EFFECT OF DIRECT AND INDIRECT COSTS ON BIRTHS AMONG POOR HOUSEHOLDS IN TILMAPUR VILLAGE, VARANASI DISTRICT

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CERTIFICATE

This dissertation entitled "Effect of direct and indirect costs on births among poor households in Tilmapur village, Varanasi district" is submitted in partial fulfillment of the requirements for the award of the degree of Master of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work

Anjali Gupta

We recommended that this dissertation be placed before the examiners for evaluation.

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(Chairperson)

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(Supervisior)

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Dedicated to

MY Parents!!

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Abbreviation

ANC	Antenatal Care
ANM	Auxiliary Nursing Midwife
ASHA	Accredited Social Activist
AWW	Anganwadi Worker
BPL	Below poverty Line
CHC	Community Health Centre
DH	District Hospital
EmOC	Emergency Obstetric Care
FC	Forward Class
FRU	First Referral Unit
GDP	Gross Domestic Product
GNP	Gross National Product
GOI	Government of India
HDI	Human Development Index
HPI	Human Poverty Index

ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
JSY	Janani Suraksha Yojana
MGBAY	Mahamaya Garib Balika Ashirwad Yojana
MNREGA	Mahatma Gandhi National Rural Employment Guarantee
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MP	Madhya Pradesh
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
OBC	Other Backward Class
OECD	Organisation of Economic Co-Operation and Developed
OOPs	Out of Pocket Spending
PDS	Public Distribution Shop

PHC	Primary Health Centre
RCH	Reproductive and Child Health
RSBY	Rashtriya Swasthya Bima Yojana
SC	Schedule Caste
SCs	Sub Centers
ST	Schedule Tribe
TBA	Traditional Birth Attendants
UP	Uttar Pradesh
UNDP	United Nations Development Programme
WHO	World Health Organisation

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Introduction

Without social development, economic development is worthless because, these two sectors balance each other. The neglect of social sector such as health and education results in less development and the slow tempo of the economic growth. According to the United Nations Development (UNDP) report on Human Development Index (HDI), India's economic performance has been improving, but the Human Poverty Index (HPI) has not improved significantly. Based on the HDI, India ranks 127th out of 177 that includes both developed and developing countries. Among developing countries it occupies the 58th rank (Antony & Laxmaiah, 2008). In India, a large percent of the population (26.1%) live below the poverty line. These people spend most of the income on food and other consumptions and thus they do not have enough money to spend on other social securities' like health, education etc. Under such conditions, the government has greater responsibility to provide the social safety at minimal cost to the underprivileged who cannot afford these services (Duggal, 2007). Therefore to give the safety net to the vulnerable population, government should increase the investment in these sectors.

Although, public health expenditure in India is continuous and initiatives taken by the government over a period of time (1951-2001) have significantly improved in terms of burden of disease and other health indicator but the pace of the increment is inadequate as well as the morbidity and mortality rate is still high compared to the developed countries as well as some developing countries. The government health spending is less than the private. The total expenditure on health as percentage (%) of GDP was 4.2 in 2003 where as in the year 2007 it was 4.1, which means it has been decreased from previous level. The share of the private health expenditure as percentage of the total expenditure on health was 73.8% (Rao and Choudhury, 2012). Due to the expanding private sector's share in health, out of pocket expenditure has been increased which was 89.9% of the total private expenditure on the health (mospi.nic.in/Mosp_New/Upload/SAARC_Development_Goals_India_ Country_Report_24mar11.pdf).

The dominance of the private sector in health care is main cause of the problems faces by the poorer as they have to pay higher cost on treatment due to which they sell their assets or taken loan at a higher interest and get indebtedness. The share of the private investment in the health department has not increased suddenly but gradually with the decreasing share of the public expenditure in health (Peter et al. 2002).

Deficiencies of government funding in the health sector is one of the causes for the prominent role of the private sector. Evidence shows that in health care sector, the private sector is playing a dominant role in large parts of India. Due to increasing role of private sectors, poor and deprive section of the society are not able to seek the proper health services. This private sector is strongly support by the Indian government by giving subsidies, low tax as well through the soft loan (Ravichandran et al. 2009). The private expenditure was 4.25% out of 6% of total health expenditure in the 2004-05 year. This also suggests that there has been an expansion of the private sector in the health that around 57% of the hospitals and 32% of the hospitals' beds are in the private sector (Bhat, 1996). Due to the significant presence of the private sector in the Indian health care system, households spend disproportionately on health care. Various rounds of NSSO indicate that about 50-60 % of their total consumption expenditure spend on the health and 11% of non food consumption expenditure (Macroeconomic Commission, 2005). It is estimated that the growth of inpatient expenditure was highest during 1995-96 to 2003-04, which was in the range of 16-18%. In 2001, the OOP expenditure was recorded 72,759 crore which was 3.2% of the GDP at the current market price (Macroeconomic Commission, 2005).

Brief introduction of the chapters

Chapter I: The first chapter is "Health expenditures in India and its effect on the poor: A Review". It is divided into three sections. The first section deals with high out of pocket expenditure on health in India. The second section of the chapter covers the centrally sponsored condition cash transfer scheme- JSY while the third chapter deals with the Uttar Pradesh (U.P) state sponsored scheme MGBAY.

Chapter II: Second chapter is "Research Methodology. This chapter discusses the conceptualization of the problem as well as methodological approach which is used in the study. This chapter also includes the study area where this study has been conducted.

Chapter III: The third chapter presents the "Experiences of institutions and home births among households below poverty line in the village". It is the analysis and interpretation of the primary data on direct and indirect expenditure of delivery in poor households.

Chapter IV: Chapter forth is the "Discussion and Conclusion". It is the conclusion of the findings of the study. It summarizes the major and principal themes which are emerged from the study.

Chapter 1

Health expenditures in India and its effect on the poor: A Review

The stagnation of government funding as well as the increasing role of the private sector in health services is the main cause for the rise in out-of-pocket expenditures. Private sector now becomes a major source of both outpatient and inpatient care in India. Increase in the share of private investment has created the numerous problems especially for the vulnerable group in-order to avail the health services. Numbers of studies have shown the negative consequences of this kind of health expenditure in terms of catastrophic payments (Ghosh, 2010; Pal, 2010; Mondal et al. 2010). Moreover, health expenditure is not uniform within the country, it is marked by interstate, rural-urban and income quintile variations (Rao and Choudhury, 2008; Garg and Karan, 2005; Garg et al. 2008). The present chapter is a review of the different studies on health expenditures and their effect on households. In addition to this, the present chapter also discusses the several schemes sponsored by the centre as well as the state which give cash incentives for institutional births to women below the poverty line.

Health spending in India

It has been well acknowledged that government funding has remained stagnant and not kept pace with rising demand. Several committee reports and policy makers have been advocating to increase public spending in-order to reduce inequalities and protect the needs of the poor, who cannot afford private facilities. Apart from welfare as a reason, there are other reasons which make the presence of government funding necessary. State investment in health has positive externalities and is able to address market failures in health services. (Kethineni, 1991).

A study by the World Health Organization for 2001 shows unequal health spending across the world. These disparities are highly apparent in the OECD and some other developing countries. These OECD countries spend largely on their citizen's health comparison to the developing countries (http://www.who.int/healthinfo/paper51.pdf).

