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Maternal Healthcare Financing in India: A Review

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Abstract: Since independence, significant progress has been made in the field of maternal morbidity and mortality; yet, maternal health remains a source of concern. This study has made a brief review of literature to determine how maternal healthcare financing has been implemented in the country and whether it has had any impact on maternal health, utilization, or other maternity related health outcomes. According to the literature available, little has been done to address women's poor status as a result of different socioeconomic inequities. Despite this, the Indian government has been successful in injecting new life into the country's public health system through major infrastructure and human resource expansion, particularly under the National Health Mission. However, incentives provided under various demand-sided financing programs may be insufficient to protect poor and vulnerable people from financial risk. As a result, more empirical based research studies are the need of hour to examine the causal impact of interventions in universalizing maternal healthcare.

Keywords: Healthcare Financing, Maternal Health, Out-of-Pocket Expenditure (OOPE), National Health Mission (NHM).

Introduction

Human beings, both as individuals and as a society, value their health. "Health, like education, is one of the basic characteristics that lends meaning to human life," says Nobel Laureate Amartya Sen. In addition to the individual benefits of improved health, health interventions can have a huge impact on human health and lifespan, and the resulting increased productivity significantly contributes to the national economy. Women, who make up half of the world's population are the embodiment of power, courage, love, and sacrifice, have been denied access to numerous social indices such as health, education, and economic opportunities. As a result of their vulnerability and lack of access to resources, they require special attention. Maternal health is one of the indicators that needs to be addressed. In its study Women and Health: Today's Evidence Tomorrow's Agenda, the World Health Organization (WHO) (2009) defined Maternal health as "the health of women during pregnancy, childbirth, and the postpartum period". Maternal health is all about valuing women and upholding their rights and choices. Despite the fact that motherhood is one of the most valued and essential periods in a woman's life, and is seen as a gratifying natural

experience that is emotional to a mother, the route to safe parenthood is not easy for every woman throughout the world. During pregnancy, women from underprivileged groups confront numerous hurdles, including health problems and even death. Almost 536,000 women (or one per minute) die each year as a result of maternal problems, with nearly all of these deaths (99%) occurring in underdeveloped nations. South Asia and Sub-Saharan Africa are responsible for over 85% of all maternal deaths worldwide (United Nations, 2009; Pandey et al., 2011). According to recent World Health Organization estimates, approximately 303,000 women died during and after pregnancy in 2015. As per WHO et al. (2019), the maternal mortality ratio has decreased generally but remains high in underdeveloped nations. In contrast to the nine maternal deaths per 100,000 live births reported by developed countries, developing countries reported over 450 maternal deaths per 100,000 live births (United Nations, 2009). Despite having almost 17.5 percent of the world's population, India accounts for more than 20% (78,000) of all maternal fatalities (358,000) each year (Sharma et al. 2018).The majority of maternal deaths occur during or shortly after childbirth, and almost all of them could be avoided if expectant women had full antenatal care visits, gave birth in an institutional health facility, and had proper postnatal care check-ups, which included proper assistance by a health-care professional with the necessary skills, equipment, and medicines to prevent and manage complications (Khan et al. 2006; United Nations, 2009). Since, poorer and less educated women, as well as those who reside in rural regions, are considerably less likely than better-educated women who live in wealthy households or urban areas to give birth in the company of a professional health practitioner. Physical inaccessibility and exorbitant expenses are two reasons for this, but it could also be the result of unsuitable socio-cultural practices. It is not enough that services are available; they must also be of good quality and delivered in a culturally relevant and responsive manner to women's needs.

Despite significant economic growth, government spending on healthcare in India has been stagnant since the early 1990s. In comparison to other countries with similar levels of poverty, per capita income and inequality, the country's public healthcare spending is quite low (Goli et al., 2016). Individual families' out-of-pocket expenditures (OOPE) are the primary source of healthcare funding. According to the National Health Accounts 2015-16, households fund more than 60% of Total Health Expenditure (THE) through out-of-pocket expenditures (NHA, 2018). Therefore, health services, including childbirth care, are inaccessible to the underprivileged population, particularly the poor, due to a high reliance on out-of-pocket spending (OOPE) (Mohanty and Srivastava, 2013; Bonu et al., 2009).

According to available research studies, women's use of maternal healthcare services is still highly linked to their wealth, and high financial expenditures are seen as a key barrier to maternal healthcare consumption (Lagarde et al., 2009; Bonu et al., 2009; Saksena et al., 2014).

