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ORGANISATIONAL ARRANGEMENT FOR THE WELFARE OF INFORMAL ECONOMY – A HEALTH PERSPECTIVE

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ABSTRACT

Informal workers consist of those working in the informal sector or households, excluding regular workers with social security benefits provided by the employers and the workers in the formal sector without any employment and social security benefits provided by the employers''. More than 90 per cent of workforce and about 50 per cent of the national product are accounted for by the informal economy. Informal workers are socially and economically underprivileged. They are more vulnerable since small shocks can push them deeper into poverty. Unanticipated events are much harder and these may include accidents, disasters, illness, crop failures etc. Among all these health risk is more severe. Informal workers are more vulnerable to health shocks as these threaten their income-earning capacity. Accidents and ill health affect them directly and indirectly. These health shocks contribute to the loss of work days and hence directly impoverish them on the one hand and reduce their productivity and efficiency on the other. Traditional risk management strategies (like borrowing from money-lenders, friends and relatives, temporary migration etc.) are inadequate, unsuitable and sometimes significantly reduce the ability of informal workers to withstand future shocks. But, the state in most developing countries has not been able to fulfil health care needs of its population. Shrinking budgetary support for health services, inefficiency in public health provision, unacceptably low quality of public health services and the resultant imposition of user charges is reflective of state's inability to meet health care needs of the informal sector. Institutional arrangement, in this regard, is necessary to enable them to fight risks and shocks. Keeping in view of the above, the paper has been designed to explore the unexplored issues of welfare of informal sector with special reference to health care, to derive insights for policy decisions at the different levels.

INTRODUCTION

''Faster, sustainable more inclusive growth'' is the theme of 12th Five Year Plan. Inclusive growth basically means ''a broad-based growth, shared growth and pro-poor growth''. It, by its very definition, implies an equitable allocation of resources with benefits incurred to every section of the society. 'Inclusiveness' is a multi-dimensional concept. Reduction in poverty, employment generation, reducing inequality in income and wealth distribution, access to basic services such as education, health, clean drinking water and sanitation, support infrastructure, growth of agriculture are some of the dimensions of inclusive growth. The earlier faith in development through the accumulation of material capital has, in recent years, been replaced by a new creed of investment in human capital. In this regard, developing countries/LDCs are now concentrating in the improving the abilities and skills of people and modifying their motivations and values so as to be more suitable for 'development efforts'.

Informal sector plays a pivotal role in the development of any underdeveloped economy, India being no exception. Faster and sustainable growth needs special attention to informal economy. It is well recognised fact that the contribution of informal sector to the Indian economy is extremely large. More than 90% of the workforce and 50% of the national product is accounted for by the informal sector (NSC, February, 2012). India is an emerging economy with 47 crore workers in 2016-17. The estimated number of informal sector workers in 1016-17 is 39 crore which constitutes 82 per cent of the total employment in the country. (Employment, Annual Report 2017-18, 2018) In rural areas the share of informal sector workers in each population segment recorded more than 90 percent and the share of female workers (94.50 percent) is more than male workers (90.34 percent). (NSSO, NSS Survey 68th Round) But unfortunately, they are the most unprivileged and underprivileged – socially and economically. Informal workers, whether rural or urban, are more vulnerable since small shocks can push them deeper into poverty. They are deprived of adequate access to the basic needs of the life such health, education, food, security, employment, justice and equality. In addition, as they are not organised, they lack institutional arrangement to raise the voice to demand law and justice, social protection and social security. Hence, the protection and promotion of health and welfare of informal sector workers is the need of the hour. An integrated policy to promote health status, provide healthy working condition, ensure social security to be adopted to improve the living standard of the informal poor.

OBJECTIVES

1. To study the socio-economic status of informal workers in the study area.
2. To identify the health related issues of the informal sector in the study area.
3. To examine the social protection available against health risk.
4. To identify the challenges and issues with existing institutional set-up.
5. To suggest measures for improvement.

METHODOLOGY

The data for the study has been gathered from primary and secondary sources. A cross-sectional study was carried out in Udupi Municipality area and a small village of Alevoor. Sample size is 80 out of which 20 from Municipality area and 60 from Alevoor village. Households are selected randomly from different occupational, social and economic groups. The survey was quantitative and qualitative. Data was analysed with the help of simple averaging. The materials collected from the print and electronic media are secondary sources.

SCOPE AND IMPORANCE OF THE STUDY

Conceptual Framework

Variety of definitions is available with regard to the meaning of **informal workers**. Keith Hart was the first to introduce the term 'Informal Sector' in very narrow sense to mean *small self-employed individual worker*. Later International Labour Organisation (ILO) has evolved and presented the concept in a broader sense and given the guidelines for the collection of statistics on informal sector in February 1993 (ILO, 2013).