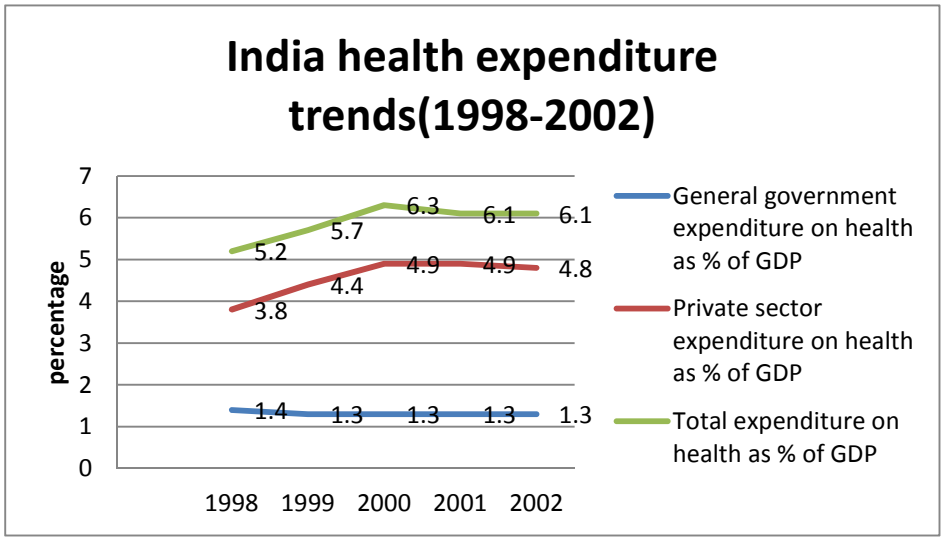
India is also one of those countries where health expenditure is very low. The achievement in terms of health indicators such as improvement in life expectancy,

infant mortality rate, crude birth and death rate has been well accepted, but, this achievement is not equal in all over the India. In fact these inequalities are clearly visible in the various forms which include rural-urban; regional; class, caste and gender wise disparities. In the country most of the health services in rural areas are inadequate and underutilized where as in urban areas they are marginally better in terms of availability of health services (www.iimahd.ernet.in/dileep/PDF).

Several studies have analyzed the monetary resource allocation of the central as well as states. In the study of Guruswamy et al. (2011), the author has presented the pattern and trend of central and state investment in health and also exposed that the revenue expenditure of the centre has remained stagnant over a period of time but in the case of states, it has been declining. The fluctuating share of government funding has raised the problem of high out of pocket expenditure and financial risk for poorer households. So it has been advised by the author that, to check the financial risk of the deprived people, the government should monitoring the insurance schemes, health programmes and policies, which they have launched earlier (Guruswamy et al. 2011).

In India, the total expenditure on health of the GDP has increased but this is incremental and very gradual. The evidence shows that the total health spending in 1998 in India was 5.2 whereas in 2002 it was 6.1 but the reason behind the little increment in this health spending was not because of the public funding but due to the increasing the investment of the private health expenditure (see figure 1.1) (www.who.int/macrohealth/ documents/ Electronix_Annex_C.pdf)

Figure 1.1 Trends of the Indian health expenditure



Source: www.who.int/macrohealth/documents/Electronix_Annex_C.pdf

Inter-state differences in public health expenditure

Variations in the state health expenditure in terms of the per capita health expenditure as well as in the share of gross state domestic product have been observed. Evidence shows that there is an association between the per capita health expenditure and Gross State Domestic Product (GSDP). The stagnant nature of GSDP is also declining the proportion of per capita health expenditure. Therefore, per capita health expenditures are higher in those states where per capita GSDP is higher (Rao & Choudhury, 2008).

A study of the trend in State health expenditures revealed an interesting picture. The analysis was based on the expenditure on health by selected states which was conducted at two different point of times- 1985-86 and 1989-90. The analysis shows that out of 16 states, 10 states (Andhra Pradesh, Assam, Bihar, Kerala, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal) have indicated the faster growth in their health expenditure then their state domestic product (SDP) and rest of them such as Haryana, Karnataka, Madhya Pradesh and Gujarat all of them economically developed but showed the negative growth in their health budget allocation. During two points of times of the study, U.P has fastest growth in the health budget (Bansal, 1999).

Uttar Pradesh is one of the states that has been performing unsatisfactorily with poor government funding for health. The allocation of funds has been very low compared to the other states. It was also found that most health expenditures are spent on the

staff salaries and some other recurrent expenditures but not much spending on essential items like as drugs and other necessary equipments (uphealth.up.nic.in/transfer/uphsdp_reports/ HealthSectorDevelopment.pdf).

In India health is a state subject but the centre is the one who gives the money to the state although there is no provision of the fixed amount of spending on health in the Indian constitution. Therefore decreasing in the grant which is given by the central government affects the state health expenditure (Shewade and Agarwal, 2012).

Duggal (2007) shows that Indian states have never played an important role in the provision of the health financing in India while health being the state subject. The neglect in government funding has given the chance to the private sector to play a dominant role in terms of health financing and due to this, the out of pocket expenditure has become an essential source of health care financing (Duggal, 2007).

Out-of-pocket expenditures in various income quintiles

Garg et al. (2008) have found that 5 % of total household expenditure spends on health OOP which is equal to India's 11% of total non-food expenditure. This proportion of expenditure is lower in urban compare to rural areas but as the level of consumption increases, the expenditure too increases in both. It has been also estimated that the 75% of the household OOP spend on drugs, in which 77% in rural and 70% or less in urban parts. Due to high expenses on health and drugs, many people fall into poverty line. The 1999-2000 statistics also states that 3.2% people have come under poor line after bearing expenses of OOP. This shows a nature of regression in which poor spends more on drugs compare to richer. Further, the study has revealed that the share of out of pocket payment in total expenditure is higher in high income quintile compare to low income as well as it is higher in developed states than in deprived and under developed states, except some states (such as Gujarat and Tamil Nadu). The impact of the health expenditure causes more poverty in the poorer states (Bihar, Orissa, R.ajasthan, Assam etc.) of rural areas. (Garg et al. 2008).

It is has been observed that the pattern of health expenditure varies across different socio-economic background. The average per capita and per episode expenditure in the middle as well as upper middle classes is higher than the lower and lower middle classes. The reason for lower expenditure by the latter could be due to greater reliance

on government hospitals and unavailability and lack of money to spend on private health care. In the government hospitals, there is lack of resources and it suffers from a variety of difficulties in terms of funding, facilities, essential drugs etc. On the other hand, the financial resources are flowing towards the private health sector from the community (Ray et al. 2002).

In India, it is noticeable that the out of pocket (OOP) expenditure is much higher among all sources of private funding but inpatient expenditure is high either in public or private institutions. The amount of expenditure which patients bear is greater in private than the government hospitals. Based on an analysis of the NSSO data, it is found that average per episode out of pocket expenditure has increased from 528 (five hundred twenty eight) rupees in year 1986-87 to 4950 (four thousand nine hundred fifty) rupees in year 2004 in the private hospitals. Out of pocket expenditure for inpatient treatment is unreasonably higher for two higher quintile compared to the two lowest quintiles. The study also shows that treatment in private institution is much costlier and a great burden for the poor than the rich (Dilip, 2010).