Policy Framework on Maternal Healthcare in India

After independence, India set forth a roadmap and planned effort to raise living standard of people and put thrust on healthcare by making it an integral part of socio-economic development. The policy of government on maternal healthcare can be divided into four periods (Hunter et al., 2014). The first period which was started in fact prior to independence lasted for almost 15 years, an integrated approach to healthcare was adopted by the government to promote maternal and child health by using different strands of public health (Qadeer, 2005). This period was guided by policy recommendations provided by the Bhore Committee incorporated by Sir JC Bhore on healthcare (Hunter et al., 2014). During this period, the cadre of Auxiliary Nurse Midwife (ANM) was created to provide community healthcare and the job of traditional midwives (Dais) was reduced to great extent (Sadgopal, 2009). This period was also characterized by the need for social orientation of medical practice through setting up of Primary Health Centers (PHCs) and District Hospitals (DHs). The second period started during 1960s when the authorities at the helm of affairs become concerned about the rapid population growth. Family Planning was given impetus after the recommendations of Mukherjee Committee, 1965. The Family Planning Program was launched with the objective to control the accelerated growth in population. The mission of population stabilization couldn’t be achieved until and unless maternal health issues and child survival issues are addressed efficiently and effectively. All this paved a way of change in approach from family planning to family welfare.

Until 1977, Family Planning was the central activity but was transformed into Family Welfare program later on with a special focus on child and maternal health. This marked the beginning of the third period of government policy on maternal health in independent India. Since, family planning continued to play a major role, family welfare was committed to child mortality, however, maternal health still failed to acquire the significant attention by the policy holders. Nonetheless, to ensure better maternal health outcomes, there have always been programs both at the national and international level. In 1978, India signed the Alma Ata Declaration, an international commitment to primary health and put maternal and child health within the ambit of comprehensive primary health care approach. In response to this declaration, the Government of India launched the country’s first National Health Policy in

1983. The NHP rendered its utmost preference to maternal and child health with a special focus on underdeveloped and vulnerable sections of the society. However, maternal health care attracted increased attention worldwide after a revolutionary paper written by Rosenfield and Maine in 1985 titled as "Where is the M in MCH?" Then it was only in 1987 that the Safe Motherhood Initiative was launched by an Interagency Group (sponsored by World Bank, UNICEF, WHO, Population Council and IPPF) in Nairobi. The focal point of this initiative was to draw attention to dimensions and consequences of poor maternal health and to extend interest of government towards high rates of maternal mortality and morbidity. The aim was to reduce maternal mortality ratio by half by the end of the year 2000. In response to these initiatives taken at the global level, policyholders in India had consolidated for immunization, nutrition and maternal healthcare into the Child Survival and Safe Motherhood Intervention by 1992. The main aim of the maternal component of this intervention was to improve access to "essential" maternal services by training Auxiliary Nurse Midwives (ANMs) and traditional birth attendants (Dais) to detect early signs of high-risk pregnancies and the development of referral systems for women with maternal complications (Hunter et al., 2014).

Following the International Conference on Population and Development in Cairo, the fourth period started in 1994. The National Maternity Benefit Scheme (NMBS) was incorporated in 1995 as one of the components of National Social Assistance Program (NSAP). Later on, the scheme was transferred from the Ministry of Rural Development to the Department of Health & Family Welfare during the year 2001-02. The Government of India began the Reproductive and Child Health (RCH-I) Program in 1997-98 by combining the Child Survival and Safe Motherhood (CSSM) Program with other Reproductive and Child Health Services. The program included maternal and child health, family planning, treatment and control of reproductive tract infections and adolescent health. This paved the way for the National Population Policy 2000 and National Health Policy, 2002 (Srinivasan et al., 2007). During the fourth period, medical professionals had become more concerned about maternal health by focusing on reduction of maternal mortality and increasing access to healthcare by eliminating the "Three Delays"- (i) delay in deciding to seek the appropriate medical care, (ii) delay in identifying and reaching an appropriate healthcare facility, and (iii) delay in receiving the appropriate care after reaching healthcare facility (Barnes Josiah et al., 1998). In order to put an emphasis on the attainment of the Millennium Development Goals (MDGs) particularly Goal 4 and 5 (reduce child mortality and improve maternal health), the Government of India launched National Rural Health Mission (NRHM) on 12th April 2005,

