme (CGHS) for the employees of Central Government and its autonomous bodies. The proportion of expenditure on ESIS and CGHS as a percentage of total Government health expenditure has increased steadily over successive plan periods. At present there are 9.4 lakhs card holders and 42.76 lakh beneficiaries of CGHS. As on March 1996, the ESIS alone covered 73.95 lakhs insured persons and nearly 213 lakhs family members. However, the experiences show that these schemes suffer from serious drawbacks.

Apart from the ESIS and CGHS, various departments of State Governments and other public sectors such as Indian railways, post and telegraphs and department of
defense etc. also provides all sorts of medical facilities to their employees and family members. Besides these schemes, there are several types of health insurance schemes operating in India through General Insurance Corporation of India, Life Insurance Corporation of India and Unit Trust of India. However, the schemes are biased towards only the salaried class and better off people, whose resulting distribution of services is often regressive. Further, these schemes cover mostly hospital expenses and routine outpatient care is not covered. The coverage is also subjected to number of exclusions and restrictions on eligibility. Moreover, reimbursement under these schemes is cumbersome and not helpful for the low-income group engaged in unorganised sector.

The unorganised sector constitutes a significant section of population in India. According to 1991 census, this segment of labour force is about 90.6 per cent of total labour force in the country. This population in various cities and towns is growing two to three times faster than the overall urban population. The adverse effects of ill health are greater for labourers engaged in unorganised sector, as they get ill more often, due to poor living conditions. Their income depends exclusively on physical/manual labour and they do not have enough savings to fall back upon and moreover lose their daily earnings. Even in case of labour households in urban areas, where, the income is higher and more in comparison with their rural counterparts, the quality of life is worse as their conditions are unsatisfactory and requires higher direct and indirect costs to sustain in urban areas at a level where they can ensure their well-being. These households, moreover, are considered high-risk group for a wide range of morbidity including various types of communicable, respiratory and other contagious diseases. Besides, the prevailing urban environment with its inadequate sanitation, over-crowding and housing conditions, pollution etc. exposes the people to a variety of infectious diseases. Many empirical studies on urban unorganised labour have shown poor health status of this segment of population. The surveys conducted by the Labour Bureau of the Government of India also endorse similar observations.

Despite the fact that both Seventh and Eighth Five Year Plans emphasized the need for the improvement of overwhelming majority of workers in the unorganised sector by providing adequate social services including health care, no major step has been taken to improve their health conditions. Contrary to this, the experiences in India have shown
that private household spending as a proportion of total consumption is quite significant and the Government expenditure on health of the people is relatively small in proportion to what is being spent by the household sector. Many studies in India have estimated that more than 70 per cent of the total health spending in India is contributed by household sector. This health expenditure is further expected to rise with the increasing demand as well as the emerging pattern of new diseases and widespread availability and use of advanced technology of treatment. Moreover, Government's open support gradually coming to private health care and privatization of public provision may also lead to a rise in direct household health expenditure. This brings household health expenditure as an even more crucial issue to understand and analyze. Furthermore, with the structural adjustment programmes being followed in India in recent years, the issue of household domestic budgeting patterns, particularly financing of various social services becomes a vital area of research.

Given the limits of the Government budgets on the one hand, and the requirements of health facilities on the other, financial contribution by the population would appear to be a unique solution for the health care financing problems in countries like India. In India, the significance of household contribution for health care of population has been recognized long back by Mudaliar Committee (1959)\(^\text{14}\) and subsequently by the current National Health Policy (1983).\(^\text{15}\) Since then many years have passed but no major attempt seems to have been made to mobilise resources for higher allocations to health care, although few States in India are experimenting the user charges system in secondary and tertiary level facilities. Moreover, no attempt was made to study the willingness to pay for user charges or health insurance scheme. Health insurance protection to the poor rests on the premise that an episode of illness imposes undue economic burden on their incomes. It may also act indirectly as an income protection scheme for the poor since it prevents the erosion of their lower income.

This study also assesses the willingness to pay for user charges in public health facilities and also considers whether a community health insurance scheme in urban area is a viable alternative to generate additional financial resources for providing quality services and guarantee efficiency and accessibility.
1.2 Scope of the Study

The present study provides an insight into the relative spending pattern on health care by the labour-households in organised and unorganised sectors. The findings also reveal their expenditure towards both curative and preventive health care services. Moreover, an estimation of indirect costs including opportunity costs involved in seeking health care may help to understand the real financial burden faced by the labour-households. The findings of the study may be used as proxy estimates and also can provide a baseline for further and more detailed research.