Rural-urban disparities

Selvaraju (2003) measured the expenditure on health at state level (macro) and households (micro) level in the rural areas of India. This study revealed that health expenditure spent by the households in the year of 1993-94, was the major share of the total expenditure which accounted seventy to eighty (70-80%) percent of total expenditure in India. This study result shows that villagers spent about 5.40 percent of their income on health expenditure, whereas the government only spent 1.09 percent on health during 1993-94. It also shows that the structure and pattern of the government health spending went towards machinery, equipments, personnel salaries etc while patient spent their money on medicines, doctors' fees, transportation etc (Selvaraju, 2003).

Mahal et al. (2001) also showed that the rural and the urban areas have still inequalities in health facilities' utilization. It has been estimated that the secondary services utilization of public services was quite low due to poor quality service as well as the presence of the private institutions in these areas. This study also revealed that government finance as well as healthcare services is biased towards the rich but there are some states such as Tamil Nadu, Maharashtra, and Gujarat where the health care

services are not biased while it is equal to everyone. Thus, the author suggested that the state government should take major steps towards improving the quality of secondary care which will provide better health services to the poor in rural areas. (Mahal et al. 2001).

George (1997) conducted a study in Maharashtra and Madhya Pradesh and estimated that private sectors were used more in rural Maharashtra as compared to urban areas. In Madhya Pradesh the utilization of the private sector was same for both rural and urban areas. The cost per episodes was higher for both states in the rural as well as urban (George, 1997).

Using the NSSO data of 1999-2000, Garg & Karan (2008) showed that out of pocket expenditure is about 5% of total household expenditure. This is higher in the rural counterparts as well as prosperous states. It has been found that the major contribution of the out of pocket expenditure was the cost of drugs that contributed to nearly 70% of the total out of pocket expenditures. This OOP expenditure has been estimated 80% in 1995-96 (Peter et al. 2002) and 70% in 2000-01 (Macroeconomic Commission, 2005). The major part of the expenditure of the OOP expenditure is on private health spending which is accounted 97% of the total private health expenditure (Garg and Karan, 2005). The percentage of the OOP spending on inpatient care, outpatient care and drugs in rural as well as urban area in 1999-2000 has been given in table 1.1.

Table 1.1 Percentage of the OOP expenditure on inpatient, outpatient and drugs in rural and urban area in 1999-2000

	Rural			**Urban**		
Consumption expenditure quintile	Inpatient	Outpatient	Drugs	inpatient	outpatient	Drugs
Poorest 20%	3.0	10.3	86.7	5.0	10.9	84.7
2nd Poorest 20%	4.3	11.4	84.3	6.8	12.6	80.7
Middle	5.6	10.7	83.8	10.7	13.5	75.9
2nd Richest 20%	7.6	11.7	80.7	11.7	15.2	73.0
Richest	11.9	12.9	75.3	17.4	17.8	764.7
All households	7.4	11.8	80.9	10.9	14.4	74.7

Adapted from Garg and Karan, 2005, pp.24

From the above table it is obvious that OOP expenditure is high in rural in the rich quintiles whereas it is high among all quintiles in urban area and also this table shows that the cost of drugs accounted for higher OOPs in urban and rural areas (Garg and Karan, 2005).

Negative consequences of the out-of-pocket expenditure and catastrophic payments

Out of pocket health expenditure is considered as catastrophic when the health expenditure exceeds some threshold of the household budget which effect negatively on basic and necessary needs of the people such as food and non food consumption (Ghosh, 2010).

"This catastrophic payment defined as higher level of out of pocket expenditure, spent by the households on the health care, which exceeds (fixed proportion of their incomes) from the threshold of their budget. It is suggested that those who have paid

more than 5% of the total consumption expenditure on medical care have greater chances of trap in catastrophic web" (Tyagi et al. 2009).

The Out-of-pocket expenditure has reversed and deepening effects on those who are already living in the below poverty line, for example around ten to fourteen (10-14%) percent households have came under the poverty line as a result of high expenditures. The result has also shown that in the urban area more than quarter of the households had taken money from the private money lenders to meet their medical expenses and in rural areas it was around nineteen (19%) percent people had borrowed money from the private sources such as micro credit institutions, which are major source of loans for the poor in UP and Rajasthan. Data indicates that the share of the borrowing money in rural and urban areas, majority (52%) of UP and Rajasthan's villagers comes under cash debt due to the health payments. While in the urban area it is around more than the quarter of the total sample. It is no surprise that the catastrophic expenditure in India is very high and it can be interlinked with the socio-economic and public health deficits. The medical loans are prevalent in the most of UP and Rajasthan's area (Alam & Tyagi, 2009). The table no1.2 present the prevalent of medical loans in UP and Rajasthan.

Table 1.2 Utilization of public-private hospitals by catastrophic households:- Z=5% and 25%

Catastrophic Level	Place of Residence									
	Rural		Urban*		Slum		Non Slum		Total Hospitalization	
	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public
Catastrophic1: 5%	41.1	58.9	56.0	44.0	35.0	65.0	62.1	37.9	47.2	52.8
Chi2(1)	Pr.=0.0334		Pr.=0.005		Pr.=0.090		Pr.=0.031		Pr. =0.197	
Catastrophic2:25%	41.8	58.2	64.3	35.7	75.0	25.0	57.1	42.9	48.9	51.1
Chi2(1)	Pr.=0.895		Pr.=0.032		Pr.=0.000		Pr.=0.731		Pr.=0.351	

*including households from slum and non-slum areas of Delhi.

Adapted from Alam & Tyagi, 2009, pp.143.

This study also reveals that catastrophic expenditure is not only a result of utilizing private facilities but it also occurs in public facilities. It is mainly seen in outpatient cases and especially in the private sector. The person who has been treated in public institutions or has been hospitalized in a public hospital can also be driven into the category of catastrophic expenditure (Alam & Tyagi, 2009).

The high share of out of pocket spending affects badly on poor households and it is one of the major causes of impoverishment of the poor in India. Due to their medical expenses, they are compelled to take loan on a large interest. If the health payment is not necessary or in the absence of medical expenses, the households' non- medical expenses would be high and it would contribute positively to raise the welfare of the households' (Berman et al. 2010).

Whereas in a study an intensity of catastrophic payment is also measured and thus it is found that rich household spend large part of amount on their given threshold compared to the poorer. It could be expected that in low income states, the government have less money to invest in pharmacies and that is why drugs are not available in the public hospitals and people have to purchase the medicines from their

own pocket. This could be the main reason why drugs remain the cause for high out of pocket expenditure for the poor (Ghosh, 2011).

Proportion & nature of the direct and indirect costs of medical care

There have been a lot of studies on out of pocket expenditure which includes only direct cost of illness or hospitalization but rarely does one find studies that have calculated the contribution of indirect cost of hospitalization. Dror et al. (2008) included indirect costs and showed that indirect costs alone constitutes more than thirty (30%) percent of the health expenditure. The study included the direct formal cost (allopathic consultations, prescribed allopathic drugs, test and hospitalization), informal cost (traditional healers' cost and drugs etc.) and in the indirect cost which includes the loss of wages of the care givers during hospitalization of the family members, transportation costs and foregone consumption (Dror et al. 2008).

From the findings it is found that the ratio of the direct and indirect cost was two third (2/3) and one third (1/3) respectively during hospitalization, while the informal costs contributed around three percent only. The median cost per episodes of illness including all the three components which have been mentioned above was 340 INR. The result also shows that in the case of acute disease, the cost were higher due to pathological tests and medicines. In case of chronic illness, drugs and hospitalization are the reasons for high costs whereas in the accident, hospitalization was the major cost for catastrophe of the households. The total (direct and indirect) costs were higher in the case of chronic illness and these costs increased with increase in households' income. As mentioned above hospitalization is the prime reason for catastrophic expenditure whenever hospitalization was needed. The second costly item was drugs for all types of illness as well as hospitalization. Thus, it was not shocking on the basis of aggregated that drugs alone accounted more than fifty percent of the total health payment (ibid).

