Health Insecurities of Workers in Informal Employment: A Study of Existing and Possible Interventions

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CONTENTS

CHAPTER - I

Introduction

Informal employment has grown over the years and contrary to the experience of the advanced countries, self employment did not decline with industrialization. The character of the labour market is undergoing a massive change in both the developed and developing countries as a result of globalization. Self-employment is on an increase with a decline in wage employment. The most significant development in the last two decades in the developing world has been a widespread growth in home working and self-employment. The share of employment in regular, permanent and full time jobs with adequate social protection has declined. The logic behind this change in the labour market has been the flexibalization process, induced by globalization. The widespread growth in the use of flexible and often unprotected workforce directly or through subcontracting of work has resulted in increased labour market insecurity for a large proportion of the workforce.

The absence of institutional regulation in the informal economy may affect various elements of the work process, since each specific situation defines a very distinctive type of activity. The status of labour may be undeclared, lacking the social benefits to which it is entitled, paid below the minimum wage, or employed under unusual circumstances. The conditions of work under which the labour is employed involves the tampering with health conditions, public hygiene, safety hazards or the location of activities. Although all workers face a broad set of work-related economic contingencies and risks, and informal workers and a-typical workers have a higher degree of exposure to such risks (Lund and Unni 2002). The employment structure in many developing countries is such that only a small proportion of their workforce is engaged in formal employment with stable contracts and associated benefits.

Informal Sector: Risks and Opportunities

The risks faced by those who work in the informal economy differ by their employment status, by the industry or trade in which they are engaged, and by

the wider social, economic, and political context in which they live and work. However, four broad generalizations can be made in this regard. Firstly, those who work in the formal and informal economics face the same **general risks**, notably: illness, property loss, disability, old age, and death. However, informal workers often face **greater exposure** to these general risks given the nature of their work and living conditions. Secondly, those who work in the informal sector face greater **work-related risks** than those who work in the formal sector do. Dependent informal workers face little assurance or guarantee of work, low wages or earnings, few worker benefits, and unsafe or unhealthy working conditions. Independent informal workers often have insufficient market information, skills, or power and, therefore, less access to existing or emerging market opportunities. Thirdly, those who work in the informal sector typically have **fewer mechanisms** – including access to formal financial instruments – for dealing with risk than those who work in the formal sector do.

The sources of insecurity faced by workers in the informal economy are of two types. One is the random shocks that hit households from time to time, or contingencies. A second source of insecurity comes from the structural features of the household or individual, which remain more or less constant over a period of time. These include age, marital status, gender, ownership of assets and castee. An important structural feature that affects workers is the activity status that is whether the worker has a salaried job, is a casual employee or a self-employed worker. This is particularly important for workers in the informal economy, who do not constitute a homogeneous group. Taking in to consideration these insecurities, there is a need for social protection in order to address these issues.

Traditional social security was geared to address this form of insecurity. During the late 1800s and early 1900s, many (now) industrialized economies introduced a system of protection against social risks – called social security – that included: **social insurance** to protect the labour force against "normal" or "common" contingencies in a modern society (old age, disability, death of breadwinner; insurance against accidents at work and work-related illnesses; unemployment benefits); **social assistance** to protect those, who were assumed to be a minority, facing "subnormal conditions" or temporary "uncommon contingencies" ; **family allowances** (benefits for families with children); and, in some cases, **national health schemes**. Social insurance, which covered the large formal workforce, was financed by a mix of taxation and contributions from employers and formal workers themselves (Mesa-Lago 1992), and countries differed widely in the relative contribution made by each party, and in whether the state, too, made a contribution. However, globalization and an increasing informalization of the labour force, has led to the general withdrawal of the state from various aspects of provisioning of goods and services and to a greater reliance on market mechanisms. Millions of workers, worldwide, lost access to

formal mechanisms of social protection– such as health insurance, disability allowances, or retirement benefits –they once had through their place of employment or from the state, or a combination of the two. This has affected people negatively, particularly those on the lower rungs of society.

Moreover, informal work is characterised by high risks, both economically and physically and at the same time demands by informal workers for security and protection can lead to replacement of workers from their jobs. Therefore growth in the informal sector means increasing vulnerability among large section of workers. Therefore there emerges perceived need for social protection of these workers particularly on two grounds – first and foremost, in terms of their basic human rights; and second, on that grounds that a healthier and more secure work force increases productivity. However, social security programmes in most developing countries cover mainly a small part of the population – the organized sector, where the structure of enterprises facilitates the collection of taxes and contributions, as well as the administering of schemes. Therefore for the vast majority of the population who belong to the informal sector, especially designed social insurance schemes like welfare funds financed by taxes or a cess are required (Subrahmanya, 2000), as well as social assistance programmes financed by government revenue and targeted to the poor (Guhan, 1994). Thus as the traditional economic and social order undergoes transformation as societies develop there emerges a perceived need for social security to provide for those who lack an income (due to disability, old age, death of a breadwinner, maternity, work-related injury, unemployment, etc.) or who have medical needs.

There have been two shifts in the general approach to healthcare provisioning. The first approach in the 1940s and '50s was based on national health systems funded through state revenue in richer countries. The high costs associated with these systems and their decreasing ability to provide decent healthcare led to the adoption of a primary healthcare policy, in which state resources were transferred to primary, cheaper interventions, leaving people to fund more expensive health interventions out of their own pockets. The second shift has been an ideological shift from government's responsibility for healthcare provision or financing responsibility. This has been replaced by an increasing reliance on insurance schemes, including private insurance such as has been seen in certain Asian countries (WHO Report, 2000, pp. 14-16).

Coming to health insecurities of workers in informal employment employment, it can be seen that there are strong links between poverty and ill health. Illness can create economically detrimental impact and can cause household impoverishment through income losses and medical expenses that trigger a spiral of asset depletion, indebtedness and cuts to essential consumption (Gilson 1988; Pryer 1989; Haines et al. 2000; Kabir et al. 2000). The financial impact of ill health consist of both direct and indirect costs (McIntyre and

Thiede, 2003, p. 1). The direct costs include increased household expenditure on treatment, travel, user fees, proper nutrition for the patient, while the indirect costs include the opportunity costs of expenditure decisions and income foregone in the event of illness. If the individual is economically active, sickness can result in loss of current income. Other household members may also be required to devote time to the care of the ill household member, leading to loss of income. These costs affect the workers in the informal economy more severely where income depends on daily activities and the workers do not have any kind of social protection. Direct and indirect costs will be influenced by type and severity of illness and health service characteristics that influence access and choice of provider. Illness costs going beyond the household's daily or monthly budget may trigger coping strategies such as borrowing or asset sales. In situations of poverty where households struggle to meet daily food and fuel needs, the loss of a daily wage due to illness or a relatively small treatment expense is likely to trigger such strategies, including claims on resources outside the household such as social networks or local organizations that offer credit. Illness costs and coping strategies then have implications for household asset portfolios and processes of impoverishment.

The term cost burden refers to direct or indirect costs expressed as a percentage of household income. Some analysts assume that a cost burden greater than 10% is likely to be catastrophic for the household economy, meaning that it is likely to force household members to cut their consumption of other minimum needs, trigger productive asset sales or high levels of debt, and lead to impoverishment. However, this 10% figure is somewhat arbitrary because it may not be catastrophic for high-income households that can cut back on luxuries or for resilient households that can mobilize assets to pay for treatment.

The nature of the contingency thus depends on several factors: (a) Who in the household is ill or injured? (b) How long is the household member unable to perform their usual roles in the household division of labour? (i.e. is the illness a one-off event or does it lead to long-term incapacitation?) (c) How much does one-off or recurrent treatment cost? The nature of the contingency is crucial in determining the range of responses households will be forced to consider. The incapacity of an adult labourer as opposed to a child or elderly household member can be expected to impose different opportunity costs in terms of income foregone. These opportunity costs may be reflected in decisions (not) to allocate resources to the treatment of different household members. Once a decision to seek treatment has been made, the distinction between acute or prolonged episodes of ill- health may be crucial to both the impact on a household's labour endowment and calls on household expenditures in the longer term.

Households often encounter great difficulties in paying for health services, but have no option to avail the services in order to save their relatives. The

money used to pay for health care may otherwise have been used for food, agricultural development or education. Payment for health services is thus made at considerable social cost to the family and can scarcely be said to represent a "willingness" to pay in the normal sense of the word.'[1] Poor households cope with direct costs by using the savings initially along with a reduction of household consumption. Thereafter the liquidation of household assets is done and finally recourse is taken to borrowing from family, community or micro-lenders (McIntyre and Thiede, 2003, p. 17). Each of the above coping mechanisms can lead to an impoverishment of the household and the individual members of the household, and often it can take a household two generations to emerge from such a trap (McIntyre and Thiede, 2003, p. 27. Van Ginneken, 2003, p. 23). The resultant poverty trap caused by out-of-pocket medical costs has two potential impacts - pushing a household into poverty, or destroying strategies that a household has developed to enable it to move out of poverty.