as a part of Reproductive and Child Health Program (RCH-II).The purpose of the Mission is to provide equitable, affordable and quality healthcare to the population especially to rural poor and women of the country with a special focus on Eighteen States, including Empowered Action Group (EAG) States, the North-Eastern States, Jammu and Kashmir and Himachal Pradesh(Government of India, 2005). Subsequently, the program was extended to all the states and urban areas of the country by the name as National Health Mission, in 2013. The NRHM is a centrally sponsored flagship program aimed to allocate the funds to the high focus states to strengthen their physical and human infrastructure. To make NRHM more accessible, government has introduced sub-schemes like Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK) and Accredited Social Health Activist (ASHA). JSY has made remarkable changes in institutional deliveries from 0.74 million in 2005-06 to 10 million in 2009-10 particularly through the intervention of ASHA, who acts as a plausible link between the expectant women and the community care providers (Modugu et al., 2012). In 2011, the Government of India launched JSSK to enhance the institutional delivery further and to reduce out-of-pocket expenses for families of all expectant mothers in the public sector facility. The scheme aims to reduce OOPE and improve access to health care by providing free and cashless services (Tyagi et al., 2016). With the implementation of these programs, India has achieved a 77 percent reduction in maternal death rates, from 556 per 100,000 live births in 1990 to 130 per 100,000 live births in 2016 (PK Singh, 2016). Nonetheless, India is still responsible for more than 20% of all maternal deaths worldwide (Sharma et al., 2018).

Equity, Fairness and Justice in Health

In healthcare, equity means that everyone, regardless of caste, race, colour, religion, or socioeconomic level, has an equal chance to be healthy. Equity and fairness are important public policy values, and they are significant concepts in political, public, and legal debates (N Daniels 2008; Amartya Sen, 2000). In addition, equity and fairness play a crucial part in the pursuit of Universal Health Coverage (UHC) (Frenz and Vega, 2010; WHO, 2012; Marmot et al., 2008). They influence not only the UHC goal, but also the key decisions that must be made along the way. When UHC cannot be realised immediately, progress must be made in a fair and equitable manner. Furthermore, countries must attempt to expand key services, involve more people, and lower out-of-pocket payments in an equitable and fair manner. Essentially, equity and fairness are concerned with how advantages and liabilities are distributed in society. There is no agreement on the specific bounds or content of the ideas of fairness and equity. However, there is a useful distinction to be drawn between

horizontal and vertical equity. Horizontal equity necessitates equal treatment of cases that are relevantly similar, but vertical equity necessitates properly unequal treatment of cases that are dissimilar. These principles can be used to distribute health benefits and coverage, as well as the distribution of obligations, such as financial payments to the health system (WHO, 2014). Comparing health with its socioeconomic factors among more and less advantaged groups of society is all that is required to assess health equity.

Socio-economic Inequalities

World Health Organization defines health as, "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The WHO's Alma Ata Declaration (1978) acknowledged that health is a fundamental human right whose realization has become a major societal aim around the world, necessitating the participation of social and economic sectors in addition to health sectors. Thus, health is not only limited to biological factors, but also includes socio-economic factors that have a significant impact on a woman's health. As a result, there is a need to comprehend many socio-economic inequalities that exist at various levels and are influenced by factors such as income, education, geographic location, and so on. The persistence of these inequities leads to significant health inequalities among individuals, which need to be addressed.

Education: The most important determinant of health disparity is education (WHO 2017). Several researchers have discovered a strong link between maternal healthcare utilisation and education (Becker et al., 1993; Cleland and Ginneken,1998). It is well acknowledged that educated women use contemporary health services more than illiterate women (Mondal et al., 2016). They are more likely to consume a healthy diet during pregnancy and undergo the necessary antenatal check-ups and receive requisite Tetanus Toxoid injections, reducing complications during childbirth and lowering the risk of death for both mother and child. Female education is a major predictor of maternal health-care utilisation, but the size and type of the association varies depending on social context. Furthermore, it was discovered that, for the most part, the use of maternal health care services does not differ significantly among educated women based on their level of education, and that, as a result, the number of years of schooling was positively associated with the use of maternal health care services (Navaneetham and Dharmalingam, 2002).

Income: Economic progress is inextricably linked to healthcare access. The family's income is regarded as the most important measure of economic condition, as it may provide every opportunity to the household. It is considered that the higher the household's economic position, the more maternal healthcare is used. Several national and international research

investigations (Sontakke et al., 2009; Balarajan et al., 2011) have demonstrated a robust link between income disparity and maternal morbidity and mortality. In comparison to the affluent quintile, the poor quintile has a higher rate of maternal mortality and morbidity. When compared to their colleagues in the poorest income category, women in the richest economic stratum may be six times more likely to have an institutional delivery. Infant mortality is also higher in poor and resource-strapped households than in wealthy families. (Macro International and the International Institute for Population Sciences (IIPS), 2007). The unequal distribution of economic resources and power among the population exacerbates these disparities even further. As a result, low income, which leads to poverty as a result of social and economic inequality, is critical to women's health. Therefore, these socio-economic imbalances must be addressed in order to achieve health equity.