In the case of births, indirect costs have also contributed significantly apart from direct cost. Studies have shown that indirect cost was the main reason for the increasing overall costs in case of births. Worrall et al. (2011) study in slums of Mumbai showed that indirect expenditure contributed around 19% of the total spending on maternal services like as user fee, drug cost, diagnostic tests etc. and it was regressive. This maternal care is not only regressive in nature but the neo-natal care is also found in same nature in the lowest quintile, because they spent more on

transportation, commissions on the staff of health facilities, loss of wages etc as in the highest quintile while direct expenditure of delivery is found progressive in nature. The previous saving is the main source of the maternal and neonatal health care expenditure in the highest quintile followed by current income and loan. The finding also shows that the loss of wages is the prime cause to fall to the poor economic group people in chronic poverty. Most of the lowest quintile bears these expenses from borrowing money (Worrall et al. 2011).

Pattern of the utilization of the health facilities and cost of the illness

Gupta and Datta (2003) found that in rural areas, the poor suffered more and paid more unreasonably on acute illness than the rich. The result also revealed regarding the selection of health facilities that socially deprived (SC/ST) group and labours mostly used. These groups tend to access public hospitals mainly because of the cost differential reason. In the rural area, poor people also select the unregistered practitioners or go for self medications for the treatment. From the analysis it has also revealed that there is a negative relationship between income and utilization of government hospitals, which means that the patient from high economic status rarely use the public facilities for health and spend more on private institutions for treatment. The option of no medication or self medication is linked with the education and economic status. The person from low economic background or uneducated generally use the self medication or remain untreated due to the lack of money and adequate knowledge (Gupta and Datta, 2003).

Peter (2004) analyzed the patients' satisfactory level especially of the poor and who belong to low caste families. This study was done in Uttar Pradesh to check the utilization of health services after introduction of reforms in terms of integrated health facility (Community Health Centers (CHCs), Primary Health Centers (PHCs), District Hospitals (DHs) etc.) in the state. The study showed that the project has increased the utilization of the all types of facilities for the poor as well as rich but most benefited persons are wealthier than the poor. In the case of lower caste people, result show that the project has increased the new outpatients' visits at each type of facilities. This study revealed that the satisfaction of the patients was also greater at the lower level of health facilities such as CHCs and PHCs compare to the district hospitals. But the richer were the major gainers of all types of health facilities and most benefited from the higher level of health facilities like the district hospitals (Peter, 2004).

Dilip and Duggal (2003) conducted a study among one thousand and thirty five (1,035) households in a municipal ward in Mumbai. This study showed that private institutions were the major source of inpatient care treatment and found that about fifty six (56%) percent of total sickness had treated in private sectors. For outpatient treatment, the role of private institutions was not very low and was around seventy nine percent. Regarding the cost of out of pocket expenditure the study also pointed out that it remained higher (Rs. 13,206) in the private institutes than the public (Rs.4,830) sectors. The rate of the morbidity is higher in the age group of sixty (60) and it is more prevalent in those households with a monthly income of Rs. Two thousand (Rs. 2,000) or less than to it compare to age group of all and in households with an income of Rs four thousand (4,000) and above (Dilip and Duggal, 2003).

Ray et al. too reveals the same result that the people who belong to upper socio-economic groups use the private facilities more compare to the other socio-economic group's use the private facilities more compare to the lower. Reason could be the lack of money to spend on health. There is a wide gap between the cost of non hospitalized utilization of public and private institutes in per episodes per year, which was Rs. 10.9 and Rs. 77.1 respectively as referred in the Table no1.3 (Ray et al., 2002).

Table 1.3 Utilization of health facilities

Facility	**Socioeconomic status**			
	Lower	Lower-middle	Middle	Upper-middle
No facility/home remedy	3 (1.9)	9(1.5)	8(1.7)	0
Chemist shop	36(23.2)	109(18.5)	67(14.0)	7(15.5)
Public sector	38(24.5)	121(20.6)	89(18.6)	3(6.6)
Private sector	73(47.0)	338(57.7)	308 (64.3)	33(73.3)
Both public and private sector	5(3.2)	8(1.2)	7(1.5)	2(4.4)
Total	155	585	479	45

(p=0.002, Chi-square test; values in parentheses are percentage)

Adapted from Ray et al. 2002, pp.258.

The entry of the private sector in the health sector and insufficient public health facilities has made people to pay from out of their pocket (OOPs) for availing treatment. Private sector in the health system is present in medical technologies, drug companies, hospital infrastructure as well as the provision of medical services. And for these reasons the out of pocket expenditure of households is increasing day by day. It is understood that the main objective of the private sector in the health care is only to obtain the maximum profit and it is less concern of the improvement of patient's health. The declining government share and increasing the private investment in health services is the major reason for increasing the cost of treatment in India (Selvaraj and Karan, 2009).

Therefore to reduce the burden of cost of treatment, the Center as well as the State government has launched several insurance schemes for the poor in order to ensure better access to health institutions as well as reduce health risk. Rashtriya Swasthya Bima Yojana is an example of these insurance schemes, but the coverage of these schemes is very limited and poor. In some studies, it is found that education of the head of the household has a throw effect on the budget of health care. It might reduce the probability of illness. It is also observed that the family who are economically sound has opposite relationship with the health care expenditure. Because affluent people has rich amount of monetary resources and they pay less on health comparison to money they have. It is also seen that, if the family has medical insurance than the probability of catastrophic out of pocket expenditure can be reduce by ten (10%) percent and thus it might be helpful to the vulnerable people to protect the event of the health stock (Joglekar, 2008).

A south Indian study revealed that around thirty six percent people have no knowledge of health insurance which protect from health risk. They are unaware of the insurance schemes. It is found that education play a main role for understanding the concept and benefit of health insurance. Most of the people who are aware of the insurances belong to the middle socio-economic background and accepted the value of health insurances. Low income group person also knows the importance of the insurances and willing to be part of it at the reasonable premium cost but they highly trust on government schemes than the private, because of the guarantee of the capital (Reshmi et al. 2007).

Few studies also show that socio-economic status of the households was also an important determinant of the utilization of the health services. Like as, Ashokan et al.

2008 found that there are a lot of differences among gender and socio-economic background. The health expenditures of males are considerably higher than the females in terms of medicines, diagnostic test, report of illness etc. It is also generalized that the number of hospitalized males are higher compare to the female and as we move up towards high socio-economic group, found that use of government institution is declining. Most of the people are in favor of modern medicines as it is more reliable and fast recover when people get ill, while homeopathy and some other streams of medicines are costlier which disturb and unbalance the family budget. In terms of caste wise it is estimated that most of the Schedule caste has taken loans to bear the inpatient care, followed by the Other Backward Class (OBC) and Forward (FC) class (Ashokan, 2008).