As per estimates made by WHO, 178 million people may suffer 'financial catastrophe' as a result of out of pocket health expenditure per year, and that 104 million people are forced into poverty for health payments. While low and middle income countries account for 18% of global income, they represent 84% of the world's population and carry 93% of the disease burden, but only access 11% of the world health spending (WHO, 2000). Although paying for health care is made out of great difficulty, especially for the households without any stable income, which are usually the households belonging to the informal sector, yet, in many developing countries people are expected to contribute to the cost of health care from their own pockets. As a result, people's ability to pay (ATP) for health care, or the affordability of health care, has become a critical policy issue. Research and policy debates have focused on willingness to pay (WTP) for essential services, and have tended to assume that WTP is synonymous with ATP.

In reality, households often persist in paying for care without having the capacity to do so. In order to mobilize resources they may sacrifice other basic needs such as food and education, borrow money, sell productive family assets and at even involve children in productive activities. Although the consequences of these strategies may have a devastating impact on livelihoods and health, yet few studies have investigated them in any detail. The present indepth household study therefore proposes to develop understanding of ATP for policy initiatives which might contribute to more affordable health care of households belonging to the informal economy.

Table 1.1 presents a typology of tangible and intangible assets which can be drawn upon or liquidated in times of need.

Labour

- labour endowments: structural variables such as household size, composition, age and gender
- human investments in education, skills and health which determine labour capacity of a household
- labour roles within the household, both of the ill or injured household member and of carers

Productive assets

- private productive assets, e.g. land, livestock, farming equipment, houses, domestic utensils
- collective assets, e.g. access to common property resources

Stores of value

- stores of food and cash crops
- small or large livestock
- stores of real value, e.g. gold, jewellery
- cash savings in household or bank accounts

Claims

- claims on other households, including kin, neighbours and friends, for productive resources, food, labour, livestock, or cash. Claims may be in the form of loans or gifts.
- claims on local community organisations e.g. village committee
- claims on government, e.g. poverty alleviation and social relief assistance, medical fee exemptions

Two key factors influence household ability to cope with illness costs successfully. The first is the household's vulnerability or ability to cope with a shock, which is founded on its asset portfolio that includes tangible assets such as physical and financial capital, and less tangible assets such as education (human capital) and social resources. The latter are the social networks on which claims can be made to obtain other resources, particularly information, opportunities, and support. Social resources include kin and friendship networks, links to influential contacts, and membership in organizations such as credit associations or funeral societies.

The issue of health security therefore emerges as an important factor which has two aspects: low exposure to risk, and access to health care services, with the ability to pay for medical care and medicine. Such health security should be equally available and accessible to all citizens and remains the primary responsibility of the state. Although health care is equally important for everyone regardless of labour force participation or employment status, yet in many developing countries large numbers of workers - particularly those outside regular wage employment - have no satisfactory health coverage. Strategies for providing for affordable access to healthcare for the households in the informal economy, who are outside the purview of any kind of social protection would enable an improvement of both the health and the quality of life of their ability to generate income in a sustainable manner.

In India, the large public sector health infrastructure includes public hospitals, primary health centers and sub-centers and para-medical staff in rural areas. All this is under threat with declining public health expenditures and an increasing reliance on the private sector. The preventive measures of universal immunization and maternal and child health programmes such as Integrated Child Development Scheme (ICDS) are continuing.Besides the state and the private sector, a third type of institutional mechanism increasingly involved in the delivery of certain social protection instruments comprises NGOs and member-based organizations (MBOs). Since 1992, Self Employed Women's Association (SEWA) has introduced a unique integrated insurance plan. It offers an integrated social security package to its members at Rs. 60 a year. It covers illness, widowhood, maternity, accident, fire communal riots, flood and other calamities that result in loss of work and income to poor families.

Although studies have documented strategy types and sequences, few have evaluated the implications of strategies for the household economy, in terms of assets, income and consumption patterns, debt levels, and livelihood sustainability. Moreover, the existing studies have focused on the direct medical costs of illness and the out of pocket expenses that have been met in order to avail treatment and other health related services, without looking taking into account the indirect costs of illness which also play a very strong role in the household's economic condition. Indirect cost measurement can vary considerably based on the factors that are being considered such as the loss of economically active people, the time spent seeking treatment by the patient and caregiver and their loss of productive labor time due to illness. There is a need therefore for a better understanding of how households cope with direct as well as indirect costs of illness, in order to design appropriate strategies for protecting against the risk of impoverishment. In other words, more research needs to ask the questions: are strategies successful or sustainable, in terms of preserving assets, sustaining production and income levels, and averting the collapse of the household? Or do strategies damage asset portfolios, reduce income and

consumption, lead to high levels of debt, and threaten the sustainability of the household economy and its existence as a social unit? Because of the need to understand these internal processes in relation to their context a case study approach was chosen, looking at a small number of households in depth. This allows a detailed understanding of interrelated events, effects, and the underlying explanations that are either associated with, or may result in, a particular phenomenon – providing an essential complement to numeric, frequency-based estimates.

Rationale of the Study

There are several studies as pointed above which have been carried out with the wider objective of finding out the quantum of health expenditure of the households in different income groups. Studies have also pointed out that those households which avail only public health care facilities, also end up doing a lot of out-of-pocket (oop) expenditure on health care. Taking these factors into consideration the issue therefore is not to repeat what has already been studied, i.e. pattern of health expenditure, but to go beyond and analyze the impact of health expenditure on the households in terms of the vicious circle of it and find out a possible solution in the existing situation. Health expenditure as explained has many forward linkages such as indebtedness, loss of income on account of poor health, decline in workers' productivity, curtailment of other necessary consumer expenditure etc. The present study would therefore make an attempt to understand the coping strategies that are adopted by the households and their willingness to participate in alternative community based health care financing system. The household will be the unit of analysis for assessing the costs of illness because decisions about treatment and coping are based on negotiations within the household (but not necessarily from an equal bargaining position), illness costs are incurred by caregivers as well as the sick, and costs fall on the household budget

Objectives of the Study

1. To understand the insecurities and vulnerabilities of the workers in the informal sector and locate within it the health related insecurities.

2. Impact of health insecurities and the coping strategies adopted by the households.

3. Effectiveness of the existing community-based health financing programmes in meeting the health needs of the workers in the informal sector, the effectiveness of such programmes and the willingness of the households to participate in such programmes and compare the situation with a locality where such alternative health care financing programme is not available.

Methodology of the Study

The study has been conducted in Delhi which has a growing importance in terms of being a major provider of jobs especially in the informal sector and also for the functioning of several alternative health financing programmes. The study has been conducted in slums chosen in a purposive manner to cover two categories of slums – (i) with no alternative health financing programmes and (ii) with alternative health financing programmes, in order to facilitate comparison. For the purpose of sampling a list of the households involved in the informal sector has been drawn in each of the slums and taking into account the heterogeneous composition of the workers, the sample constitute a proportionate share of the different groups of workers. The sample covers an approximate size of 500 households. The data is generated through questionnaire method, which is supplemented by qualitative data obtained through focus groups discussion and a few case studies. The reference period for collecting information regarding health expenditure of the households will be one year prior to the time of the study. Besides obtaining information from the head of the household, information has been collected from the female members for information on maternity health, etc. Besides household survey, the study also covers the nearby government health care services, health programmes run either by NGOs, etc. Informal discussions has been carried out with several important stakeholders such as NGOs, medical practitioners, community health workers, informal doctors of that area, etc.

Scope of the study:

The study has been conducted in the Delhi which being the capital of the country is expected to have a good health delivery system. Since the study focuses on the health insecurities of workers in informal employment with low income, therefore in order to make the study representative the study has been conducted in all five regions of the state covering North, South, East, West and Central. In order to make a comparative analysis, two slums – one having access to other health facilities have been covered in each of the five zones.

Preliminary information on local healthcare resources, organizations, accepted descriptions of well-being, and health-seeking behaviour patterns were obtained from key informant interviews and focus-group discussions. An initial cross-sectional survey of 506 households (stratified by socioeconomic status) in 10 slums provided a profile of illness and cost burdens, and enabled selection of households. Ten case-study households, with high cost burdens of illness, were then selected from the original sample using two criteria: socioeconomic status and level of social resources. In 10 monthly visits, data were collected on health expenditure and descriptive explanations of illness occurrence, treatment actions, use of social networks, and changes to livelihood. Monthly expenditure data

were collected three times during the fieldwork. Eighteen of these households have participated in in-depth interviews on: their life history (description of the household's long-term experience); illness narratives (of key illnesses, as a background to actions taken during the study period); social networks (a map of key individuals providing support, and the nature of those relationships); health-seeking behaviour and trust (general patterns of healthseeking behaviour, and provider characterist ics thatinfluence those patterns), and a final interview to understand how illness and other shocks have shaped the household's livelihood over the past 1 year or so.

