BURDEN OF OUT OF POCKET (DIRECT AND INDIRECT) EXPENDITURES OF INSTITUTIONAL DELIVERY FOR BPL HOUSEHOLDS IN SELECTED VILLAGE OF VARANASI DISTRICT

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ISSN 2277-7733
Volume 8 Issue 3,
December 2019

Abstract

High rate of maternal mortality has become one of the most serious public health issues in India. Although the estimates shows decline in maternal since 1992 (437 per 10, 000 live births) to 2010-12 (178). Even Sample Registration System Reports highlight that Maternal Mortality rate (MMR) has reduced by the 6.15% as compared to previous survey 2014-2016 (https://www.jagranjosh.com/current-affairs/sample-registration-system-report-finds-decline-in-maternal- mortality-rate-in-india-1573456912-1), but the reduction rate is sluggish. The causality of slow decline of MMRs in India is multiple axes of inequalities- regional, caste and class. Evidence shows an association between MMR and these socio-economic inequalities. Therefore Government of India has launched programmes and schemes viz. conditional, unconditional and voucher based for population below poverty line. Though government has adopted these schemes as a tool for improving the access to health services and decline of MMR still a large number of child births are home based with very low medical facilities available. Cost barrier, both direct and indirect is one of the main obstacles leading to low institutional delivery.The objective comprised to study the effectiveness of government (central and state) schemes financing institutional child birth for BPL households.This qualitative study included both secondary (government records, published articles, journals and micro level studies) and primary data. Primary data was collected through in-depth interview. It has been found in the study, though government gives incentives to poor sections for direct expenditures but indirect (tips, transportation cost, loss of wages etc.) expenditures are also largely accountable for inaccessibility to health services.

Keywords: *Maternal Mortality rate (MMR), Out of pocket expenditure (OOP), Direct cost, Indirect cost, Cash assistance programmes*

High rate of maternal mortality has become one of the most serious public health issues in India. Although the estimates shows decline in maternal since 1992 (437 per 10, 000 live births) to 2010-12 (178). Even Sample Registration System Reports highlight that Maternal Mortality rate (MMR) has reduced by the 6.15% as compared to previous survey 2014-2016 (https://www.jagranjosh.com/current-affairs/sample-registration-system-report-finds-decline-in-maternal-mortality-rate-in-india-1573456912-1), but the reduction rate is sluggish. The causality of slow decline of MMRs in India is multiple axes of inequalities- regional, caste and class. Evidence shows an association between MMR and these socio-economic inequalities. Therefore Government of India has launched programmes and schemes viz. conditional, unconditional and voucher based for population below poverty line. Though government has adopted these schemes as a tool for improving the access to health services and decline of MMR still a large number of child births are home based with very low medical facilities available. Cost barrier, both direct and indirect is one of the main obstacles leading to low institutional delivery.

Types of Costs

Direct cost: NSSO only include direct cost in out of pocket expenditure and according to this organization, Out of pocket expenditure is the direct cost which is

paid by the patient for medical treatment. This includes medicines or drugs, doctors and nurses fees, diagnostic and other miscellaneous services. The patient has to incur this expenditure from their pocket since it is not provided free of cost by public services or covered by insurance (NSSO, 2001).

Indirect Cost: Indirect expenditure can also be seen as a direct cost which is paid by the patient for accessing the health services and that are not officially sanctioned by the facility. These indirect medical expenses incurred due to the transportation cost, loss of wages, tips and bribe, payment diet on sick as well as care givers and other informal payments for utilizing the health services (Simkhada et. al 2012; Misra et.al, 2013).

Central and State led schemes

Rastriya SwasthyaBima Yojana: The RashtriyaSwashtyaBimaYojana scheme has been launched by Ministry of Labour and Employment , Government of India to giving the insurance coverage for the below poverty line. Under this scheme, beneficiaries are entitled the coverage of Rs. 30,000 for the most of the diseases that need hospitalization. This coverage includes five family members –head of the households, spouse, and three other dependents. Beneficiaries have to pay only Rs. 30 for registration while central and state government pays the premium to the insurer (www.rsby.gov.in/about-rsby.aspx). Transportation charges are also covered upto a maximum of Rs. 1,000/- with Rs. 100/- per visit (http://www.rsby.gov.in/faq_scheme.html#1).