Another study of Kerala found a lot of variation in the per capita health expenditure among caste groups. The expenditure on health has depend on their status on caste hierarchy means, forward caste are spending more and lower caste spending less and it is clearly visible in those place where health insurance does not exist, inadequate public provision as well as greater reliance on private sectors. The lower caste groups are suffering most and severely deprived in accessing the health care. The lower caste people not only backward in accessing health care but also poorest in terms of economy as it is found that majority of landless households are from lower caste (Paniya in Kerala). To meet their health expenditure the result show that, Paniya and OBC group people are more dependent on the loans and donations than the FC (Forward Class), while SC/ST bear the health expenditure from their savings and availability of cash. Thus it highlights the difficulties and problems faced by the different caste groups to meet their expenses of health care services (Mukherjee et al. 2011).

Majumder (2006) has found that education was another essential determinant of the utilization of the public health facilities. The author found that who was educated till secondary level was more likely to use the public health facilities while more than secondary level educated people was in the favor of the private facilities and more depended upon private sector (Majumder, 2006).

These studies underlie the high cost that is borne by poor households in order to access outpatient and inpatient care in rural and urban areas. In response to this growing evidence, the government proposed a targeted public insurance scheme such as Rastriya Swasthya Bima Yojana (RSBY) a central government insurance scheme

launched by the Prime Minister, Manmohan Singh, on October 1, 2007 for the below poverty line (BPL) households. Its covers up to Rs. 30,000 (thirty thousand) for inpatient care expenses, for reducing this burden (Desai, 2009) and in the case of births, introduced a cash transfer to incentivize institutional deliveries.

Features of cash transfer scheme- Janani Suraksha Yojana

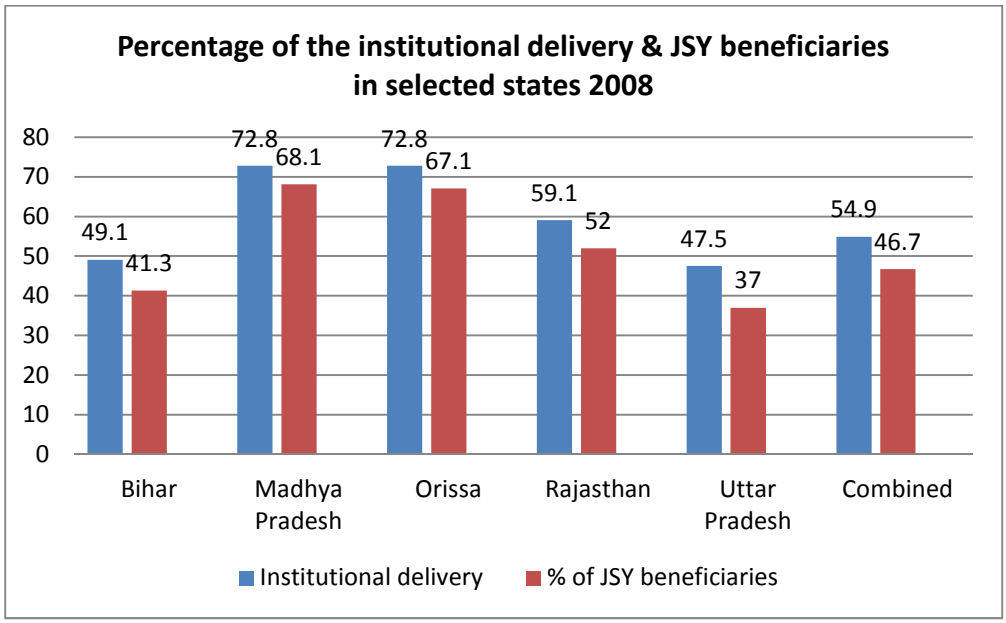
Janani Suraksha Yojana is a scheme which launched under RCH II (Reproductive and Child Health) programme of NRHM (National Rural Health Mission in April 2005. This is a safe motherhood intervention which has been especially launched to reduce the maternal as well as neo-natal mortality through increasing 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 where as 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).

India has played an important role in global burden of maternal deaths, which contributes more than twenty (20%) percent of all maternal death. To tackle this problem, the central government of India has launched the Janani Suraksha Yojana. Through this scheme, the government has targeted to promote the institutional deliveries, three antenatal checkups and also in this scheme there is a provision of cash incentives given to mothers, if the mothers have delivered the baby at the institutions. But due to various reasons (such as lack of awareness of the programme, cumbersome process, delay in getting the amount etc.) the mothers are not availing this scheme (Devadasan et al. 2008).

The success of the scheme is dependent upon the ratio of the institutional births either in the public or private. During the year 2008, Orissa and Madhya Pradesh were highest in the institutional delivery while Uttar Pradesh and Bihar, total number of institutional births were less among all five (Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh) states. The mothers who delivered the baby at home

reported the various reasons such as the cost of institutional delivery, inconvenient, distance of the institutions, and unavailability of the health personnel like as ASHA, ANM for the home delivery among all five states. (See figure1.2) (www.mohfw.nic.in/NRHM/Documents/JSY_study_UNFPA.pdf).

Figure 1.2 Percentage of the institutional delivery and JSY beneficiaries



(www.mohfw.nic.in/NRHM/Documents/JSY_study_UNFPA.pdf).

Varma et al. (2010) studied the institutional births in rural Uttar Pradesh. This study has done into two phases. The first survey has covered four thousand seven hundred and fifty four (4,754) which included married women, their husband, ANM, ASHA, Anganwadi worker (AWW), staff of the government health centre and panchayat members. Out of four thousand seven hundred and fifty four, four thousand four hundred and seventy two (4,472) women interviewed. The second phase conducted in-depth interview with the family, health care providers and panchayat members. From the above sample, the result revealed that only forty four (44%) percent had delivered in the hospital while rest had delivered at home. Though, from the data result shows the increment in institutional births during the period of 1992-93 to 2007-08, but this increment rate was little and slow. However this little increment was because of JSY. For the key reasons of those fifty six (56%) percent women who had delivered at home were the perception of normal birth, husband and elders' decision, unavailability of money and transportation at the time of delivery, labor pain at night,

lack of privacy on health institutions, trust on Dai, convenience at home, lack of drugs and other facilities, behavior of the staff in the institutions, distance from the hospitals were some reasons for which, women deliver at home. The women who has delivered in the hospitals were mostly belongs to the forward class and educated compare to the others (Varma et al. 2010).

Awareness and utilization of the JSY scheme

Regarding the awareness of JSY (Janani Suraksha Yojana), a study (Mandal et al. 2012) found that ninety (90%) percent mothers knew that some incentives are given to the pregnant women but only sixty four (64%) percent heard about the JSY scheme. The result also shows that there is positive association between husband education, awareness of JSY and getting the amount of this scheme. The delayed in the payment of JSY and insufficient fund of JSY were the other reasons for low coverage of Janani Suraksha Yojana in the country (Mandal et al. 2012).

Gupta et al. (2011) studied the levels of awareness of the JSY and showed that only a small number of respondents heard the name of JSY scheme but majority of respondents knew that there is scheme of institutional delivery. Thus it can be said that JSY could not made its important position in the people's mind. In the study majority of the respondents were get informed by ANM, Dai, ASHA while only few were motivated by the doctors. In the case of home and institutional births, most of the women were in favored of home births and said that home delivery is better than institution delivery. In the utilization of amount of the JSY, it is found that one third (1/3) of the respondents wanted to use it for nutrition while one sixth (1/6) were interested to buy medicines for herself and their babies. ASHA or ANM were only motivated 52% for institutional delivery because the women highly depended on her husband or head of the family for health expenditure (Gupta et al. 2011).