CHAPTER - 2

Profile of the Households

As the unit of the present study is the household, therefore the head of the household was chosen as the principal respondent of the study. However, in most cases, the family data that was being collected from the head of the household was supplemented by other family members.

2.1: Distribution of respondents across slums and locality

Region	Locality	Name of the slum	Proportion of respondents
North	Inderlok	JJ Slum, Shahjadbagh - Millat	36(7.11)
	Sarai Rohilla	Daya Basti Jhuggi	66(13.06)
South	Molarband	Bilaspur camp	32(6.32)
	Madanpur Khadar	JJ Resettlement Colony	56(11.04)
East	Patparganj	Nehru Camp, Mother Dairy	81(16.00)
	Kalyanpuri	Indira Camp	30(5.93)
West	Shannagar II Manglapuri	Rajiv Gandhi Camp	9(1.78)
	Raghubir Nagar	Tankiwali Jhuggi	90(17.78)
Central	Karol Bagh	Ambedkar Basti	46(9.09)
	Anand Parvat	Taliwalan Jhuggi	60(11.85)
Total			**506(100.00)**

Personal Profile of the Households

A look at the personal composition of the respondents, show that of the total 506 respondents, majority were Hindus (77.5 per cent) which was followed by Muslims who composed 22.3 per cent of the population and only one per cent of the respondent population were Christians. The respondent households mostly belonged to the socially backward sections of the society with scheduled

castees constituting more than half of the respondents (52.2 per cent), followed by other backward castees which constituted 34.2 per cent of thee respondents. It was seen that a sizeable number of respondents (13.4 per cent) belonged to upper castees. This looks a little unusual as the sample households are all involved with informal activity and 90 per cent of them are migrants. This shows that thee is a growing tendency among the households of the upper castees to be involved with informal activities and also migrate out of their native places in search of work.

2.2:Social composition of the Respondents

Social composition	**Proportion of Respondents**
Religion	
Hindu	392 (77.5)
Muslim	113 (22.3)
Christian	1 (0.2)
Total	506 (100)
Castee Category	
Upper caste	68 (13.4)
OBC	173 (34.2)
SC	264 (52.2)
Others	1 (0.2)
Total	506 (100)

Coming to the age of the respondents and their classification in to six age cohorts, we could see that the modal age cohort is 31-40 years (47.62 per cent). This is followed by the age cohort 21-30 years (28.06 per cent) and the age cohort 41-50 years (21.54 per cent). The number of respondents decreases with the rise in the age beyong 50 years which corroborates the general trend of the age distribution of workers in informal economy who are also migrant workers.

2.3:Distribution of the sample respondents across age group and gender

Age group (years)	Male	Female	Total
Below 20	5 (1.00)	0	5 (0.98)
21-30	141 (28.25)	1 (14.28)	142 (28.06)
31-40	236 (47.29)	5 (71.42)	241 (47.62)
41-50	108 (21.64)	1 (14.28)	109 (21.54)
51-60	6 (1.20)	0	6 (1.18)
Above 60	3 (0.60)	0	3 (0.59)
Total	499 (100)	7 (100)	506 (100)

As the unit of the study is household and the head of the household was chosen as the principal respondent, therefore it can be seen from the table given below that 98 per cent of the respondents are male. There were only seven households in which the respondent or the head of the household was a woman. It can be seen that except for one female respondent or head of the family in the age group of 21-30 years, the remaining female head of the household were either in the age group of 31-40 years or 41-50 years age group. Moreover, as can be seen from table 2.4, the female headed respondents are those who are widows or have been separated from their husband.

Coming to the marital status of the respondents it is seen that 93 per cent of the respondents were married. This is because of the fact that in order to understand the financial implication of illness on the household, household has been kept as the unit of analysis and the respondents have been purposely chosen in terms of households.

2.4: Marital status of the Respondents

Marital status	Male	Female	Total
Married	471 (93.1)	3 (0.6)	474 (93.67)
Unmarried	20 (4.0)	0	20 (3.95)

Marital status	Male	Female	Total
Divorced, Widowed, Separated	8	4	12 (2.37)
Total	499 (100)	7 (100)	506 (100)

2.5: Educational status of the respondents

Educational status	No. Of respondents	Percentage
Uneducated	543	25.7
Primary	968	45.9
Middle	392	18.6
Secondary	152	7.2
Higher secondary	34	1.6
Above higher secondary	20	.9
Others (Diploma)	0	0
Infant	383	15.36
Disabled	1	0.04
Total	2493	100

The 506 households of the sample comprised of a total sample population of 2493 people, with the average size of the households being 4.9 members. A look at table 2.5 shows that of the total sample population, the population below 14 years of age comprises of 41.47 per cent of the population and the sample population above 60 years of age comprises only 0.92 per cent of the population. The population in the 15 to 60 years age group, which is the economically productive age group comprises only 57.60 per cent of the population. Thus one can see from the table given below that majority of the sample population belong to the dependent category.

2.6: Distribution of sample population across age group and gender

Age group (years)	Male	Female	Total
0-5	197 (7.9)	195 (7.82)	392 (15.72)
6-10	217 (8.80)	229 (9.10)	446 (17.90)
11-14	99 (3.97)	097 (3.89)	196 (7.86)

Age group (years)	Male	Female	Total
15-18	120 (4.82)	089 (3.56)	209 (8.38)
19-40	480 (19.26)	463 (18.57)	943 (37.83)
41-60	184 (7.38)	100 (4.01)	284 (11.39)
Above 60	15 (.60)	8 (.32)	23 (0.92)
Total	1312 (52.63)	1181 (47.35)	2493 (100)

Although the sample population below 14 years of age comprises 41.47 per cent of the population, yet in the table below which shows the present status of the population, it can be seen only 26.51 per cent of the population are involved in studying full time. This implies that the remaining 14.96 per cent of the children below 14 years of age, either do not study, or combining work with study or are full time child labourers, which is a cause of great concern. Coming to the distribution of male and female respondents who are working, it can be seen from the table given below that 52.13 per cent of the male respondents are found working as compared to only 4.91 per cent of the female sample population. Similarly, with regard to the population who are neither studying nor working, it can e seen that there are 69 per cent female population who fall in this category as compared to only 19.96 per cent of the male population. This is because of the fact as revealed through discussions is that the male children get involved with work at an early age, whereas the girl children even if not involved in studies, stay at home and take care of the household activities and their younger siblings.

2.7: Genderwise distribution of sample population across present status

Present status	Male	Female	Total
Studying	364 (27.74)	297 (25.14)	661 (26.51)
Studying & working	2 (0.15)	0	2 (0.08)
NSNW	262 (19.96)	826 (69.94)	1088 (43.64)
Working	684 (52.13)	58 (4.91)	742 (29.76)
Total	1312 (100)	1181 (100)	2493 (100)

As regards the level of education among the sample population, 37.18 per cent of the population are illiterate. Taking in to consideration the fact that 15.36 per cent of this figure comprises of children who are yet to start their education, it can be said that 21.82 per cent comprises of people who are illiterate. Moreover, among the people who are literate, it can be seen that the majority (38.82 per cent) are educated up to primary level or are literate without any formal schooling. Only 15.72 per cent of the sample population is educated up to middle school and the figure goes down further to only 6.09 per cent of the population who are educated up to secondary school and 1.36 per cent of the population who are educated up to high school. This has two implications. The first is that the households in the informal sector have very limited income, for which it is often not possible for them to continue education till a higher level. They are usually compelled to start work at a very early age in order to sustain their livelihood, which can be seen also from the findings of the present study where very young children have been found to have started work already at the time of this study. Secondly, the kind of jobs in which these households get involved in the informal economy, do not require much educational or technical skills. Most of the work is learnt by the workers during the course of their work as on-job training.

2.8: Distribution of sample population on the basis of educational status and gender

Educational status	No. Of respondents	Percentage
Illiterate	927	37.18
Up to primary or literate without any formal schooling	968	38.82
Up to middle school	392	15.72
Up to Secondary	152	6.09
Up to Higher secondary	34	1.36
Above higher secondary	20	0.80
Total	2493	100

Thus it can be seen that the poor households belonging to the informal economy have low level of education and many of them have no formal schooling in their lifetime. They also have very low level of employment training, and have limited access to such training.