The estimation of income-elasticity of health expenditure of labour-households in organised and unorganised sectors may help to develop a model, which can help the researchers in the field. A comparison of per capita health expenditure of labour-households in organised and unorganised sectors in JJ clusters of Delhi would give an insight into the role of existing health insurance as a source of mobilising additional resources and as a mechanism in providing health care services to insurers and their family members.

Furthermore, the study also highlights various factors influencing the pattern of health care expenditure by the labour-households in organised and unorganised sectors. An understanding of the various factors influencing the pattern of health care expenditure becomes important for policy makers and administrators for encouraging certain pattern of services and discouraging other categories. Moreover, the results of willingness to pay for user charges in public health care facilities and the premiums willing to pay for community health insurance schemes by the households may help the planners, policy makers and administrators in the formulation of future policies relating to the mobilisation of additional resources for health care through mechanism such as user charges and health insurance schemes.

1.3 Objectives of the Study

1. To ascertain the health care expenditure of households engaged in organised and unorganised sectors as a proportion of their household income and consumption expenditure.

2. To determine the factors influencing the health care expenditures of households in the proposed sectors.
3. To estimate the average amount of user charges the households in both sectors are willing to pay for each outpatient visit and inpatient day in public health care facilities for quality health care.

4. To examine the willingness to pay for a viable health insurance scheme through community participation by the households in the proposed sectors.

1.4 Hypotheses

1. Indirect costs of health care borne by the households engaged in unorganised sector are relatively higher than the households engaged in organised sector.

2. Socio-economic characteristics of the households influence their health care expenditure.

3. Household health care expenditure is less elastic with respect to household income in the proposed sectors.

4. Regardless of the sector engaged, the households are willing to pay for quality care in public health care facilities.

5. There is a positive relationship between household’s willingness to pay for health insurance and their socio-economic characteristics.

1.5 Techniques and Methods

The study used both descriptive and empirical analysis. As this 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 Juggi Jhompri colonies (JJ colonies) of Delhi. Multi stage random sampling technique was applied for the selection of areas. Through household listing all the households engaged in the organised sector in the selected areas were identified for the study. From the vast majority 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. The details of techniques and methods followed in the study are presented in the methodology chapter.
1.6. Limitations and Constraints

The study has been conducted among the labour households living in juggi-jhopri colonies of Delhi. The findings of this study, therefore, can not be generalised as a whole. Moreover, labour in both organised and unorganised sectors differs according to their level of skills and occupation etc. The inter and intra sectoral differences in their skill levels and occupations have not been looked into this study. Further, the study basically deals with the utilisation of health care services and spending on health care by the households engaged in organised and unorganised sectors. All factors responsible for the utilisation of health care services have not been dealt within this study. For example, psychological factors, cultural factors and supply side factors including the impact of medical organisation have not been fully dealt by this study. Furthermore, the households’ health expenditure estimated by this study is based on the illness prevalence during the reference period. Though the study period covered the rainy and winter seasons, the summer season has not been adequately covered. Thus, this study has not fully taken into account the seasonal variations in the health care expenditure. Finally, the willingness to pay for the proposed health insurance scheme in this study, is based on the hypothetical market situation, rather than the observed market behavior of the households. The amount of money willing to pay for the proposed health insurance scheme may not reveal their actual willingness to pay, but the valuation is based on their expected utility or perception of the benefit from the scheme.

1.7 Some Basic Concepts

1.7.1 Meaning of the term ‘Health’

Health is a biological term. Traditionally it has been viewed as an 'absence of disease' and if one was free from disease, then the person was considered healthy. This concept known as biomedical concept viewed human body as a machine, and disease as a consequence of its breakdown and one of the doctor's tasks as repair of the machine. The other school of thought viewed health as a dynamic equilibrium between man and his environment. According to the definition of Dubos (1965) health implies the relative absence of pain and discomfort and a continuous adaptation and adjustment to the environment to ensure optimal function.
The contemporary development, however, revealed that health is not only a biomedical phenomenon, but one which is influenced by social, psychological, cultural, economic and political factors of the people concerned. Accordingly, these factors are taken into consideration in defining and measuring health. The holistic model developed by the World Health Organization (WHO) recognizes the strength of social, economic, political and environmental influence on health. This concept described health as a unified or multi-dimensional process involving the well being of the whole person in the context of environment. This view corresponds to the view held by the ancient philosophers that health implies sound body, in a sound family and in a sound environment. Following the holistic concept, the WHO defines "Health as a state of complete physical, mental and social well being and not merely an absence of disease or infirmity". This definition envisages health as a multi-dimensional concept, which covers the provision of diagnostic, curative and preventive care for attaining a state of physical, mental and social well being. The perfect and harmonious balance of the state of individual's existence in a conducive environment constitutes health. The state of physical health implies the notion of perfect functioning of the body. It conceptualizes health biologically as a state in which every cell and every organism is functioning at optimum capacity and in perfect harmony with the rest of the body. Mental health refers to the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. Social well being implies harmony and integration with the individuals, between each individual and other members of society and between individuals and the environment in which they live. However, in this work health is taken to be that part of human welfare which depends on the normal functioning of the body.