Difficulties in availing the JSY scheme

Narayanan et al. (2008) have showed the same issues with JSY. In the scheme, the BPL card required to avail this JSY scheme. Where BPL card had not been updated or issued, various other criteria specified and it varies from state to state. In some state, there is no time limit for getting the amount of JSY whereas some (such as Maharashtra) states have made some limits (like as within seven days after submitted the documents) to avail the scheme. Late reimbursement another and most common

reason, was found in the scheme for not replenished by the government (state/ district) whereas the state or district government argued that not submission of documents and certificate on time by the ANMs and ASHA were the reason. The corruption was the big issue as beneficiaries reported. Most of the beneficiaries have got only half amount of scheme instead of full amount. The users wanted to increase the assistance of JSY as they bear the other charges during hospitalization. They felt that there should be also a provision of assistance of child's treatment in the scheme. After showing the result by the authors, it was concluded by them that JSY has prime target to increase the institutional delivery and thereby reducing the maternal and neonatal deaths. Strong evaluation of the scheme is necessary to make it successful (Narayanan et al. 2008).

Under JSY, it is also mentioned in the report that transport facilities will give to the pregnant woman for easy access to the health facilities in the case of complications. But the study of West Bengal, it is reveal that majority of the delivery cases have faced the difficulty of transportation on the time of reaching the health institutions (www.cortindia.com/RP%5CRP-2007-0503.pdf)

Payment paid by the beneficiaries

As mentioned earlier that Janani Suraksha Yojana (JSY), which provides financial assistance to the pregnant lady for choosing the institutional births, has increased the number of births in the hospitals. The data represent that where the institutional births are estimated major, the mortality rate of maternal as well as neo-natal are fewer and vise versa. Then, is it an instrument for reducing the mortality rate and can it be use for achieving better health indicator. Through this study it is found that JSY has many issues in terms of health facilities of the hospitals, quality of care, and delay in getting the amount of JSY, unpaid amount or half incentives of JSY (Jain, 2010).

Vishwanathan et al. had explored the reasons for not getting the amount of JSY schemes. In the study, three hundred and sixty were eligible for the scheme, out of that only one hundred and eighteen have got the money of Rs. 1400. The general reasons for not availing the scheme amount were lack of information; JSY document was not available on time (Vishwanathan et al. 2011).

To increase the institutional births a study has suggested that cash incentives which are given to the mother at the time of or after delivery should be given to the pregnant prior to the birth of the baby and thus family need not to take loan from private money

lender or some local loan provider at high interest. It is also suggested in the study that government should increase the health facilities at the public hospitals for instance equipment, beds, drugs, transportation services etc to change the scenario of present conditions of health facility and this types of cash incentive program (Lahariya, 2009).

Lack of essential obstetrics equipments

Das et al. (2011) have indicated the number of problems in JSY scheme. This scheme has worked well in the high performance state but the outcomes in the poor states are not good where maternal and neonatal mortality are higher such as UP, Bihar and Rajasthan states and thus it represent twin result in performing its works. The author also pointed out that to improve the maternal and infant outcomes, it is necessary to increase the proper well equipped health services such as emergency obstetric care (EmOC), blood transfusion at the hospital, and should be processing of caesarian section at PHC. In short quality of care should be increased at public hospitals. After introducing of JSY, people should be tension free from the cost of the normal birth but in the study it is show that still people are taking loan from local money lenders at a very interest rate as well as poor families are selling their jewellery, land or some other assets to bear the hospital expenses (Das et al. 2011).

Paul et al (2011) study shows that due to inadequate facilities in the public hospitals, most of the mothers discharge within hours. Thus they do not get much aware of important information regarding babies care and other details such as breastfeeding, postpartum care etc. It has been also found that deliveries were conducted by the untrained staff rather than doctors or nurses. Corruption, delay in payments and lack of referral emergency system and also multiple referrals are other core problems in the JSY scheme (Paul et al. 2011).

It is reported in one of the study of Iyenger et al. (2009) on JSY that the cause of maternal mortality in India is hemorrhage followed by anemia, sepsis and other causes. But it is observed in the study of Rajasthan, anemia alone contributed 24% of all mother's death in only one hospitals during the study. Tuberculosis, malaria were other reasons which were also responsible for maternal mortality. The main target of JSY is to reduce maternal and child mortality by increasing and promoting the institutional births. In this scheme, there is provision to given the cash incentives to the mothers for bearing institutions expenses, transportation cost as well as for food.

But it has been observed that families have to bear hospitalization charges, purchase of the drugs, and hire the transportation at their own risk and most of them take loan at high rate of interest. The lack of liquidity has become core reason for women's death. As it has been seen from the various studies that in most states there is a higher utilization of private institutions but in Rajasthan it is low. They use private hospitals for antenatal care or some other reproductive related problems and use the public hospital for birthing. The findings also show that there is shortage of basic amenities in the government (SCs, PHCs, CHCs and FRUs) institutions as well as insufficient number of staffs, blood banks and drugs which people compel to bear from their pocket (Iyenger et al. 2009).

Effect of the JSY scheme on institutional births

Though the scheme reported the raising of institutional births, but in the economically deprived area, cash incentives could not see its magic as it is hard to move the women to the institutions for giving their child birth because of the various reasons such as loss of wages of care giver during hospitalization, distance of hospitals, non availability of transportation and poor quality of health services at government hospital (De Costa, 2009).

Khan et al. (2010) conducted a study on the impact of Janani Suraksha Yojana in Uttar Pradesh showed that the ratio of women received at least three ANC checkups had increased in the year 1992-93 (19.2%) to 2008-09 (34.4%). But despite of this fact there is also other side of the picture that still huge number of women about sixty six (66%) percent who had not received the last three ANC checkups (Khan et al. 2010).

Another study showed that there was an incremental increase in institutional births. About seventy six (76%) percent deliveries took place within the JSY scheme. The reason reported were most of the families were near to the house (44%) and only seventeen (17%) people reported about the availability of good facilities in the institutions. The analysis also showed that the women, who belong to the general caste and above poverty line, selected private hospitals or nursing home. The reason they stated were they were familiar and comfortable with the medical staff of the private institution and also opined that private institutions was meant for ladies belonging to upper castes. The remaining twenty four (24%) percent had home births because there was lack of transportation. Unavailability of transportation was the

biggest barrier of institutional births in the study and second was that mother felt that previous deliveries were easy and therefore there was no need to go to hospitals. So it is found that there was an important program uptake with a large number of women had delivered baby in the hospitals. However there were some problems which complained by the women who had delivered the baby at home. If the difficulties they have (women) faced include in the scheme, than it is beneficial for the scheme and increase the efficiency of the scheme as well (Sidney et al. 2012).

Malin et al. (2008) have focused on the present status of JSY scheme in the Orissa State. ASHA's training which is given by the government, although it was benefited but required further training for solving the problem, faced by the ASHA during visits. Out of total sample size, it was found only half of users or non-users had knowledge of various dimension of Janani Suraksha Yojana (JSY). Most of the users complained that there were lack of transparencies in money distribution and felt also that there were lot of complications in the procedure in this scheme and that's why cash assistance of JSY was received late. Transportation problem and lack of 24 hour health services were the major problems for the patients and their families. Sometimes at odd hours, hiring the transportation was big issue for those who needed it. Therefore the authors have recommended that in the JSY scheme, there should be the provision of private and government hospital association to reduce the problems of patients as well as to reduce the out of pocket expenditure in case of caesarian section. The authors also have pointed out the issue that the procedure of JSY should be simple and card should be issued as early as possible to lessen the inconvenient of poor people (Malin et al. 2008).