Situating Migrant Labour Households in the Informal Economy

Migration of households primarily reflects household subsistence strategies in the face of economic, social, cultural and other constraints. The pattern of labour migration is reflected both by the pattern of development and social

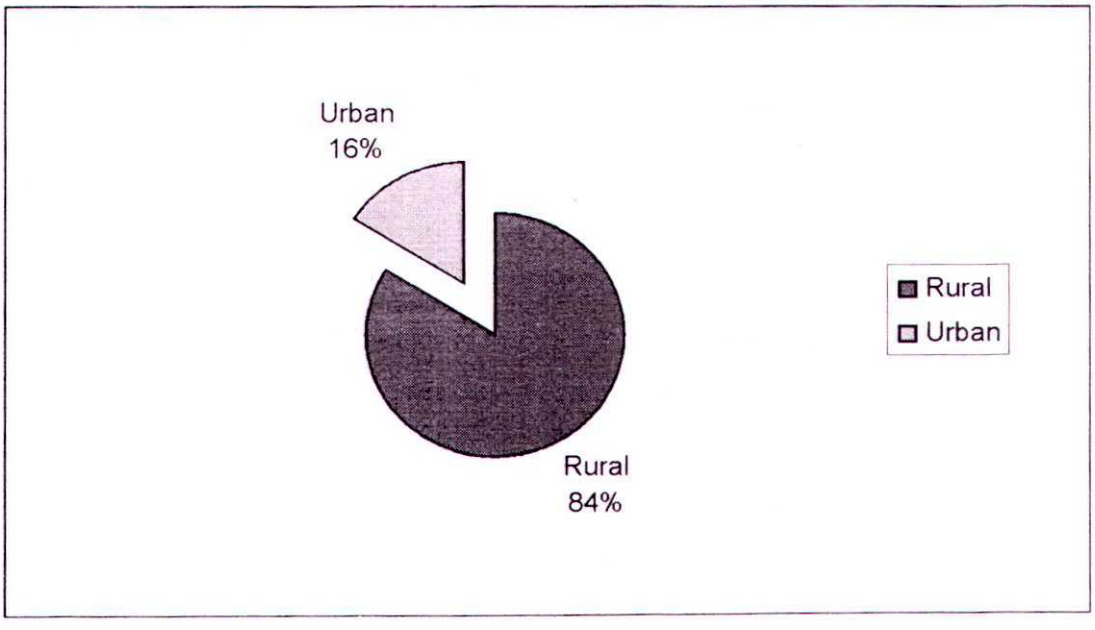
structure (NCRL, 1991) thereby reflecting both the 'pull' as well as 'push' actors. Analysis of the recent trends of labour mobility on the basis of NSS estimates has reflected that there has been a sharp increase in urban labour mobility with a significantly large number of male migrants reporting employment related causes for migration (Srivastava and Bhatacharya, 2002)

2.9 : Migration status of households/Respondents

Status	No. Of HHs	Percentage
Native	49	9.7
Migrant	457	90.3
Total	506	100

As per the findings of the study, majority of the respondents (90.31 per cent) were migrants. It can be seen that of the total migrants, majority belonged to rural areas (84 per cent), but moved out to urban areas for employment prospects. This indicates the dominance of rural to urban migration in terms of labour migration flows. It was interesting to note that of the total migrants, 97 per cent had migrated for the first time to Delhi. The remaining three per cent had also migrated to other urban destinations, before migrating to Delhi.

Chart 2.1: Migration from Rural/Urban



The respondents mainly belonged to Uttar Pradesh (67.17). This was followed by migrants from other states such as Bihar, Rajasthan, West Bengal, Orissa, MP and Maharashtra.

2.10: Distribution of households according to State of origin

State	Proportion
UP	307 (67.17)
Bihar	71 (15.53)
Rajasthan	41 (8.97)
West Bengal, Orissa, MP, Maharashtra	38 (8.31)
Total	457 (100)

The causes of migration are generally traced to economic determinants. Economic explanations centre on the search for better opportunities of income and employment. The table below shows the push and pull factors of migration in the study areas. The primary push factor was lack of better employment opportunities in the place of origin which was said by 26 per cent followed by unemployment quoted as a reason for migration quoted by nearly 20 per cent of the migrants. A small number of migrants (six per cent) had also migrated for other reasons such as drought, family disputes, etc in place of origin The main pull factor were favourable employment situation in cities which was a major factor responsible for the migration of 47 per cent of the migrants.

So lack of employment and better earning opportunities coupled by better employment opportunities in the cities is responsible for a lot of migration from rural to urban areas. Moreover, as can be seen from the previous table that majority of the migrants are from backward states where workers do not have adequate employment and earning opportunities and therefore the pull factors play a very important role. Thus, more than unemployment, it is the underemployment factor that is particularly responsible for migration.

2.11 : Reasons for migration

Push and Pull Factors for Migation	Reasons	Proportion
Push Factors	Lack of better employment opportunities in place of origin	119 (26.03)
	Unemployment in rural areas	91 (19.91)
	Other reasons like drought, family disputes, etc in place of origin	30 (6.56)
Push Factor	Favourable employment opportunities in cities	217 (47.48)
Total		457 (100)

Information networks between the city and village are especially important in shaping rural urban migration streams. Information regarding the labour market passes through these networks and functions to encourage or discourage potential migrants accordingly. Further the information about the job prospects in the urban labour market is spread by the migrants during their visit to the native places. Social networks also perform an important adaptive function for the migrants once they reach the city. This study shows that the vast majority of the workers have migrate to Delhi because they have kinship relations, persons of the same caste or village friends already Delhi who could help them to find a job and help them to adjust to the new urban life. Thus social networking plays an important role in coping with urban life since it works as 'social capital'. The urban poor maintain both kinship as well as neighbourhood network in the city. This type of network becomes social capital in the context of migration to the city – by providing employment related information to the workers, helping them with initial accommodation in the city and to adapt to city life. After migration to the city, neighbourhood becomes important in terms of their social network. It was seen in the study that majority of the migrant households settled down in a particular neighbourhood with the help and guidance of the kinship networks.

2.12 : Information of employment in city provided by-

Who helped	Number of Respondents	Percentage
Relative	104 (22.75)	20.6%
Friend	90 (19.69)	17.8%
Neighbour	46 (10.06)	9.1%
Labour contractor and employers	24 (5.25)	4.7%
Self	193 (42.23)	47.6%
Total	457	

The findings shows that migration is facilitated to a great extent by traditional networks such as relatives, friends and neighbours. Of the total people who migrated, 52.5 per cent of the migrants were given information of the job opportunities in present destination by relatives, friends and neighbours. Only a small section of the sample (5.25) came to the present destination by the help of institutional networks such as labour contractors or contact with employers.

In the context of studying the trends, pattern and nature of migration, it would be interesting to seek answers to the following questions: (i) In the case of family migration, who took the migration decisions? (ii) If migration decisions were jointly taken by men and women (husband and wife), was the migration decision based on the net expected income of both men and women or that of men only or that of women only?

Among the respondent households in our sample, although at the time of the study all the migrant households were staying at the destination with their family which meant that it was a family migration, yet the decision to migrate was taken independently by more than half the households (52.29 per cent). Migration decision was jointly taken by both men and women in 47 per cent of the households and in only 0.65 per cent households the decision to migrate was taken solely by women. Discussion with the households revealed that these households were women headed households.

2.13 : Migration Decision

Decision to Migrate	No. of Households
By the Male Members	239 (52.29)
By the Female Members	3 (0.65)
Jointly	215 (47.04)
Total	457 (100)

It is important to note that even though the decision to migrate was jointly taken, the physical movement was first made by men and other members of the family moved later. Among our sample respondents, majority of the migrants had either migrated alone (38.29) or along with friends/ neighbours (40.70). 18.59 per cent of the migrants who were relatively in the younger age category had migrated along with their parents or relatives. Only a small number of migrants (2.40 per cent) whose job was already arranged in the place of destination made the initial movement along with their wife and children .

2.14 : Table 3. Initial migration with

Migrated with	Percentage
Alone	175 (38.29)
With friends / neighbours	186 (40.70)

Migrated with	Percentage
With other parents/relatives	85 (18.59)
With wife and children	11 (2.40)
Total	457 (100.00)

This is because the migrant workers are not very sure about the kind of job and accommodation they would get in the destination point. Most of the workers as we have seen earlier come to know of employment opportunities through informal networks. Moreover, the workers usually stay with their friends and relatives in the cities till they earn a decent wage to hire independent room. This in a way reflects the kind of insecurity with which the migrant workers move to cities looking for employment. However, at the time of the present study, all the migrant workers were staying with their family. This is because of the fact that being a household based study, the respondents living with their family were purposely chosen as sample of the study. Moreover, as can be seen from the table below, except for 21 per cent of the migrants, the remaining migrants were staying in Delhi for more than five years and many of them had been staying for more than ten (49.68 per cent) and twenty (10.71 per cent) years. This is a long time for the migrants to find a reasonably decent job in the destination and bring their families to the destination point.

2.15 : Duration of stay across migrant workers.

Duration Of stay	Proportion
1-5	95 (20.78)
6-10	86 (18.82)
11-15	97 (21.23)
16-20	130 (28.45)
21-25	30 (6.56)
More than 25 years	19 (4.15)
Total	457 (100.00)

It can thus be observed that the informal sector employs a large number of migrant workers. These workers inspite of the fact that they have been staying in the place of their destination for long period of time, which is sometime up to 25 years, yet they are employed in the informal sector or are self employed.