Caste: In India, caste has played a significant part in one's social status and growth. It has an impact on the growth of the economy, social, political, cultural, and educational systems, resulting in social inequality. As a result, it has an impact on health disparities which in turn influences women's health, particularly reproductive health. The available literature shows that women from lower social strata, particularly Dalits (Schedule Caste), Adivasi (Tribal), and other backward castes, have health inequities compared to women from higher social strata. According to a study by Sontakke et al. (2009), the average number of obstetric morbidity among Scheduled Tribes/Scheduled Castes and Other Backward Castes was 2.51 and 2.45, respectively compared with 2.05 among other castes. Consequently, these disparities have an impact on women's health and access to health care.

Gender: Women are generally denied equal access to opportunities, resources, and rights, which is influenced by societal gender stereotypes. Work, family, social, economic, and cultural roles are clearly divided based on gender disparities; although this is changing, but at a gradual pace. The decision-making process is still mostly in the hands of men. In India, males are still given more preference than females, and women have less power distribution. Women's freedom in the socio-cultural, economic, political, health and educational spheres is limited by the patriarchal social system. Women lack autonomy, economic freedom, control over their bodies, and the ability to make their own decisions. As a result, gender discrimination and other forms of socio-economic discrimination emerge. “Girls in India are discriminated against in other ways as well,” according to research (Mehrotra and Chand 2012). They receive fewer months of nursing, less caring and play, less medical treatment if they become unwell, less special cuisine, and less prenatal attention. As a result, females are significantly more vulnerable to sickness and infections than boys, resulting in poor health.

Hence, women's empowerment and the recognition of health rights as women's rights are essential.

Geographical Distance/Location: This is another factor that has an impact on maternal health. In fact, it is one of the most significant roadblocks to receiving timely and proper health treatment. In the absence of transportation or the existence of an inefficient transit system, it becomes extremely difficult for a woman to visit the health facilities on a regular basis, particularly in rural areas. The disparity in maternal healthcare use between rural and urban areas is likely attributable to disparities in the availability of acceptable maternal health care facilities, as well as the distance to the nearest healthcare center (Navaneetham&Dharmalingam, 2002). It also poses barriers for women from low-socioeconomic backgrounds (pre-existing inequality) and from rural places. According to research, poor service quality and resource resupply in remote areas prevent people from using offered services, hence increasing health disparities. In comparison to rural areas, the ratio of hospitals, doctors, and health expenditure is also higher in metropolitan areas (Deogaonkar 2004). This shows that there is socio-economic disparity as well as unequal access to health care and other resources based on geographic distribution, which may have an impact on women's health.

Impact of Maternal Healthcare Financing in improving Maternal Health

The cost of healthcare for households are divided into two categories: direct and indirect costs. User fees, investigation charges, medicines, hospital charges, blood transfusion, special attendants at the health institution, and so on are examples of direct costs. Indirect costs include transportation, food charges, wages lost, cost of escorting person, and the cost of home caregivers (Mondal et al., 2016). The greatest impediment to obtaining good maternity healthcare in India is direct payment in the form of Out-of-Pocket Expenditure (OOPE). “OOPE is the payment made by households at the point they get health services,” according to the World Health Organization. This includes the expense of a doctor's consultation, medications, and hospital fees. Also, any reinsurance reimbursement is deducted from out-of-pocket payments” (Xu et al., 2003). Improving maternal health is heavily dependent on the availability, affordability, and accessibility to effective utilization of quality maternity care services in order to meet the Sustainable Development Goals (SDGs) (WHO, 2015). However, the cost of healthcare, particularly out-of-pocket expenses, is a major determinant of maternal care consumption (Say and Raine, 2007). The Government of India launched the largest ever flagship program, the National Rural Health Mission (NRHM), in 2005, with its two key interventions, JSY and JSSK, formed in 2005

and 2011 respectively, to increase utilization of maternal healthcare services in public health institutions and to reduce high out-of-pocket expenditure on maternal healthcare. Increased institutional deliveries and improved financial access to institutional deliveries were the goals of these interventions.