Factors influencing the utilization of the health facilities

ASHA is an important part of the JSY scheme who motivate the pregnant women for institutional delivery, three ANC checkup, immunization, post partum checkup as well as counseling the mother regarding breast feeding etc. Though the selection of the ASHA is done by the recommendation of the Gram Pradhan, ANM and Angadwadi workers but still there is little transparency in the selection procedure of ASHA, because the socio-economic background of ASHA has affects on her works. It is found in some states especially in Madhya Pradesh, ASHA belonged to good family background of the village and keenness towards works for the poor doesn't matter for her. The availability of drugs kit which is provided to the ASHA is not adequate to do

her work efficiently. Though data shows that ASHA has received around 69% kits in 2009-10 year but still it is low in figure. There have been also found the differences in the quality of training of ASHA among states. There has also found the positive impact in increasing the ratio of women taking at least three antenatal checkups, immunizations, institutional births (Bajpai et al. 2009). Therefore it is better to accept her as a social activist rather than health worker to enhance her role in health care in the village (Husain, 2011).

A study from Uttarakhand showed the positive link between socio-economic backgrounds and number of ANC visits. The women who belonged to upper class had higher number (93.02%) of ANC visits than the lower middle class. The data also reflected that the women who lived in joint families had a greater percentage of ANC visits compare to nuclear families. In the case of iron folic tablets (IFA) tablets consumption according to the data of the present study, reflect the absolutely opposites result as illiterate women consumed hundred IFA tablets of the rural counterparts compared to sate level's findings (Sharma et al. 2012).

In case of cesarean deliveries, post natal checkups are higher compare to the normal births. Even in the case of cesarean, not all babies received all three checkups and this percentage is lower even in the normal delivery as well. The findings shows that cesarean baby more likely to go checkup in the private institutions while the normal baby in public hospitals. Another observation is that the poor more likely to access the government hospitals than the rich who utilize the high proportion of private one (Singh et al. 2012).

A study of Vyas et al. (2011), which was conducted in Ahmadabad city, the authors have presented the differences in the total average of normal births and caesarian section in the government, private, corporate hospitals and also in the home delivery. In this study they found huge differences within these types of hospitals. These significant differences were found mainly because of the medical expenses. In the government hospitals, there were no charges of the hospital's bills; only patients have to pay on medicines and other consumerable things, but in the home delivery the cost of the delivery were given in the cash form and even sometimes in some condition it become more expensive than in the normal delivery in the public hospitals. In the caesarian sections, indirect cost and non medical fee were found higher in the government hospitals because of the long stay in the institutes during hospitalization. The charges, which patients use to bear in the private and corporation are very high in

the normal delivery and even in the caesarian, it exceed hundred percent (Vyas et al. 2011).

Uttar Pradesh state sponsor scheme (Mahamaya Garib Balika Ashirwad Yojana)

According to the Anganwadi worker of the Tilmapur village, Mahamaya Garib Balika Yojana (MGBAY) was the Uttar Pradesh state sponsored scheme which was launched by the former chief minister 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 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).

Chapter 2

Research methodology

Introduction: This chapter will present the conceptualization, objectives, design and tools that have been used to conduct the given study. This chapter also included the Uttar Pradesh and Varanasi's health infrastructure, maternal mortality, institutional delivery etc. The village profile has also described in this chapter.

Conceptualization of the problem

Indian health policy has become a very critical issue over the last several years because of the dramatic changes in the Central Government's approach towards health expenditure. Based on the report of the global and national commission on Macroeconomics and Health (by World Health Organization in 2001), it has been estimated that the government health spending in India is much lower as compared to the low income countries. Therefore, the government has been paying special attention to boost the health care expenditure. A lot of national programmes and schemes have been launched to improve percentage (%) share of health in GDP. For instance, a new national scheme was launched under the National Rural Health Mission (NRHM) in April 2005 to increase the health expenditure from its previous level (1% of GDP) to targeted (2-3% of GDP) level by the end of 11^{th} five year plan. (Berman& Ahuja, 2009)

In India, the share of the States in government health spending is ¾ (three fourth) and any kind of fluctuation in the state health spending influences the total spending much more than the centre's. The share of the government health spending is only 0.9% whereas private share in health is around 4.8% of the total health expenditure in the percentage of GDP. Health being a subject of state, investment in health services is primarily by the state governments and it is affected by resources allocation which is provided by the centre. The budgetary allocation to the health sector during 1990s to 2000 has declined and the share of state spending on health has also declined over a period of time (Macroeconomic Commission Report, 2005).

During this period, the patterns of privatization in health sector have been increased tremendously, due to the reformation in health sector. In this period, private sector in

health care has played a dominant role in the medical education and technologies, diagnostic, manufacture as well as pharmaceutical companies etc. The consequences of the interference of the private sector in the health care services, the cost of health services has gone up and which further cause not only high OOP expenditure but also rapidly growing over a period of time (Macroeconomic Commission Report, 2005).

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).

This increases the Out of pocket expenditure and forces the patient into medical poverty trap. Approximately 32.5 million people fell below poverty line because of out of pocket expenditure in year 1999-2000. (Garg and Karan, 2009)

The studies that I have referred to, most of them have used the direct cost to measure the OOPs burden. The National level surveys like- NSSO, NFHS do not include indirect costs such as transportation cost, loss of wages, premium of insurance, food etc. If it is included in the OOP expenditure which are around more than 70%, than OOP expenditure will be extremely high. That's why there is need to include the indirect cost in out of pocket expenditures and then analyses the OOP spending burden on poor households. So the purpose of this study is to examine Out of pocket expenditure incurred by BPL households for births both institutional and at home.

Broad objective

To study the causes and consequences of high out of pocket expenditure incurred by BPL households for births in Tilmapur village of Varanasi district.

Specific objectives

- To identify the BPL households, where there was a birth during the last one year.
- To study those Government (Central & state) schemes that have financed the institutional births. To study the direct and indirect costs incurred by BPL households for institutional and home births.

- To study the quantum effect of out of pocket spending (OOPs) for births on household's consumption and treatment.

Design of the study: A qualitative research design has been employed for this study to achieve all the objectives of the study. The research design has been mentioned in table 2.1.

Table 2.1 Design of the Study

Specific Objectives	Primary data		Secondary data
	How will get the data	Whom will interview	
1-To identify the BPL households, where there have been births during the last one year.	1-From the interview of MO of the PHC 2-Anganwadi worker 3-ASHA	BPL households where delivery cases have occurred during the last one year	
2-To study the government (central and state) schemes that have financed the institutional births.			Published government reports, Micro level studies, Published studies and articles.
3-To study the direct and indirect costs incurred by BPL households for births.		BPL households where delivery cases have occurred during the last one year	
4-To study the quantum effects of out of pocket expenditure (OOPs) for delivery on household's consumption and treatment.		BPL households where delivery cases have occurred during the last one year	

As mentioned in the table 2.1, it is clear that the secondary source of data such as published reports, published article, published studies as well as micro level studies on OOPs have also been used for making the study appropriate.