Housing and Basic Facilities

Housing is considered to be one of the basic needs along with food and clothing. Despite this recognition, housing facilities has been inadequate in most developing countries. Although a large number of housing schemes have been introduced in India, yet such schemes have not been implemented well which leaves majority of the people with housing problem, particularly for the informal workers who do not have adequate and stable source of income. According to the condition of housing survey of the National Sample Survey in 1993, about 25 per cent of the households in the country live in dilapidated or *kutcha* houses (made of non-permanent material). The proportion of households living in *pucca* structures made of brick and concrete, was 43 per cent in the country as a whole, the proportion being much higher, 74 per cent, in urban areas.

However, when we come to the urban poor, we see that the urban poor have little access to urban land and they mostly build their houses on vacant private and government land and thereby become squatters in the city. Most of them live in jhuggis which are constructed from low cost housing materials like tin, bamboo, straw and polythene. These houses become more vulnerable during rainy season as most of these jhuggis are either kutcha jhuggis or semi-pucca jhuggis with permanent walls and tin roof. In many cases more than five members of the households live in one congested room.

2.16 : Distribution of households by ownership and type of houses

Ownership of House	Type			
	Kutcha	Semi-Pucca	Pucca	Total
Own house	14 (2.76)	247 (48.81)	30 (5.92)	291 (54.94)
Rented	1 (2.76)	55 (10.86)	159 (31.42)	215 (42.49)
Total	15 (2.96)	302 (59.68)	189 (37.35)	506 (100)

In the present sample it can be seen that more than half the households (54.94 per cent) lived in their own house. This is inspite of the fact that 90.31 per cent of the respondents are migrants. This is partly because of the fact that almost 80 percent of the migrants had been residing in Delhi for more than five years and also partly because of the fact that those respondents who had their

own house, the type of house was either kutcha or semi-pucca which can be seen from the table below. Only a small percentage of respondents had own pucca house (5.92 per cent). Moreover, it was observed during the study that the condition of the semi-pucca or pucca houses were far beyond one can imagine by the term. In most cases, these houses were usually built in a very indigenous manner by joining pieces of bricks. The condition of the houses can be assessed by the fact that except for about ten per cent of the houses who reported that the value of their house is around Rs.1,00,000.00 all other respondents reported that the value of their houses were below Rs.40,000.00 (60 per cent) and below 60,000.00 (20 per cent).

Table 2.17 : Distribution of HHs by Basic Amenities

Basic amenities	Available	Not available	Total
More than one room	71 (14.03)	435 (85.96)	506 (100)
Ventilation/window	294 (58.10)	212 (41.90)	506 (100)
Separate kitchen	54 (10.7)	452 (89.3)	506 (100)
Drinking water Within 200 metres	350 (69.17)	156 (30.83)	506 (100)
Separate toilet	52 (10.3)	454 (89.7)	506 (100)
Electricity	500 (98.8)	6 (1.2)	506

The majority of households do not have basic household facilities and 85.96 per cent of the households live in single rooms with the average size of the households being 4.9 members as has been discussed earlier. Any of the houses (42 per cent) do not have any window and live in very cramped and dingy condition without any sunlight coming to the house. Majority of the houses (89.3 per cent) do not have separate room for cooking facilities and they cook inside the only room in which they live or in open spaces outside their room. Most of the households do not have access to the city's water supply and they collect water for drinking from a common municipal tap or from hand tubewells which is not always located near their house and have to wait for a long period of time to get water from public municipal taps. The situation becomes more difficult during the summer when there is a scarce supply of water public municipal taps. In our sample, one third of the households did not have access to drinking water within a range of 200 metres from their houses and only10 per cent of the households had separate toilet facilities. Although the findings of the study

showed that 98 per cent of the households had access to electricity in their houses, yet discussion with the respondents revealed that electricity connections have been taken from informal sources, for which access often becomes irregular after raids are carried out by the electricity department officials and the connections are disconnected. Most of the households in the slums did not have access to drainage facilities and municipal waste disposal facilities and disposed the household waste nearby posing a serious challenge to the cleanliness of the neighbourhood and the environment

Thus there is steady deterioration in the quality of life of migrant households. They are deprived of basic amenities like housing, water supply, drainage etc. Slumdwellers are the worst victims of urban environmental degradation. Thus the living and working conditions for the rural migrant in the urban areas are deplorable. Many of the migrants on account of a lack of a permanent address in slums do not have ration cards, which deprives them of their access to subsidized ration.

CHAPTER - 3

Informal Economy and Insecurities of Workers

The informal economy is a major source of employment and contributes significantly to the GDP of most countries, especially developing countries. Workers working in the informal economy could be doing so in the factories, shops, roadsides or at home. They may be paid on a daily wage or on a piece rate, on the basis of a commission or could be self-employed. The conditions of work in the informal economy are quite dismal for most workers. Conditions include: working for long hours; bare survival wages/incomes; little or no social security. Most of the workers in developing countries work in the informal economy and they are among the most exploited workers. The majority of the workers remain unrecognized, unorganized and unprotected under labour laws. Informal economy covers a wide variety of activities, enterprises and different types of workers with diverse employment relationships. It is highly fragmented depending on the nature of enterprise and the kind of employment offered. Moreover, while cities do offer better opportunities to earn income, it should be noted that not all the poor have equal access to income or employment. Access to employment in the informal sector in India is often strongly related to caste or religion, as different communities have established economic niches in areas of employment, production or markets (Benjamin and Amis, 1999).

The poor people working in the informal economy face lower incomes, greater financial risks, lower standards of human development and greater social exclusion compared to better-off workers, especially those who work in the formal economy. Although there is no simple relationship between working in the informal economy and being poor or working in the formal economy and escaping poverty. The relationship with informal employment appears only when informal workers are classified by employment status (i.e. employer, own account worker, wage worker or industrial outworker/homeworker). As a general rule, average earnings or wages decrease as one moves down the employment status ladder: from being a micro-entrepreneur who hires others to working on one's own account to working as a wage worker to being an industrial outworker.

However, in some sectors or countries, informal wage workers earn more on average than own account workers.

In the present study, of the total 506 informal sector workers who were taken as the respondents of the study, it is seen that half the workers (50.39 per cent) work on contract basis. Of the remaining workers, majority (33.00) are involved as casual daily wage labour and 16.60 per cent are self employed. This show that the workers in the informal economy do not have a secure and stable source of income. The workers are constantly under the threat of being discontinued from their work which is a great cause of their insecurity. Moreover, as migration by workers to urban centres has been much than what the urban employment opportunities can absorb, therefore increasing number of workers get involved in self employment.

3.1: Distribution of respondents across nature of employment

Nature of Employment	Number of respondents
Regular wage workers	255 (50.39)
Casual labour	167 (33.00)
Self Employed	84 (16.60)
Total	506 (100)

The workers who work on a contractual basis earn their wages in terms of monthly wage. One-third of the workers who are the casual workers get their job as well as their wages on a daily basis. These workers who have extreme uncertain employment conditions are more vulnerable among the informal sector workers. Each day these workers are faced with insecurity their job and their income.

3.2 : Frequency of payment

Frequency of payment	No. of Respondents
Daily	123 (29.14)
Weekly	37 (8.76)
Monthly	262 (62.08)
Total	422 (100)

In the table given below, the list of activities in which the informal sector households are involved has been given. It can be seen that except for the workers employed in factories, shops or as security guard, the remaining workers either work a casual temporary workers or are self employed.

3.3 : Distribution of respondents across main/principal occupation

Main occupation	Number of respondents
Factory worker	194 (38.33)
Security guard	43 (8.49)
Shop/Salesman/Marketing	94 (18.57)
Construction Helper/ Beldar	43 (8.49)
Domestic workers	22 (4.34)
Carpenter/Painter/Plumber	11 (2.17)
Vendors	27 (5.33)
Tailoring and repairing work	30 (5.92)
Rickshaw puller	16 (3.16)
Other miscellaneous work	26 (5.13)
Total	**506 (100)**

Since there is no organized pattern of recruiting workers and employment is not stable, therefore the informal sector workers are in a state of constant flux in terms of their employment status. They have to look for a new job quite often and use informal networks to find new job. In the table given below, it can be seen that 48.2 per cent of the workers have changed six or more employers during the last one year and another 21.1 per cent of the workers have changed 3-5 employers during the last one year. This highlights the insecurity faced by the workers in informal employment.

3.4 : Change of employers / contractors during the last one year

No. of Employers Changed	Number of Respondents	Percentage
Not a single	23	4.5%
1-2	48	9.5%
3-5	107	21.1%
6 and above	244	48.2%
Self employed	84	16.6%
Total	**506**	**100.0%**

The employment insecurity of the workers in informal sector, compel households to involve other family members in economic productive activities which could range from either taking up a part time job, working as a self employed home-based worker or taking up a full time job, depending on the need of the family and the availability of work. About 27 per cent of the respondents reported that there were two earning members in their households and another eight per cent of the households reported that there were three to four earning members in their household. Since most of the households are nuclear household comprising of a couple and their children, therefore the involvement of more than two family members generally denote the involvement of the children of the family who are many a times below the age of fourteen as can be seen in our previous data and discussion.