Janani Suraksha Yojana: Janani Suraksha Yojana is a scheme which launched under RCH II (Reproductive and Child Health) programme of NRHM (National Rural Health Mission) in April 2005. This is a safe motherhood intervention which has been especially launched to reduce the maternal as well as neo-natal mortality through increasing the institutional delivery (www.nrhm.in/UI/Reports/Documents/JSY_study_UNFPA.pdf). It is a hundred (100 %) percent centrally sponsored scheme. Under this scheme there is provision of giving the cash incentives to the BPL (below poverty line) pregnant women when she delivers the baby in the government health (DHs, CHs, PHCs or SCs) institutions (jknrhm.com/PDF/JSR.pdf). In the case of private institution's births, the beneficiaries only get cash incentives when she or her family have genuine BPL card, approved by census or SC/ST certificate. In this scheme the mother get Rs. 1400 in rural whereas the mother who reside in the urban area get Rs. 1000. This cash assistance (Rs. 500) is also given to the BPL pregnant (aged 19) for home delivery and restricted to only two live births (angul.nic.in/JSY.pdf).

Mahamaya Garib Balika Ashirwad Yojana: At the time of field visit Mahamaya Garib Balika Ashirwad Yojana (MGBAY) was running in the district of the Uttar Pradesh state. This scheme was state sponsored scheme, launched by the former chief minister (Mayawati) of the U.P in 15 January 2009. Under MGBAY, there was the provision of giving the fixed deposit of Rs. 20,000 for the first girl child of the BPL or Antodaya card holder families. As per the rule of this scheme, this would get only to the daughter at the age of 18 (eighteen) years when she would not get married.This scheme was not implemented in the whole country as a part of the Integrated Child Development Services (ICDS) but this scheme was implemented by the state government for the welfare of the girl children in BPL households to prevent the female feticide and child marriages to giving the financial security to the family. In the scheme, parents'

name must be in the current BPL list and date of birth (DOB) which was given from the health institutions at the time of baby birth also needed to avail this scheme and these were the main difficulties, because of the large number of the parent's name were not mentioned in the current BPL list which were the reasons for not getting the benefit of the MGBAY (nhrc.nic.in/Documents/Reports/misc_SKTiwari_Gorakhpur.pdf).

Setting for the study

This study has been conducted in the state of Uttar Pradesh, with focus on selective village Tilmapur of Varanasi district. It is an attempt to understand the how effective these scheme are which are meant for BPL people for increasing the institutional delivery by accessing health institutions. This village has been chosen on the basis of the convenience of the researcher in Uttar Pradesh where the percentage of home deliveries is still high despite of the government has launched the several cash assistance programme for institutional delivery to reduce the burden of birth expenses.

Health Infrastructures: Tilmapur village has some basic health facilities. It has a private hospital, run jointly by government and health work committee. There are other four private hospitals too, in which, two of them are physician's clinics, located on the kaccha road (balua) and the rest two nursing homes, situated in the new colony of this village. Villagers usually are more likely to go to the private institutions for the major or minor illness because of the distance factor and some other reasons.

Objective

To study the effectiveness of government (central and state) schemes financing institutional child birth for BPL households.

Design of the study

A qualitative research design has been employed for this study. To achieve the objective of the study, primary as well as secondary data are used. The secondary source of data such as published reports, published article, published studies as well as micro level studies on OOPs have been used for making the study appropriate and also to know the various central as well as state led schemes which were functioning in the village (study area). Primary data has collected through the in-depth interview of those twenty two BPL households where child births have been occurred during last one year with the help of interview schedule. These twenty two households are selected through the purposive sampling.

Data analysis: Data analysis was performed by using content analysis.Some common words that emerged through interviews of the respondent were drawn from the primary data and then coded it according totopic related area by the researcher. After coding, the contents were critically examined and thus key finding were arrived.

Limitations: This study has been conducted with the help of twenty two cases of births; in which eighteen were institutional and rest four were at home. As, home births were very few in number, therefore it has been difficult to arrive at a generalized finding based on home births. The time period was too short to understand the experiences of the people and their way of tackling problems faced during hospitalization. In this study, the researcher also felt that there is need to include more information about hospital staff, which would further help in understanding the role of schemes and clinical staffs.