1.7.2 The Concept of Health Care

Health care is not synonymous with medical care. Health care (services) may be defined as all those personal and community health services including medical care and related activities directed towards the protection and promotion of the health of the community. The health of the community is strongly influenced by the quality and availability of health care services to them. Medical care is a sub-set of a health care services system. The term medical care which ranges from domiciliary care to resident hospital care refers to those personal services that are provided directly by physicians or
rendered as a result of physician's instructions.

According to V.R. Fuchs, health services can be defined as those services rendered by: 1) labour—the personnel engaged in medical occupation such as doctors, dentists and nurses, plus other personnel working directly under their supervision, such as paramedics, and other staff; 2) physical capital—the plant and equipment used by these personnel such as hospitals, X-ray machines etc., and 3) intermediate goods and services such as drugs, bandages and purchased laundry services. Payment for this labour, capital and intermediate input is the basis for estimating health expenditure. This definition however does not provide for health-related resources that can improve or promote health of the population such as clean water supply, sanitation, etc. From an individual's point of view, these resources are provided to the public free of cost or at nominal price. For instance, municipal water tax may be considered as part of expense for promotion of health.

The demand for health care derives from demand for health. Ill-health is the primary determinant of the demand for health care. The demand for health care services also depends on the total cost an individual faces for the services which include price of the services, travel costs, lost income while receiving services and non-monetary cost such as time, the prices of complements or substitutes to the health care services, the income of the individual, values and attitude of the individual.

### 1.7.3 Household Health Care Expenditure

Health care expenditure of a household may be defined as the amount incurred by the household on meeting the health care requirements on both preventive and curative care of its family members. This expenditure has some theoretical implications. Firstly, the households utilise various public health services, which are generally free or heavily subsidized. Secondly, households spend money, which is partly or fully reimbursed by the employers particularly in organised sector of an earning member of the household. Thirdly, expenditure which every family incurs as part of its personal consumption expenditure which is either a residual part of the above two or is wholly a personal burden of the household. The present study has taken into account only the third category, namely household expenditure on health care.
The two major macro-level comprehensive studies conducted in India by NSSO (42nd round)\(^1\) and NCAER\(^2\) (which are followed by series of surveys by NCAER and 52nd round by NSSO) give statistical information on average health expenditure per illness episode. The NCAER study included pay out to doctors, hospitals, chemists and other costs such as clinical tests, transportation costs to the medical facility, rituals performed for the recovery from illness, expenditure towards special diet, tips paid for securing hospital admission etc. NSSO on the other hand, included all items in the NCAER study except transport expenses, expenditure on special diet, amount paid as tips as also expenditure on purchase of durable items such as ice bags, hot bags, etc. Household expenditure on health care in this study include cost of medicines, diagnostic or investigation costs, doctors’ fees including charges of traditional practitioners, disability related expenditure, pregnancy, abortion and delivery related expenditure and expenditure on preventive care such as immunization and vaccination against diseases. There are some expenditure which are indirectly borne by the households such as transportation cost, expenditure on special food during illness and pregnancy, belief related expenditures and home remedies. It also includes the opportunity cost of time in seeking medical treatment or taking care at home When the earning member of a household is ill, he/she has to abstain from work for a day or more. Similarly, if other members of the household are not well, the earning member often has to accompany them to the hospital, which also causes loss of time or money wages to the worker. Therefore, loss of income/wage due to illness has also been considered for estimating household health expenditure. Besides, there are other components, which can indirectly promote health of the population such as municipal taxes on clean water supply and sanitation, money spent on services of servants/maid servant for cleaning houses, the cost incurred by households on disinfectants used for cleaning floor, toilets, bathroom and premises of houses, money spent for utilising health club facilities, such as yoga may also be included under household health expenditures. Theoretically, imputed wage of above services rendered by the member of household should also be included under this category. However, there are some practical problems involved in estimating these cost. These components have not been considered in the study, as they are found not relevant to the study population.
1.7.3.1 Health Care Expenditure Surveys

Several family budget surveys of working class households have been conducted in India. The Bureau of Economics and Statistics conducts working class family budget surveys covering several industrial and agricultural centers in order to compute the working class consumer price index numbers. The National Sample Survey Organization (NSSO) is the major source of consumer expenditure data, which forms the basis for much of the analytical framework in India. The results of both quinquennial and annual consumer expenditure surveys have been published regularly. The Central Statistical Organization (CSO) also conducts many studies on family living of various socio-economic classes in India. These organizations, however, have not made any detailed attempt to estimate the share of health care expenditure in the household budget.