3.5 : Distribution of households by no. of earning members

No. Of earning members	No. Of HHs	Percentage
One	324	64.03
Two	139	27.47
Three	33	6.52
Four	8	1.58
Five and above	2	0.40
Total	506	100

Besides employment insecurity, another compelling factor that forces households to involve other household members including children in productive activities is the low wages and income of the households. It is important to note that three-fourth of the respondents (71.74 per cent) have a monthly income between Rs. 1000-3000, which makes it necessary to explore other source of income in order to maintain the livelihood of the household.

3.6 : Monthly income of respondents

Income from main source	No. Of HH	Percentage
Upto Rs.1000	1	0.19
Rs 1000-3000	363	71.74
Rs 3001-5000	134	26.49
Above 5000	8	1.58
Total	506	100

A look at the per capita income of the households show that majority of the households (32.60 per cent) have per capita income in the range of Rs. 401-600 which is followed by again another 25 per cent of the households having a per capita income in the range of Rs. 601-800. As the range of per capita income of households increases, there is a steady decrease in the number of households in the sample. However, contrary to general expectation that the per capita income would be higher only among the upper castes, it is seen that there are quite a large number of households among the OBCs and SCs with high per capita income. This is because of the involvement of family members in economic activities.

3.7 : Per capita income of HHs across different social group

Per Capita Income (Rs.)	Upper Caste	OBC	SC	Others	Total
100-200	0	0	1 (0.37)	0	1 (0.19)
201-400	0	8 (4.62)	13 (4.92)	1 (100)	22 (4.34)
401-600	26 (38.23)	53 (30.63)	86 (32.57)	0	165 (32.60)
601-800	15 (22.05)	35 (20.23)	73 (27.65)	0	123 (24.30)
801-1000	11 (16.17)	31 (17.91)	37 (14.01)	0	79 (15.61)
1001-1200	2 (2.94)	8 (4.62)	28 (10.60)	0	38 (7.50)
1201-1500	7 (10.29)	21 (12.13)	14 (5.30)	0	42 (8.30)
Above Rs.1500	7 (10.29)	17 (9.82)	12 (4.54)	0	36 (7.11)
Total	**68 (13.44)**	**173 (34.19)**	**264 (52.18)**	**1 (100)**	**506 (100.00)**

As there is no stability of job opportunities in the informal sector, therefore the number of working for a worker depends upon the availability of work. At times the workers may barely get to work for four days a week. In order to compensate the lack of work opportunities, workers work all throughout the week depending on the availability of work. In our sample, almost half the workers (55.92 per cent) of the workers work for five days in a week, followed by 22.52 per cent of the workers working six days in a week. As many as 18.57 per cent of the workers had worked all seven days in a week during the last one year. Similarly although 66 per cent of the workers worked more than 25 days in a month, there was 8.49 per cent of workers who got work for 16-20 days in a month. Thus there is a wide variation on the working days of informal sector workers, which affects the family income in a major way.

3.8 : Average working days in a week and month during the last one year

Work Days	Number of Respondents	Working days in a month	Number of Respondents
Less than 4 days	15 (2.96)	10-15 days	4 (0.79)
5 days	283 (55.92)	16-20 days	43 (8.49)
6 days	114 (22.52)	21-25 days	125 (24.70)
7 days	94 (18.57)	Above 25 days	334 (66.00)
Total	506 (100)	Total	506 (100)

Majority of the workers work all throughout the year as household income depends on the availability of work. It was conveyed by the workers that except when they were unwell or went to their native place, they were available for work.

3.9 : No. of months in a year do you work

Months	Number of Respondents
1-3 months	1 (0.19)
4-6 months	2 (0.39)
7-9 months	37 (7.31)

Months	Number of Respondents
10-12 months	466 (92.09)
Total	506 (100)

Although 83 per cent of the workers worked for an employer/contractor, yet none of them were aware about minimum wages. They had no idea if they were being given a minimum wage by their employer and felt that the wages received by them would be proper as other workers received similar wages for the same work. Moreover, as 98.03 per cent of the migrant workers who comprised of 90 per cent of the workers, earned more than what they earned in their native place, therefore they were content with the wages received by them. The lack of awareness among the workers regarding their minimum wage is another factor for the vulnerability of the workers.

3.10 : Earning more than native place

Earning more	No. Of respondents
Yes	448 (98.03)
No	9 (1.96)
Total	457 (100)

Although the earning opportunities as well as the household income is more in cities, yet it may not e adequate to meet the expenses of a city life which is evident in our study. Although 98 per cent of the migrant workers earned much more than their native place, yet as many as 48 per cent of the respondents conveyed that their income was not sufficient for the family and 31 per cent felt that it was barely sufficient.

3.11 : Is your income sufficient for your family

Income sufficient	Number of Respondents	Percentage
Yes	103	20.4
NO	243	48.0
Barely sufficient	160	31.6
Total	506	100.0

With regard to the monthly household expenditure, all households spent essentially on two heads which are food and health. Except for 18.18 per cent of the households which spent more than Rs. 2000 on food, it was seen that all other households spent within Rs.2000 on food and a significant one-fourth of the households spent within the range of Rs. 1000-Rs. 1500 on food. Taking in to consideration the average size of the households being 4.9, one can estimate the nutritional in take of the households within this amount. Moreover almost all the families spend up to Rs. 500 on health. Therefore taking in to account the limited income of the family, the family expense is comprised on other essentials such as food, education and clothing.

3.12 Distribution of households across expenditure on different essentials

Expenditure in Rs.	Food	Health	Education	Clothing
Up to Rs. 500	4 (0.79)	493 (97.43)	332 (94.31)	489 (97.60)
Rs.501-1000	42 (8.30)	12 (2.37)	17 (4.82)	10 (1.99)
Rs.1000-1500	127 (25.09)	0	1 (0.28)	0
Rs.1501-2000	241 (47.62)	0	1 (0.28)	1 (0.19)
Above 2000	92 (18.18)	1 (0.19)	1 (0.28)	1 (0.19)
Total	506 (100)	506 (100)	352 (100)	501 (100)

The gap between income and expenditure is generally bridged through borrowing. It is observed that 69.2 per cent workers borrowed money. These workers are mostly those with casual daily-based employment or belong to the self-employed group, who do not have a stable income to support their families. Although it is true that the household income for majority of the households has increased after migration, yet simultaneously the household debt has also increased. This implies that the increase in income after migration is not adequate to support families, given the high cost of living in cities and towns.

3.13 : Borrow money

Borrow money	Number of Respondents	Percentage
Yes	350	69.2
No	156	30.8
Total	506	100.0

The workers rely on their informal network for borrowing money and borrow money either from their relatives/friends, money lenders or employers. Majority of the workers (72 per cent) borrowed money from money lenders as almost half of the workers do not have regular employment and therefore do not have regular employer.

3.14 : Reason for borrowing

Reason for borrowing	No. of respondents
HH Expenditure	157 (44.85)
Medical expenses	120 (34.28)
Education	27 (7.71)
Marriage and other social occasion	15 (4.28)
Work related investment	31 (8.85)
Total	350 (100)

Data on household borrowing showed that almost 45 per cent of the households borrowed money in order to meet their household expenses which were followed by 34 per cent of the households borrowing money to meet health expenses. The other factors for borrowing money were meeting the costs of education of the children, meeting the costs of social occasion in the family work related investment for households which were self employed.

3.15 : Savings and Remittances

Do you save	No. of respondents	Send money home	No. of respondents
Yes	184 (36.36)	Yes	193 (38.14)
No	322 (63.63)	No	313 (61.85)
Total	506 (100)	Total	506 (100)

It is interesting to note that in spite of the gap between income and expenditure and the work insecurities of workers in informal employment, 36.36

per cent of the households saved some money although the amount saved was up to Rs.500 for almost three-fouth of the households. Moreover, in spite of the financial constraints and debts, as many as 38 per cent of the households sent money to their homes. Migrant workers particularly saved money to carry the money to their families during the annual trip home.

CHAPTER - 4

Health Insecurities of Workers in Infomal Economy

The workers of the informal sector commonly concentrate in locations which are closer to the industrial areas or areas having access to livelihood generation. Their poor economic condition compel them to live in areas which either have low rent to or on urban land which is lying vacant and can be squatted upon. They live in areas with poor, insanitary conditions which are frequently located on polluted land close to industrial facilities or where wastes are dumped. In addition, as noted earlier the workers working in the informal sector work without any protection in hazardous and unsafe working conditions. As a result of the unsafe living and working conditions they are vulnerable to health relate problems. These vulnerabilities of the workers in informal employment create other vulnerabilities and insecurities for them in the form of high cost of treatment which leads to indebtedness, loss of income as well as ability to take up livelihood activities, thereby creating a major shock for the household economy.