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Findings

Reimbursement of funds:As we all are aware that, government is running many reimbursement health insurance schemes for the welfare of the poor. One of the schemes called RSBY (RashtriyaSwasthBimaYojna), in which unorganized workers can get health benefits. According to this scheme, BPL card holders should have smart cards and their names should also be registered with state as well as in central list of BPL card holders. But majority of people's names were not mentioned in the central list due to the lack of proper awareness, and as a result villagers were not able to avail benefits under this scheme and took loan to bear their delivery charges. This happens because of non-co-operation from the Gram pradhan who did not disclose schemes for the poor are of especially for lower caste groups, as he was a Brahmin by caste. Only very few villagers who were JATAV by sub-caste were enrolled in this scheme.

Direct and Indirect expenditure:During hospitalization for institutional birth, people used to pay from their own pocket for a number of expenses which included direct and indirect costs both. People paid not only for the direct costs like doctor's fees, drugs cost, user charges, pathological charges, bed charges, operation charges but also to paid for transportation cost, loss of income, premium of insurance, lodging and boarding etc. These costs further caused weaker financial situation for poor households. Expenditure on medicines as a direct cost along with indirect cost really scaled up the entire cost of the delivery. In the field, researcher came to know that the ratio of the direct and indirect expenditure of birth is 1:3 which not a small ratio. And this situation exists in spite of the fact that some conditional cash transfer scheme has been supposedly implemented for the poor.

A 45 years old lady Sheela, a Nai by subcaste, narrated her experience to the researcher that what amount she has paid for the birth of her daughter:

"*When I took my daughter to PHC of Chiraigaon block for her delivery, the doctor told me that it is not a normal birth, and he advised me to take her to the Kabeer Chaura or Deendayal Hospital (district hospital). Despite her eligibility to be admitted in the district hospital; I took her to the nearby private Umang Nursing home, as the district hospital is far away from that PHC as well as from my house. I had heard that there were lots of formalities to be done before admitting patients and my daughter was in severe labor pain. So I didn't feel like to take this risk. The total cost, I paid for her delivery, was Rs. 14,300 excluding other expenses. The other expenses which I bore were transportation cost, food, loss of money, interest of loan, etc., which overall came out to be Rs.4500 which was a huge amount for us.*" (Sheela; SC, 23 January)

Loans: It is well known fact that the costs of the birth in the institutions for poor people are not affordable. It affects adversely the BPL households. To bear these expenses, they borrow money from their relatives, friends, local money lender in the village etc. and get huge amounts of debt on their heads. Situations are worsened to an extent of selling their assets like lands and other sources of capital for instance auto rickshaw, animals, jewelries etc. For repayment of loans, poor used to forsake their essential needs such as food, clothing's and schooling of their children. Thus, this is one of the main reasons in the village, why poor people are trapped deeper into indebtedness.

Ashok, who is a daily wages laborer, explains about his critical condition. In order to bear the cost of delivery of his wife in the private institution he had to sell his auto-rickshaw the only source of income to house. Because of the complication in his wife's delivery, she was hospitalized in a private hospital. To bear all the expenses, he had to ultimately sell his auto rickshaw. Now he is doing labor job, but through this work does not get enough to feed his family. Some time, he has to borrow some ration from his neighbors or relatives to feed his children.

The given case study clearly depicts how poor people were trapped into the poverty line in order to meet the expenses incurred at the time of delivery. Many a times they had to forsake their basic needs for the same.

