The burden of maternal healthcare expenditure in India

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Although maternal healthcare services in India are offered free at the point of delivery, Tiziana Leone, K. S. James, and Sabu Padmadas find that many Indian families face significant out-of-pocket expenditures, which are a major barrier to access to maternal healthcare.

The progress in improving maternal health, as envisaged in the UN Millennium Development Goals (MDGs), critically depends on the availability, affordability, and effective use of reproductive health services. India is one of the rapidly developing economies where health challenges are myriad at the population level, yet trends in key maternal and child health indicators are showing little or no sign of progress: India continues to account for a quarter of all maternal and child deaths at the global level. The maternal mortality ratio in India showed a decline from 301 deaths per 100,000 live births between 2001–03 to 254 and 212 during 2004–06 and 2007–09, respectively, but the ratio still lags behind the MDG target of 109 by the year 2015.

Financial hardship is one of the major reasons for poor uptake of maternal healthcare services in India. For example in Bihar, one of India's poorest states where over 80 per cent of births are home births, approximately 50 per cent of women reported financial concerns as the reason for not opting for institutional delivery care, despite the fact that maternal healthcare services are provided free-of-charge in public health facilities in India. This is because informal payments for antenatal, delivery, and postnatal services are widespread in the Indian public health sector, attributed mainly to service bias, social exclusion, and impoverishment.

In India, the total health expenditure constituted 4.3 per cent of GDP (2009), with private and public sectors accounting for 78 and 20 per cent, respectively. Out-of-Pocket Expenses (OOPE) contribute to over 70 per cent of the total health expenditure—these additional expenses not only deter women from accessing healthcare services but also push households further into poverty.

Evidence on individual and household OOPE for maternal healthcare services in India is limited. We hypothesise that although maternal healthcare services are offered free at the point of delivery in India, many households bear excessive OOPE. The high indirect cost of hospitalisation and outpatient care, particularly in terms of transport and food, have been well documented, although studies have not focused explicitly on maternal healthcare expenditure. Our aim is to investigate the economic burden of maternal healthcare services on Indian households and quantify the levels of expenditure, including indirect costs incurred at the national, state, and community levels.

We used cross-sectional population data from the 2004 National Sample Survey Organisation (NSSO), which considered 9,643 households for the analysis where at least one woman received maternal healthcare services

during the year preceding the survey. Using multilevel linear regression techniques, we estimated the effect of household, cluster, and state characteristics on the proportion of maternal healthcare expenditures over total household expenditures. Over 80 per cent of households reported paying for maternal healthcare services, with those using private care facilities paying almost four times more than those using public facilities. Clearly, although public health facilities are said to provide maternal healthcare free-of-charge, the figures reported here show the opposite to be true.

The present analysis has contributed to a better understanding of the burden of expenditure associated with maternal healthcare in India since it takes into account the indirect costs including OOPE for specific healthcare components. The multilevel approach to statistical analysis confirmed the presence of unobserved heterogeneity associated with maternal healthcare expenses, which has not previously been explored systematically with NSSO data. This study has demonstrated clear evidence that despite free access to most maternal healthcare services at the point of delivery, many Indian families still pay above the minimum threshold for these services, especially those living in the poorest strata.

The expenditures incurred in public health facilities are mainly attributed to the unavailability of medicines and diagnostics facilities within these facilities. This is particularly a concern in rural households where women rely on facilities located in small towns or cities and often borrow money to cover transportation, food and accommodation costs. Interestingly, female-headed households spend considerably more on maternal healthcare than male-headed. Studies also show that female-headed households in India are poorer than male-headed households, as the former are mainly headed by elderly widows without access to adequate economic resources. Consequently, maternal healthcare expenditures can exacerbate the economic burden in these households.

To conclude, we believe that the economic burden might still be the strongest barrier to access to maternal healthcare. There is an indication that despite various health reforms – for example, *Janani Suraksha Yojana*, a national safe motherhood intervention launched under the National Rural Health Mission programme (2005–12) to increase utilisation of antenatal and delivery care services across Indian states – policymakers have not paid enough attention to the increasing cost of the maternal healthcare services in India, including in public health facilities where women still bear considerable costs.

For the complete article, including detailed data and methodology, see T. Leone, K.S. James, S.S. Padmadas, "The Burden of Maternal Health Care Expenditure in India: Multilevel Analysis of National Data", Maternal and Child Health Journal (November 2012).

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