In India, the first Indian National Commission on Labour (1966-69) defined unorganised sector workforce as '*those workers who have not been able to organise themselves in pursuit of their common interest due to certain constraints like casual nature of employment, ignorance and illiteracy, small and scattered size of establishments*'. But different criteria are used to identify the informal sector by different authorities

and departments like NSSO, Directorate General of Employment and Training (DGET) etc. depending on their specific requirement. Keeping in view the conceptual differences, the National Commission for Enterprise in Unorganised Sector (NCEUS) has set up a Task Force to review the existing definitions and formulated harmonised definitions of informal sector employment. NCEUS has defined the informal worker as '*Informal workers consists of those working in the informal sector or households, excluding regular workers with social security benefits provided by the employers and the workers in the formal sector without any employment and social security benefits provided by the employers'*.

Generally the concept of health implies a sound mind in a sound body in a sound family in a sound environment. **Health** is a term that refers to a combination of the absence of illness, ability to manage stress effectively, good nutrition, physical fitness and high quality of life. In any organism, health can be said to be a 'state of balance' and it also implies good prospects for continued survival.

Health care is the diagnosis, treatment and prevention of disease, illness, injury and other physical and mental impairments in humans. Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health and other care providers. It refers to the work done in providing primary care, secondary care and tertiary care, as well as in public health. Health care institutions are the organizations established to meet the health needs of target populations.

Statement of the Problem

Risks and shocks arise from many different factors, anticipated and unanticipated. Unanticipated events are much harder and these may include accidents, disasters, illness, crop failures etc. Among all these, health risk is more severe. Informal workers are more vulnerable to health shocks as these threaten their income-earning capacity. Accidents and ill health affect them directly and indirectly. They live and work in unhygienic conditions and are susceptible to many infectious ailments and chronic diseases. Poor economic conditions don't allow them to afford for quality health care services. Moreover these health shocks contribute to the loss of work days and hence directly impoverish them on the one hand and reduce their productivity and efficiency on the other. Traditional risk management strategies (like borrowing from money-lenders, friends and relatives, temporary migration etc.) are inadequate, unsuitable and sometimes significantly reduce the ability of informal workers to withstand future shocks. Public expenditure on health care is also declining since the adoption of neo-liberalisation policy of 1991. Shrinking budgetary support for health services, inefficiency in public health provision, unacceptably low quality of public health services and the resultant imposition of user charges is reflective of state's inability to meet health care needs of the informal sector. Institutional arrangement, in this regard, is necessary to enable them to fight risks and shocks. Service of micro finance institutions, in this regard, is appreciable. MFIs through micro credit and micro insurance services are serving the poor by providing financial protection to the needy. Faster and inclusive growth needs special attention to informal economy

FINDINGS

1. Number of persons surveyed – 80; out of which 20 from Udupi city (urban) and 60 from Alevoor village (rural). Total number of members in all the 80 families is 367 and hence average size of the family is 4.58.

2. Socio-economic status:

2.1 Occupational Distribution

Table 1: Occupational Distribution of Surveyed Households

Occupation	Urban	Rural	Total	%
Agriculture and Allied Activity	0	10	10	12%
Construction Worker	4	9	13	16%
Contractual Worker	5	6	11	14%
Coolie/casual Worker	8	32	40	50%
Domestic Worker	2	3	5	6%
Self Employed	1	0	1	2%
Total	20	60	80	100%

Source: Primary Data

Majority of the informal workers (50%) are coolie workers. There is no permanent employer-employee relationship, work being the casual or temporary, hence no job security and income security. Except in case of contractual work there is no income security to the workers.

2.2 Family Income

Table 2 : Annual Family Income of Surveyed Households

Annual Income of the Family	Number of Family	%
Less than Rs. 10000	28	36%
Rs.10001 to Rs. 25000	42	52%
Rs. 25001 to Rs. 50000	7	8%
More than Rs. 50000	3	4%

Source: Primary Data

36% household's family income is less than Rs. 10000 per year and nearly half of the surveyed families (52%) earn between Rs. 10000 and Rs. 25000 which contributed to their deprivation and vulnerability.

2.3 Educational Status of the Respondents

Table 3: Educational Status of Surveyed Households

Level of Education	Number of members	%
Primary	22	44%
Secondary	10	20%
PU	7	14%
Higher/Technical Education	2	4%
Didn't Attend the School	9	18%

Source: Primary Data

Majority of the respondents (44%) got only primary education and 20% got secondary education. 18% have not attended the school. It is mainly due to their economic vulnerability.