"Chinta Devi, a 45 year old lady from Patel (OBC) by sub caste had taken loan from the Micro pore credit agency for the payment of her daughter-in-law's delivery. For repaying this loan, she used to pay loan interest amount on every Thursday at 7:30 am. One day on Wednesday, her son got injured and she immediately took him to the hospital, where she stayed the whole night with her son. Only her daughter-in-law with her baby was at home. Due to her stay at hospital, she failed to repay loan interest on next day. On that same day, the money lender went to her home and asked her daughter-in-law for the loan installment. She pleaded to him for some time till her mother-in-law returns with her husband. But the money lender refused and said according to the terms and conditions of this finance group, ones need to pay all the installments on time otherwise they sell their land on the very same day. Fortunately, all villagers contributed and pooled money on her behalf for the installment and gave it to the money lender. Thus, with the help of villagers her land got saved. (Chinta Devi; OBC, 8 February)

Syama Devi's son Ajay, whose net daily income of INR 250-300 with a rented auto-rickshaw was the only source of income for her family of four, including her daughter and daughter-in-law. Once her son got unemployed because of Jaundice, she and her daughter started to sustain their family financially by working as Maidservants. She also took a loan of INR 10,000 from Micro pore credit Agency to cover Ajay's medical expenses. She and her daughter used to work in 2 and 5 homes respectively to earn INR 1050 as a whole for a month with an average of INR 150 per month per house.

"Out of sever Labor pain, her pregnant daughter-in-law Rani was taken to the nearest Primary health Care (PHC) which is 5.2 km away from her home. Doctors of PHC referred her to the nearest district hospital which was unfortunately 18-20km away from her home for successful delivery by Caesarian section. Syama Devi could not take Rani to the district hospital taking into account Rani's poor health condition and inefficiency of District hospital doctors (Source: Neighbors). This situation has forced Syama Devi to borrow an additional INR 15000 from Micro pore Credit Agency, out of which INR 13,000 was utilized for Rani's Caesarian section at private hospital. She is now suddenly trapped into an un-expected economic crisis due to her son's illness and Rani's caesarean delivery which has led her into a great debt of loans. She promised to pay an equated weekly installment of INR200 and INR 300 for INR 10000 and INR 15000 loan respectively for 52 Weeks. To meet the entire repayment amount, she and her family members cut their diets and started feeding starch water in

place of milk to her granddaughter (Syama Devi, 50 years old, Dhobi by Sub caste, 8 February)".

In the village there was no bank for providing loans for delivery cases as well as for personal needs. Most of the people (BPL households) have taken loan from this above mentioned finance group. This group only gives loan for generating income and employment. The villager also don't want to take loan from the bank, as according to them, there were lots of formalities that need to be fulfilled which takes not only takes time but it is also very cumbersome. Therefore, they take loan from these types of finance agencies.

Difficulties: In the study, villagers faced a number of difficulties during hospitalization for child births as well as for treatment. The primary health centre was located at some distance from their homes. So, firstly they faced the problem of distance. Secondly, they faced long queue at PHCs. Thirdly, there was no pathology centre which led patients to go to other private pathology centre. Fourthly, cleanliness was the major problem. There was no proper facility for accommodations and toilets. Therefore, patients' relatives used to sleep on the floor or in lobby of the hospitals and go outside for toilets. Non-availability of medicines and inadequate staff in government hospitals, were the other fatal problems they faced.

For availing the amount of schemes by the patients, the administrative used to take lot of time to decide and most of the time patients were not able to get the amount of the scheme. Doctors' unavailability was another serious issue including the non-cooperative behavior of the other staffs towards patients. Doctor's were unavailable at the timings fixed. Villagers also faced scolding of other staff members for their doubts and queries which they had in relation to their person admitted in the hospital.

Conclusion

The finding of this study has demonstrated that direct, indirect costs and difficulties in accessing the health services are among the major reasons for not opting for institutional births. The quantum of indirect cost also depends upon the economic background of the people. The richer are able to pay a higher amount on the transport, tips for medical staff and food. Loss of income during hospitalization is less for the rich compared to the poor. This is because the latter are dependent upon their daily income and not on personal savings like the rich. However the data shows that the ratio of the institutional deliveries is high. It is because of the awareness of the cash schemes. It means that an affordable cost and cash payment schemes can encourage the women to go for institutional deliveries especially in the rural areas. It is estimated that around 23% of total birth had occurred at home in the village during the last year which researcher has selected. Though government schemes have provided financial incentives to the mother as well as other facilities but it does not seems very significant for the poor due to the some problems such as delay in payment, inadequate amount etc. and that's why the poor have to pay for availing medical care. Therefore the target of high institutional deliveries only can be achieved by the strengthening the public health systems as well as to provide the monetary payment mechanism to meet the delivery expenditure, both direct and indirect.

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