In 1958, the NSSO for the first time estimated the value of cash purchases of medicines including indigenous medicines. However, in its subsequent studies the expenditure on medicines were included under “miscellaneous goods and services” and thus not giving a clear picture of health expenditure. The 42nd round of NSSO provides a comprehensive data-base on household health expenditure and pattern of utilization of health care services in India. Data on expenditure are collected in this round, however limited to each spell of sickness including both hospitalized and non-hospitalized cases. The surveys of the Labour Bureau, Government of India on living conditions of working class considered only the cost of medicines and excluded the other items under health expenditure.

The National Council of Applied Economic Research (NCAER), New Delhi in its earlier studies on consumer expenditure pattern, health expenditure was treated as a part of personal consumption expenditure. However, in its recent macro level multi-model survey the NCAER (1992) collected information on various parameters on education, health and material well being of the people. The subsequent surveys provide a list of information on expenditure on morbidity.

1.7.4 Organised and Unorganised Sectors

A striking feature of development in the developing economies during the second half of the Twentieth century has been the unprecedented growth of population and labour force notably in large cities. The continuous surge of rural migrants in these cities
has created an excess supply of labour and exacerbated the already existing problems. The "premature urbanisation" that failed to create adequate productive employment opportunities to the rapidly growing urban labour force resulted in a "Dual" labour market in an economy. On the one hand, there is the formal or organised sector in which organised economic activities are concentrated and on the other hand, the informal or unorganised sector consisting of workers who as a rule are not employed by organised enterprises and in fact correspond to the surplus labour force. This surplus labour force constitutes the residual labour market of the last resort in which persons enter as self-employed, low-income producers of marginal goods and services for lack of any other means of earning a livelihood. The organised sector includes all Government activities and private enterprises, which are formally and officially recognized, fostered in a way and regulated by the state. On the other hand, enterprises and individuals operating largely outside the system of Government regulations and benefits are generally termed as unorganised sector. According to Deepak Mazumdar (1973), employment in the organised sector is stable and protected, while the unorganised sector labourers are exposed to uncertainty and whims of employers.

The concepts 'formal' and informal sectors are considered synonymous to organised and unorganised sector. John Keith Hart was the first to use the formal-informal sector dichotomy. Focussing on migrants in urban Ghana, he highlighted the existence of the variety of new income generating activities particularly in the trade and service categories. By virtue of the fact that most of them were in the unorganised sector and fall outside the purview of the existing statistical data collection machinery, they are labelled as informal income generating activities or informal sector. In the dichotomous classification, the concept unorganised or informal are characterized by its extensive spread over a large number of family enterprises in all the three broad economic activities namely manufacturing, trade and services, which have a very small lay out and are protected by State legislations. According to the National Commission on Labour (1969) the unorganised labour cannot be identified by a definition but would be described as those who have not been able to organise in pursuit of a common objective because of constraints such as casual nature of employment, ignorance, illiteracy, small size of establishments with low capital investment per person employed, scattered nature of
establishments, and superior strength of employer operating singly or in combination. On the basis of these constraints it incorporated different types of labour in the purview of unorganised sector which includes contract labour, construction workers, casual labour, workers from small scale industries, handloom and powerloom workers, bidi and cigar workers, sweepers, and scavengers in the shops and commercial establishments and other unprotected workers. Extending the scope of this sector to rural workers, the Planning Commission further included landless labourers, small and marginal farmers, share croppers, rural artisans, forest labour, fishermen and self-employed persons. In this work, those establishments covered under the Factories Act (1948) including all public services was considered as organised sector.

1.7.4.1 Labour Force: Origin of the Concept

The labour force plays a crucial role in the growth of the economy. The economists attribute more importance to the qualities of labour input as one of the main factors, which causes the difference in the wealth of nation and their economic progress. Adam Smith, in his "Wealth of Nation" included the acquired and useful abilities of all inhabitants or members of society. Neo classical economists considered labour as more important than any other factors of production. Frank Knight perceived clearly and cogently both the improvement in the quality of the labour force and the economic contribution from the advances in the sciences and their effects on the rate of returns to invest. The concept labour force was first developed by the U.S. Bureau of the Census during the late 1930's to estimate the number of working age people in the United States. The U.N. Labour force conceived it as the portion of the population, which is economically active. In other words, labour force are those persons who voluntarily offer their services for hire in the labour market and who there by participate in the production of Gross National Product (GNP). In short, labour force are those who are actively participating in the production of national output.