In response to illness, households make decisions about treatment and coping strategies. These coping strategies can range from direct costs (e.g., borrowing) and indirect costs (income loss), to cost prevention strategies (ignoring illness, non-treatment) and cost management strategies (borrowing, selling assets, labor substitution). These coping strategies because of the economic burden many a times threaten the welfare and livelihood of the household.

Two key factors influence household ability to cope with illness costs successfully. The first is the household's vulnerability or ability to cope with a shock which depends on the asset which could be either physical or financial capital. The second is the social capital or networks which include kin and friendship networks and the credit for treatment from these links. However, for the poor workers working in the informal economy, who do not have regular work and social security, coping with sudden shocks such as illness becomes

difficult thereby making them more vulnerable to these shocks or contingencies.

The present household study therefore tried to capture the common health problems of the workers in informal employment, the actual situation concerning health facilities and the impact of the health problems on the household. The study has made an attempt to cover the health related vulnerabilities of the workers in informal employment, highlighting at the same time the health insecurities of the workers in informal employment. Information was collected regarding the common illness faced by the families, existence of a public health care facility within close vicinity, utilization of the public health care facilities by the households, facilities provided by employer and finally the problems faced by the household because of illness in the family and the coping strategies adopted by the households in order to cope with the contingency. The facilities provided by health systems and facilities provided at the workplace can be important determinants of households' ability to cope with the costs of ill health. Poor quality of healthcare and its cost may deter or delay utilization of health services among the poor. These problems can be aggravated if the household does not have a stable source of income during the period of illness or if there are no income safety nets.

4.1 : Distribution of Population by type of major illness

Type of illness	Proportion of Population
Malaria	201
Jaundice	86
Stomach Problem	118
TB	134
Asthma	42
Work related accidents	35
Other health problems	66
Total	682

4.2 : Availability of Public Health Care Facility within Five Kilometres

Health intervention	No. of respondents	Percentage
Yes	278	54.9
No	228	45.1
Total	506	100.0

About 45.1 per cent of the households did not have access to public health care facilities within a range of five kilometers from their place of stay. Inspite of the fact that 54. 9 per cent of the households had access to public health facility within a range of five kilometers, yet only 42.68 per cent of the households availed the public health facilities. 57.3 per cent of the households did not avail public health facility even though some of them had public health near their house. It was observed that more than one – third (35.57) of the households consulted untrained doctors who are otherwise known as quacks, or local pharmacists for their day-to-day minor illnesses. Some of the households (5.53 per cent) were even found accessing the services of health centres operated by NGOs in their area.

4.3 : Treatment Place

Place of treatment	**No. of Households**
Public Health Care Facility	216 (42.68)
Private	82 (16.20)
Local unregistered doctors/ pharmacists	180 (35.57)
NGOs	28 (5.53)
Total	506 (100)

While healthcare is relatively available, it is the quality of health care provided by the government health care facilities that has affected the utilization of health care. It should be noted that as many as 88.73 per cent of the households cited that they were not happy with the public health centres.

4.4 : Are you happy with the services provided in government hospitals/ dispensary

Happy with GH/GD	Proportion of respondents
Yes	57 (11.26)
No	449 (88.73)
Total	506 (100)

Lack of proper attention and care given by the doctors, lack of medicine and testing facilities and the long waiting time to consult doctors. Many households who did not stay close to the government health centres/hospitals cited distance and the long travel time as the major reasons for not using government hospitals. In some of our study areas (slums), health centres were operated by NGOs, which provided basic health services to the poor residents of that area. However, as the treatment and medicines provided by these health centres were restricted to basic illness such as fever, cough/cold, stomach problem, therefore the residents could not much utilize the services of such centres.

Social security Provisions

In many developing countries, a large number of workers, particularly those who are outside the formal economy, do not have any satisfactory health coverage. Although the traditional form of health benefits cover employees working for enterprises, yet casualisation of work has led to more number of workers going outside the ambit of formal health coverage and security.

4.5 : Health and wage benefit

Health Benefit	No. of respondents	Wage Benefit by employer	No. of respondents
Yes	71(16.82)	Yes	15(3.55)
No	351(83.17)	No	407(96.44)
Total	422(100)	Total	422(100)

In the present study it was seen that only a small proportion o workers received some minimal form of health benefit in terms of money for treatment. But this figure was even less in terms of wage benefit during period of illness.

Impact on Livelihood

An approach to ATP founded on basic needs and the opportunity costs of payment strategies (including non-utilization) is therefore proposed. From the few studies available, common household responses to payment difficulties are identified, ranging from borrowing to more serious 'distress sales' of productive assets (e.g. land), delays to treatment and, ultimately, abandonment of treatment. Although these strategies may have a devastating impact on livelihoods and health.

Income losses caused by illness, particularly serious and prolonged illness, are often a more significant cause of impoverishment than direct costs, undermining household members' command over essential goods and services. Asset and vulnerability-based concepts and indicators Income-based poverty approaches have been criticized for not capturing the range of resources and

strategies that people mobilize to access commodities and cope with shocks such as illness. Sen's important work on entitlements, for example, established that an individual's access to commodities, or their 'entitlement set', is determined not just by income but by a range of production, exchange and transfer processes including government services (Sen 1981; Dre'ze and Sen 1989).

Perceptions of health, illness and causal factors are to a large extent based on socioeconomic, cultural and environmental factors. Any investigation necessitates understanding how health and illness are perceived and understood. This was very evident in the answers about the general health, eyesight, hearing and breathing of the workers, with nearly all of them perceiving their health to be satisfactory or good. However, 19 per cent reported regular body ache, headache or fever (Table 4). A higher proportion of women workers (26 per cent) than men (12 per cent) reported such ailments. About 12 per cent of men and 15 per cent of women reported that their health had deteriorated over the last year. This was much greater for older women than for men, controlling for workers above the age of 40 years. It is interesting to observe the contrasting perceptions of the workers: they report their health status to be satisfactory or good, despite having regular body ache, headache or fever or their general health having deteriorated.

4.6 : If no, what do you or any family member falls ill

What do you do	Number of Respondents	Percentage
Borrow Money	267	52.8
Use saving	107	21.1
Cut expenses	2	0.4
Uncle is doctor	2	0.4
Borrow Money+ use savings	23	4.5
Use savings & cut expenses	1	0.2
NA (those who have social security + self employed)	104	20.6
Total	506	100.0

4.7 : How do you manage health expenses

Manage health expenses	No. Of respondents	Percentage
Borrow money	272	53.75
Use saving	114	22.53
Cut expenses	3	0.59
Send less money to village	17	3.36
Use saving & Borrow money	1	0.19
Use savings & Cut expenses	1	0.19
NA	97	19.17
Total	506	100.00

Although some welfare schemes were operational in the area, yet less than 10 per cent of the households received any welfare benefit from these schemes which can be seen from table 4.8.

4.8. Received any assistance from state/ private Agencies?

Type of assistance	No. of respondents	Percentage
Income generation schemes	0	0
Self help assistance scheme	0	0
Training cum self employment scheme	0	0
Micro-credit (self help group)	2	0.39
CASP Plan	42	8.30
World Vision	4	0.79
Not- received	458	90.52
Total	506	100.00

Impact of Illness

A large number of families (96.1%) got affected by illness in terms of their work. The loss in household income led to severe financial problem and the families had to resort to taking loan from their employers, relatives and neighbours.

4.9: Illness affected work

Illness affected work	Number of Respondents	Percentage
Yes	481	95.1
No	24	4.7
Not Applicable	1	.2
Total	506	100

Evidence from shows that networks are one of the most important resources mobilized by households to obtain money to pay for treatment, but some evidence suggests that the poorest have the weakest social resources and are more likely to be excluded from inter-household community support mechanisms. Second, ability to cope successfully will be influenced by the type, severity, and duration of illness.

4.10 : How do you manage health expenses

Manage health expenses	No. Of respondents	Percentage
Borrow money	272	53.75
Use saving	114	22.53
Cut expenses	3	0.59
Send less money to village	17	3.36
Use saving & Borrow money	1	0.19
Use savings & Cut expenses	1	0.19
NA	97	19.17
Total	506	100.00

The study of a family's interactions with other households and organizations builds up a rich and detailed picture of people's asset portfolios, including less tangible or measurable assets such as organizational skills, access to resources in the community (mediated by institutions) and the size and strength of social networks at times of illness.

Access to financial institutions, notably savings and credit groups, was an important factor influencing people's ability to obtain money to meet the demands of a sudden illness cost. Traditional rotating savings groups and NGO-based credit societies were the most common organizations available to people, usually women. However, the research revealed that women from the income-poorest households were unwilling to join or often excluded.

CHAPTER - 5

Policies and Recommendation

Given the relatively small evidence base and the potentially dramatic impacts of health related costs on household livelihoods, this study was undertaken in order to improve understanding of household experiences, and so provide a basis for developing policies to protect poor households from these cost burdens.