3. Health Status of the Family

Health status of the family is analysed with the help of three variables, i.e., IMR, MMR and Morbidity. Two households reported infant mortality and no case of maternal mortality is reported. Morbidity status of the surveyed families is analysed as following:

Table 4: Incidence of Diseases for the last 6 Months

Type of Morbidity	Case in last 6 months	Case in last month
Communicable Diseases	98	29
Chronic Ailment	45	10
Maternity Related Health Risk	8	3
Accidents	6	2
Bed-ridden Cases	3	0

Source: Primary Data

In last six months 98 cases of communicable diseases like malaria, typhoid, viral fever, hepatitis, pink eye etc. were reported. Chronic ailments like allergy, asthma, heart disease, obesity, migraine, back pain, arthritis were reported in 45 cases during the same period. 3 bed-ridden cases were found

due to paralysis, sine fracture and spinal code problem out of which two are due to workplace accidents.

4. Types of Care Sought:

It is observed that the type of treatment sought is more often dependent on the type of diseases. For minor problems like headache, fever etc. majority of them (80%) used to purchase the medicines from nearby medicals. For communicable and infectious diseases, maternity risks and accidents 48% respondents sought treatment from public health care centre and 52% respondents sought treatment from private hospitals. Chronic ailments were more often treated by private clinics (68%). Traditional healers are more popular in rural areas for treating chronic ailments like back pain, migraine, and for accidental injuries like fracture etc. It is also found that the people in majority cases are visiting hospitals only if inpatient treatment is required.

5. Sources of Finance:

Table 5: Sources of Health Expenditure

Sources	Number of Household	%
Current Income	5	6%
Savings	8	10%
Borrowing from Non-institutional Source	35	44%
Institutional Borrowing	5	6%
Health Insurance	26	32%
Asset Sale	1	2%
Total	80	100%

Source: Primary Data

40% of the hospital expenses were met by the health insurance providers. Among the uninsured majority are forced to borrow from employers, relatives and friends. It is obvious that health insurance schemes reduce the financial burden on the one hand and promote access to quality health care.

6. Institutional Treatment:

It is also found in some cases the respondents are not seeking the institutional care. Reasons for not seeking institutional medical care are:

Table 6: Reasons for not Seeking Institutional Health Care

Reasons	Number of Households
No Money	30
No Time	15
Loss of Daily Wage	35
Non-availability of Personnel/ medicines	32
Distant/ No transportation	2
No One to Accompany	5
Any Other	4

Source: Primary Data

Loss of wage (35%) and poverty (30%) are the main factors which keep away the respondents from the institutional health care services. Inadequate infrastructure and non-availability of doctors in the public health centres (institutional defects) are also equally responsible (35%) for the same.

9. Health Insurance:

9.1 Subscription: It is found that only 28 households (35%) have subscribed to the health insurance scheme. The penetration of health insurance is very low. Main reason for this is lack of awareness.

9.2 Awareness: Among the unsubscribed respondents, 32% are aware about any kind of health insurance scheme and rest (68%) are not at all aware about the scheme.

9.3 Willingness to Pay: 72% of the uninsured are willing to subscribe/ join the health insurance scheme. Among the insured 82% are willing to continue the scheme.

9.3 Ability to Pay: Among the insured majority i.e., 84% households feel that the premium is high. Average amount they can afford per member per year is Rs. 50-100 and per family (5 members) ranges from Rs. 500 to Rs. 750.

10. Infrastructure:

Table 7: Details of Infrastructural Facilities

Infrastructure	Deprived Household	%
Clean and Safe Drinking Water within 15 minutes walk-able distance	Nil	-
Toilet	6	12%
Drainage	59	74%
Waste Management	57	71%
Nutritious Food	52	65%

Source: Primary Data

Clean and safe environment is a necessary precondition for good health. Majority of the households are deprived of scientific waste management (64%) and proper drainage facility (48%) which is responsible for incidence of diseases.

CHALLENGES

Health security measures are of three kind viz., (i) Protective, (ii) Preventive and (iii) Promotional. Protective measure includes health care services provided by the health care centres. Preventive measure includes the provision of immunisation, better sanitation facility, drainage facility, clean and safe drinking water, health insurance etc. Promotional measure include the provision of food security, nutritious food etc. Multiple of challenges are persistent in each kind of health security mechanism.