The U.S. Bureau of the Census considers workforce as the general form of labour force. It has two components namely employed and unemployed. The employed are those who during the reference week did any work at all as paid employees, self-employed or unpaid family workers working at least fifteen hours in a family operated enterprises. It also included those who were employed but on vacation, home sick, or not on the job or
available for work and had actively sought employment sometime within the preceding four week periods. All those who are neither employed nor unemployed are identified as being out of the labour force and primarily includes students, housewives, the retired and the disabled.

The standard concepts pertaining to labour force was laid down at international level by the International Labour Organisation (ILO). The Eighth International Conference (1959) defined the total labour force as the sum of the civilian labour force and the armed forces. The civilian labour force consists of all civilians who fulfill the requirements for inclusion among the employed or the unemployed. Doubts are often expressed that concept labour force, which was evolved in the background of industrialised countries, are not suitable for Indian condition. In India, the first major attempt to apply the concept of labour force was made by the NSSO in 1952-53. Consequently, the CSO in consultation with other agencies in 1961 adopted separate definition for urban and rural areas in the country. Since then both NSSO and CSO in their series of surveys included the estimation of labour force along with other economic aspects relating to the economy. A chapter on urban labour force in India with special reference to Delhi is presented separately.

1.7.4.2 Labour Class

The term "labour" is generally used as a synonym for work. However, in the literature they are used in different sense. The word work denotes occupation or employment but not necessarily of a toilsome or fatiguing character, while the term labour implies "exertion attended with pain or fatigue, hard work, tasks, toil etc." Work may be performed not only without pain or fatigue, but with positive pleasure. Chester A. Morgan (1970) in his work had used labour class as synonymous for working class. According to him labour class or working class is defined as all manual workers in the nation plus the non-supervisory white collar employees. The manual workers, as a group may be further sub-divided into three common classification namely skilled, semi-skilled and unskilled labour. The skilled category includes skilled workers of industry, foremen and other industrial employees. The unskilled category includes unskilled workers in both farm and non-farm employments, private household workers and other
casual labourers. Semi-skilled are those who can not be put in either of the two categories.

The Labour Bureau, Govt. of India defines the manual work as work involving sufficient physical labour but at the same time not requiring much educational background in the field of general, scientific or other education. The Bureau in its working class family income and expenditure surveys defined a working class family as "one which is situated within the centre, which has at least one member working as manual worker in an establishment in any one of the seven sectors of employment viz. registered factories, mines, plantation, ports, docks, electricity generating and distributing establishments, public motor transport undertakings, railways and which derived 50 per cent or more of its income during the calendar month preceding the survey from any manual work. The Labour Bureau's concept of labour does not distinguish labour class of unorganised sector from that of organised sector. The labour class, in the present work means those who are doing manual work i.e. the work involving sufficient physical labour but not necessarily requires much of general, scientific or other education.

Summing up, health is considered as an integral part of productive life. The expenditure on health by both the Government and individuals is necessary for maintaining human capital. In India, the workers engaged in organised sector enjoy more health facilities than their unorganised counterparts. The majority of households in unorganised sector remained outside the purview of health insurance schemes, and as a result, these households spend a considerable share of their household income as out-of-pocket health expenditure. This study mainly looks into the health expenditure pattern of labour households engaged in the organised and unorganised sectors in Delhi.

This study is presented in seven chapters. The present chapter comprises the purpose, scope, objectives and hypotheses of the study followed by description of various concepts used in the study. The second chapter presents an extensive and critical review of literature on various issues related to the study. The third chapter provides a broad view of the urban labour force in India with a special reference to labour force in Delhi. The fourth chapter deals with the methodology and study design. A profile of health care services in Delhi forms the fifth chapter. The sixth chapter deals with the analysis of data and discussions. The last chapter provides a broad conclusion and recommendations.
References


5. Ibid., pp 258-59


7. Ibid., p.207.


10. Ibid., p.24, 33 &36.


13. CSO, Socio-economic Indicators-1998, Government of India


17. Ibid.

18. Ibid., p 12.

20. Ibid., pp 140-41


32. CSO, Standards of Surveys on Labour Force, Employment and Unemployment, 1961, pp 3-4