According to Mohanty and Srivastava (2013), OOPE at public health institutions has fallen significantly after adjusting for inflation as a result of increased healthcare financing in the form of NRHM. Two studies based on non-experimental methods find a decrease in OOPE and catastrophic expenditure on maternal healthcare in the post-NHM period, using nationally representative data (Tripathy et al., 2017; Mohanty and Kastor, 2017). Sidney et al. (2016) found that JSY recipients in particular the low quintile spent less on delivery care in public health institutions in Madhya Pradesh, India, based on cross-sectional community-based data. In Rajasthan, the incentives provided under JSY were shown to reduce out-of-pocket spending for normal deliveries but were inconsequential in meeting the expense for caesarean section deliveries (Govil et al., 2016). Tyagi et al. (2016) found that with the support of a cashless system called JSSK, beneficiaries were able to lower the costs associated with delivery at public health institutions. In the union territory Chandigarh, however, no such association of the program was discovered (Tripathi et al. 2014). Yasobant et al. (2017) discovered that a public-private partnership scheme called the "Chiranjeevi Yojana" (CY) was significantly linked with reduced out-of-pocket expenditure on maternal healthcare in a retrospective cohort analysis of multiparous eligible women in Gujarat. Yangala et al. (2020) conducted a study on JSSK, a flagship program to reduce OOPE during childbirth, and found that while service utilization for JSSK is high in the study area, transportation charges account for OOPE, which could be due to a lack of information sharing from concerned healthcare providers. Likewise, Mondal et al. (2016), in their cross-sectional study in rural Bankura district of West Bengal, India found that the financial help offered under JSSK could not cover the high OOPE for caesarean section delivery in the government health facility. The survey also indicated that beneficiaries are largely unaware of their entitlements under JSSK. As a result, the two biggest causes of OOPE at public health facilities were the cost of drugs and transportation. Using data from the 25th schedule of the 71st round of the Indian National Sample Survey Organization, Goli and colleagues concluded that despite the government of India's various efforts in the form of improved maternal healthcare financing, they are still insufficient to protect households from financial hardships because the mean spending on maternity care is 10 times higher than the national average (Goli et al., 2016). Given the high out-of-pocket costs of institutionalized delivery

care, despite a high-profile legislative program aimed at addressing the problem, Modugu et al. (2012) proposed that OOPE be decreased to the bare minimum to benefit impoverished households. Another study, conducted by Leone et al. (2013), found that the cost of maternal healthcare in public health institutions is often higher than the amount currently allocated to poor households under the JSY program. This is primarily due to a lack of drugs and diagnostic facilities inside government-run health facilities.

In their research study from Ghana, Nguyen et al. (2011) found that the country's National Health Insurance Program has been able to produce a reduction in OOP expenditure that ranged from 0.5 to 1 percentage point (which amounts to a reduction of 36 percent to 67 percent of the sample mean). Trakinsky et al. (2020) conducted a study in Burkina Faso, finding that the country's health-care financing has a positive impact on maternal health. Households just over the poverty line were not driven below the poverty line after spending for maternal healthcare. On the contrary, Borde et al. (2020) did a study in Southern Ethiopia, the findings appear to indicate that a significant proportion of households have high out-of-pocket expenses for maternal healthcare and have been forced to live below the poverty line as a result of high out-of-pocket payments, particularly for childbearing, postnatal, and neonatal sickness.

Conclusion

The government of India through its massive infrastructure and human resource expansion, especially under the National Health Mission has been successful in injecting new vigour into India's public health system. The mission has resulted in increased use of public health facilities for deliveries and an increase in maternal and neonatal mortality reduction. The mission has guided India in the correct direction in terms of attaining the Millennium Development Goals (MDGs), particularly goals 4 and 5, as well as moving the country closer to Universal Health Coverage. To summarize, India has played a significant role in improving maternal health through various programs. However, the incentives and entitlements provided by various demand side financing programs may be insufficient to safeguard poor and vulnerable households from financial risk. Moreover, there is a significant disparity in utilization of maternity healthcare among Indian states due to socio-economic inequality. Even when quality health facilities are geographically within reach, a daunting combination of social, economic, and cultural hurdles impede poor women from easily accessing treatment and health services. In terms of women's health, education, and income, there has been inequity. As a result, it is strongly recommended that further robust

researches for more focused study designs of vulnerable populations should be taken into consideration.

Future Directions

Looking at the scope of the paper, it could be suggested that the future work on this issue could analyze and estimate state-wise impact assessment of interventions in terms of healthcare expenditure for maternal care and poverty induced by it which is even more relevant from the policy perspectives of the states. An extensive and in-depth exploration of these indicators could be a next step for further research in this area.

Conflict of Interest: None.

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