1) **Availability:** The number of public health institutions is highly limited in relation to the demand. Availability is very poor for women, children and socially disadvantaged sections of our society. Poor quality of health services, inadequate infrastructure, location, operating time, unavailability of doctors and nurses etc. have worsened the availability of health care to the rural poor and also to urban slum populations. 52% households in our survey are not approaching the public health care centres for this reason.
2) **Affordability:** High and prohibitive out-of-pocket expenditure makes access of poor people to health services difficult. About 30% households in our survey who require hospitalisation do not seek health care because they cannot afford it and among those who seek hospital care. About 52% of households borrowed or forced to sell assets to meet their medical expenses. The OOP expenditure also deepens poverty for already poor households.
3) **Access:** The existing public health system in rural areas has become very unreliable and undependable for access to health care facilities especially in emergencies. Low coverage of health insurance, illiteracy, distance etc. are the major causes for the low access.
4) **Equity:** It means the guaranteed access of the whole population of a country to a package of health services by paying an affordable contribution or (for some people) no contribution at all. Attainment of equitable distribution of health care is considered one of issues. Inequality exists between low – high performing states, as well as between populations with different socio-economic status and also between rural and urban areas. Poor and inadequate information and knowledge about the accessibility and availability of services is the main reason for inequality.

5) **Insurance:** Lack of health insurance compounds the health care challenges that India faces. Only 11% of the population in our country has any form of health insurance coverage. Without insurance the poor are forced to resort for a long chain of debt or to sell the asset to meet the costs of the hospital care. In our survey only 35% households have enrolled to health insurance schemes. Among them only 82% are likely to continue the scheme.
6) Health Sector Reforms: Health sector is complex with multiple goals, multiple products and different beneficiaries. The implementation of large scale health sector reforms demands economic evaluation of different alternative programmes. Designing simple and easily accessible programmes for the target group has become a challenge due to the diversified health care needs and duplication of programmes already introduced which are working inefficiently.
7) Price Control: The federal government uses price controls to ensure that vital drugs are affordable to the Indian population. Ongoing challenge, in this regard, is to balance the commercial interests of pharmaceutical companies with broader social objective of curing diseases and preventing epidemics to improve the health status of the informal poor.

POLICY SUGGESTIONS

- A comprehensive and consumer need-based social security programme consisting of life insurance, health insurance and old age pension can be introduced to address the diversified needs of the informal poor.
- Encouraging private sector participation in providing social security including old age pension can reduce the burden of the government on the one hand and ensure the efficiency of the mechanism on the other hand.
- Increasing the health insurance coverage is also suggested. Moreover, the insurance programmes could be linked with the existing poverty alleviation programmes. Diseases like TB, HIV and mental illness, outpatient care, chronic diseases like diabetes, and hypertension can also be covered by the schemes. Compensation for wage loss, transportation cost can also be included in the benefit package.
- Creating the awareness among the poor is also necessary. Awareness with regard to the existing health insurance schemes, use of institutional health care services, personal hygiene, scientific waste disposal, keeping the surroundings clean etc. should be generated. Academicians, students, social workers should also join the hand in this regard. Arranging awareness camps, street plays, advertising through media are powerful instruments to generate awareness.
- Provision of micro credit through micro insurance institutions may reduce the financial vulnerability of the group. Easy and quick credit at low interest to meet health care expenses, micro health insurance will protect the informal poor from health shocks.
- To enlarge the connectivity, focus on women is necessary, as they are the catalyst of the change. Connectivity can also be enhanced by inculcating knowledge involving local celebrities and renowned personalities.
- Mobile hospitals, ambulatory services, concessional health care services (e.g. Manipal Health card) to the informal sector etc. ensures the institutional health care services.
- Prevention is better than cure. Regulation of slums in urban areas, scientific waste disposal system, and proper drainage system, good and hygienic work environment are the essentials to prevent the incidence of diseases.

CONCLUSION

Unlike the workers in the formal sector, informal sector workers do not have employment security, sustainable source of income and social security protection. Deprivation and vulnerability are the major threats faced by the sector. In the absence of institutional arrangement, they have to bear the dual burdens of health care expenditures and wage loss due to illness. This has added the vulnerability and insecurity of the informal workers. Traditional risk coping strategies are inadequate, unsuitable and sometimes significantly reduce the ability of informal workers to withstand future shocks. Public expenditure on health care is also declining since the adoption of neo-liberalisation policy of 1991. Shrinking budgetary support for health services, inefficiency in public health provision, unacceptably low quality of public health services and the resultant imposition of user charges is reflective of state's inability to meet health care needs of the informal sector. Hence, the protection and promotion of health and welfare of informal sector workers the need of the hour. An integrated policy to promote health status, provide healthy working condition, ensure social security to be adopted to improve the living standard of the informal poor. Faster and inclusive growth needs special attention to informal economy.

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