The central focus is the household that bears the dual burdens of healthcare expenditure and the income losses resulting from taking time off work. The level of these costs is influenced by illness occurrence as well as by how households adapt health-seeking behaviour and treatment strategies. Households may manage these costs through financial strategies. The impacts of these strategies can be assessed by comparing changes in household livelihood over time in response to illness. The psychological impact of any negative combination of ill health and increasing poverty can itself reduce ability to make decisions and access to social networks. Health system characteristics (including distance to facilities, household perceptions of expected quality of care) influence treatment strategies and illness costs. Social resources (including kinship networks, organizations providing home-based care, and various sources of formal and informal credit) assist households in their treatment or cost management strategies.

Illness imposed high and regressive cost burdens on patients and their families. Health service weaknesses, including low coverage, user charges, and poor quality of care, contributed to high direct and indirect costs for patients. Evidence showed that households struggled to cope and adopted unsustainable strategies that damaged asset portfolios and caused or sustained impoverishment. Because household assets in resource-poor settings were inadequate to cope with the costs of these diseases there is an urgent need for more collective health service and resource provision to support household treatment and coping strategies.

One conclusion from this review is the need for further microeconomic research on the household costs of illness, household responses, and their

implications for poverty. Such work would, in all probability, demonstrate more comprehensively the huge economic burden of illness for households in developing countries and add weight to international calls for more investment in disease prevention and pro-poor curative health services. International research efforts also need to develop a common illness cost and impact methodology to allow more meaningful comparisons of the economic burden of illness across settings and diseases. Through more cross-country comparisons, research efforts could also ensure that different epidemiologic, health service, and economic factors influencing costs and coping are represented.

Recommendations

Catastrophic health expenditure is closely linked to out-of-pocket spending and is not unique to under-funded health systems. High-tech care in affluent countries or medicine in poor countries can both expose households to catastrophic expenditure. Health systems need to protect households against such expenditures through risk pooling and prepayment schemes, to the extent that such protection can be financed and sustained. Even so, households cannot be protected against the financial burden of all that health technology has to offer. The level of exposure has to be in line with the resources available. Obviously, the health system must try to mobilize as many resources as possible. Health must be perceived as an investment in human capital that promotes economic growth. Investment in health interventions is just like any other investment in development projects. It is also important that health systems become more efficient than they currently are, in order to justify allocation of new resources. This requires reliance on the use of new analytical tools, such as national health accounts and burden of disease and cost-effectiveness analysis. Health policies need to become evidence-based.

Universal coverage is the ultimate goal and will protect all households against catastrophic health expenditures. There is no unique pathway towards universal coverage that is appropriate for all countries in the Region, and certain public programmes must remain the sole responsibility of the government regardless of the choice of health financing options. These include "public goods" and programmes that generate measurable externalities, such as clean water, sanitation, health promotion and immunization. In addition, governments' responsibilities to ensure that poor and vulnerable groups receive quality health services through a well-functioning primary health care network should not be undermined. These programmes are financed by the government through taxes and other sources of revenue and, often but not always, are provided through state-owned facilities. Finally, regulation of the private sector will always be the responsibility of the government.

The experience of the countries of the world that have achieved universal coverage shows that they all go through a transition, as shown in Figure 4.

During the transition, the share of public spending through taxation and/or social health insurance increases, while the share of out-of-pocket spending decreases. The transition period and exact pathway is determined by many factors, including the political will of policy-makers and the economic performance of the country.

Based on economic performance, the countries of the Region can be divided into three groups: low-income, middle-income and high-income. The optimal health-care financing option to protect households against catastrophic spending would be different for each group. For low-income countries, a free, basic, primary health care package for all, financed by government tax revenue and donors is the only viable alternative. Health care that is provided through a network of state-owned facilities or outsourced to nongovernmental organizations represents the basic structure of the system. Community-based health insurance can supplement the basic structure to the extent that communities can be organized efficiently to play their part. A limited number of diseases can also be targeted for government financial support to the extent that public resources permit.

For middle-income countries, a comprehensive primary health care package financed by government tax revenue with minimal user fees for some services and medicines to curb over-utilization should be available to all. Health care that is provided through a network of state-owned facilities or outsourced to nongovernmental organizations represents the basic structure of the system. Compulsory social health insurance should be launched to provide comprehensive coverage for civil servants, formal sector workers, workers in large institutions, and their family members. Special schemes need to be supported by governments to provide coverage for poor and vulnerable groups and to target selected diseases for all. Private health insurance organizations could offer coverage, including supplementary coverage, to cover the gap not covered by social health insurance. Over time, social health insurance coverage should become compulsory for all and social health insurance schemes need to be consolidated. The government needs to pay the premium for the poor and vulnerable groups out of general tax revenue.

For high-income countries, the existing government funded programmes have protected citizens and expatriates against catastrophic payments. However, in the move towards development of compulsory health insurance schemes for expatriates, countries need to adhere to the principles of fairness and equity. Moreover, the administrative cost of launching a new system and its impact on the existing system needs to be studied carefully.

The private sector, in all countries of the Region, must be regulated but it must also be regarded as a partner that has the potential to improve the performance of the health system. The role and size of the private sector depends

on the extent to which the public sector fails to provide the necessary coverage at an acceptable level of quality.

References:

Akin JS, Griffin CC, Guilkey DK et al. The demand for adult outpatient services in the Bkol regkm of the Philippines. *Soc.*' Sri. *Med.* 1986; 22(3): 321-8.

Castells, Manuel and Roberto Laserna. 1989. "The New Dependency: Technological Change and Socio-Economic Restructuring in Latin America." *Sociological Forum* 4:535-60.

Chambers, R (1983) 'Rural Development: Putting the Last First', Longman, London

Corbett, J (1989)'Poverty and Sickness: The high Cost of Ill- health', in IDS Bulletin, Vol.20, No.2, pp58-62, Institute of Development Studies, Sussex

Dhar Chakravarti, P.G. (2001), Delhi's ongoing debate on informal settlements and work places- Issues of environmental jurisprudence, Paper presented at the International Workshop on Coping with Informality and Illegality in Human Settlements in Developing Cities, Leuven and Brussels, Belgium, 23-26 May.

Dubey, Amaresh, Shubhashis Gangopadhyay and Wilima Wadhwa (2001). 'Occupational Structure and Incidence of Poverty in Indian Towns of Different Sizes'. *Review of Development Economics*, 5 (1):49–59.

Feige, Edgar. 1990. "Defining and Estimating Underground and Informal Economies" the New Institutional Economics Approach". *World Development* 18,7.

Gilson L. 1988. Government health care charges: is equity being abandoned? EPC Publication No.15. London: Evaluation and Planning Centre for Health, London School of Hygiene and Tropical Medicine.

Haines, A., Heath, I. and R.Smith (2000) Joining together to combat poverty: everybody welcome and needed. British Medical Journal 320: 1–2.

Hart, K (1973) 'Informal Income Opportunities and Urban Employment in Ghana', Journal of Modern African Studies.

International Labour Office 2003: Guidelines concerning a Statistical definition of informal employment, endorsed by the Seventeenth International Conference of Labour Statisticians (Nov-Dec 20030, in Seventeenth International Conference of Labour Statisticians, Geneva, 2003

Kabir A, Rahman A, Salway S, Pryer J. 2000. 'Sickness among the urban poor: a barrier to livelihood security' Journal of International Development

National Council of Applied Economic Research (2002), The burden of ill-health among the urban poor: The case of slums and resettlement colonies in Chennai and Delhi, NCAER, Delhi.

Project Aarogya. 2003. *Health Seeking Behavior among the Poor in Urban India*. Report submitted to the World Bank, New Delhi.

Pryer J. 1989. When breadwinners fall ill: preliminary findings from a case study in Bangladesh. IDS Bulletin 20: 49–57.

Russell S, 1996. Ability to pay for health care: concepts and evidence. *Health Policy Plann 11:* 219–237

Scoones I. 1998. Sustainable rural livelihoods: a frameworkfor analysis. IDS Working Paper 72. Brighton: Institute of Development Studies.

Sauerborn, R., Ibrangi, I., Noglara, A., Borchert, M., et al, 1995, The economic costs of illness for rural households in Burkina Faso, Tropical Medicine and Parasitology, Vol.46.

Seeta Prabhu, K and V. Selvaraju, 2001, Public Financing for Health Security in India: Issues and Trends, Pape prepared for the National Consultation on Health Security, New Delhi 26 & 27 July, 2001.

Tokman, Victor. 1982. "Unequal Development and the Absorption of Labour: Latin America 1950-1980." *CEPAL Review* 17:121-33.

Unni, Jeemol and Uma Rani, Regional Overview of Social Protection of Insecurities, Instruments and Institutional Arrangements, Paper prepared for the Workshop on Social Protection Scheme for Women in the Informal Sector, 8-10 September, 2003, United Nations Economic and Social Commission for Asia and Pacific, Bangkok

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