Study Area

This study has been conducted in the state of Uttar Pradesh, with focus on selective village of Tilmapur in Varanasi district (See in map 2.1). It is an attempt to understand the cause and consequence of high out of pocket expenditure in BPL households where delivery has been occurred for the last one year. 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. Uttar Pradesh is the one of the most populous states in India. The total population of U.P was 166.20 million in the year 2001 whereas it is estimated to be 19.95 crore in the year 2011. There has been an increase in the sex-ratio of the state which is 908 female per one thousand (1000) male in the year 2011.However, there has been a decline in the child sex ratio from nine hundred and fourty two (942) to eight hundred and ninty eight (898) (GOI, 2011).

Health infrastructure: Regarding health infrastrucutre, Uttar pradesh is very backward as compared to other states. It has been observed that there is a huge scarcity of the health institutions as well as health personnel in this state. According to the RCH bulletin 2008 and report of the Government of India and Ministry of Health and Family Welfare (MOHFW), the current position of the subcentre, PHCs as well as CHCs are much less from the required number of institutions which are 26344, 4390, and 1097. But unfortunately the availabilty of these institutions are in the given numbers of 20521, 3690, 515 respectively. The data shows that CHCs are half in number of what the required number should be in the state. The conditions in terms of number of the doctors are very critical. The doctors and other health staffs in his Government hospitals are very less. For instance, the number of doctors at PHCs was 2001 but the requirement of doctors are in the number of 3690. Gynaecologist and obstetricians at PHCs are 135 in number as against the required mark of 618,which is

one fourth less of the required numbers in U.P. (http://www.rchiips.org/pdf/rch3/report/UP.pdf)

Maternal mortality rate: According to the Registrar General of India (based on births between 2004-06) 440 women die out of the one lakh who give birth. Though it has been decreased from previous level i.e., 517 in 2001-03 and 707 in 1995-96 but still it is very high. It is 1.52 times high from the national level (www.sahayogindia.org/sites/default/files/Maternal%20Health%20.pdf).

Institutional delivery in U.P: According to the DLHS-2 (2002-04) the percentage of the births was 22 out of which only 9% of the total births took place at the government institutions and 14% in the private. A huge proportion of the births i.e.,77% took place at home whereas according to the DLHS-3 (2004-06) the institutional births has been raised which was around 25% from the year 2002-04 and around 30% of the total births were assisted by the skilled persons in this state. But there has been variations in the safe delivery in different district of the U.P state. Around fifty percent of the districts of U.P. are below the safe delivery level of the state .(www.sahayogindia.org/sites/default/files/Maternal%20Health%20.pdf).

Varanasi is a very old city. The history of Varanasi is older than 3000 years. According to the Atharva Veda, Varanasi was connected with the river Varanvati. "Varanasi" is probably derived from a combination of the name of "Varuna" and "Assi". Varanasi is mentioned in the Ramayana and Mahabharata as being the capital of the realm of Kashi (Joshi, 1965). The city is a place of pilgrimage and a holy site for sacred bath in the Ganga River. It is considered that a dip in the holy river at Varanasi can wash off one's sins.

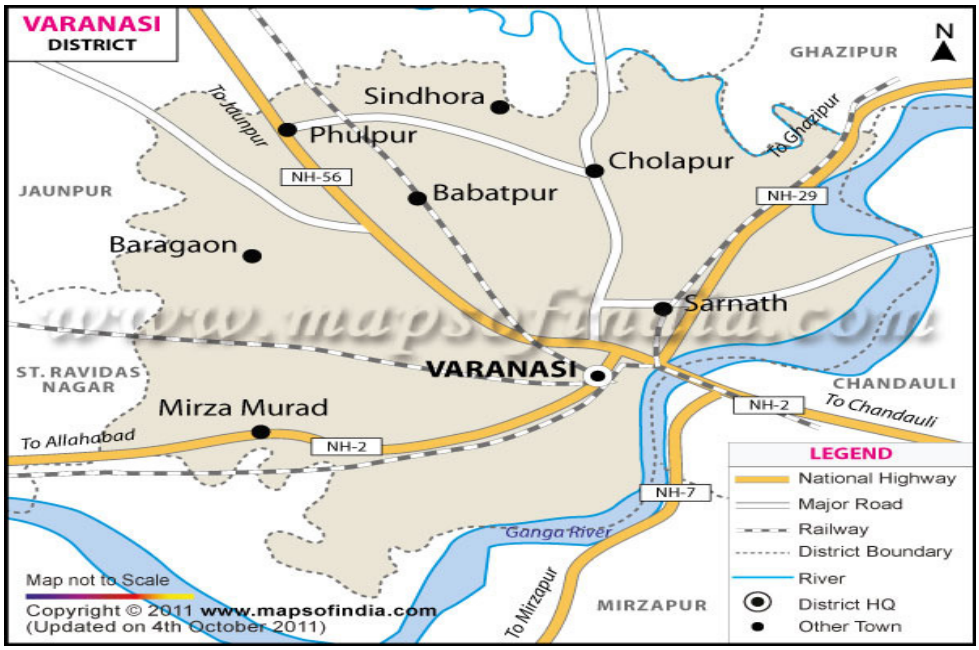
Location of Varanasi: Varanasi lies between 25'15 to 25'22 North latitude and 82'57 to 83'01 East longitude (see in map 2.2). In the city, the river Ganga flows south to North and having famous Ghats on the bank of the river. Towards the west the northern boundary of the district marches with southern boundary of the Jaunpur district for about 65 miles and the remaining part of the northern boundary towards east is contiguous with the south western part of the district of Ghazipur. The river Ganga flows between the two districts. On the south lies the district of Mirzapur (Joshi, 1965).

Health facilities in Varanasi: Varanasi city was strongly connected with the Ayurveda medicines in the beginning and the physicians and surgeons were known as Bhishaks (Vaid) at that time that generally used herbal treatment for healing. This type of medication can still be found in Varanasi district (Joshi, 1965). The city Varanasi has a number of public health facilities including the facilities of the state department of medical, health and family welfare and Varanasi Municipal Corporation, besides central government, ESI railway and cantonment facilities. There are some charitable hospitals which provide health care services at subsidized cost to the poor. In the first tier of health (Primary health care facilities), there are 21 urban health post, one medical care unit, six ESI dispensary. Along with 19 district/ joint hospital, one medical college, two railway hospitals and one for defense. In Varanasi, there are several private clinics, hospitals and nursing homes also. (http://www.nirindia.org/index.php?section=12&category=60%20%uttar%20pradesh &page=565).

Map 2.1: Map of Uttar Pradesh

Source: Source-http://www.censusindia.gov.in/maps

Map 2.2: Map of Varanasi



Source:http://www.mapsofindia.com/maps/uttarpradesh/districts/varanasi.htm

Village profile

Tilmapur village is an Ambedkar village, which is located in the Varanasi district of Uttar Pradesh State. This village comes under the Chiraigaon block. This Chiraigaon block, has eighty six villages including Tilmapur village. According to the 2001 census, the total population of the village was two thousand two hundred and ten (2,210) but as per the current Gram pradhan, it has been assumed that the recent population is more than five thousand. There were forty BPL households in 2001 but now it has been expected that more than seventy five households would come under BPL family. The total area of the village is 79.73 hectare.

Social structure of the village: This village is totally dominated by the Hindu religion. Therefore, all the villagers are Hindus, and thus people of no other religion live there.

The most powerful and dominant caste in the village is Brahmin, followed by the OBCs and Dalit respectively. The present village Gram Pradhan is also a Brahmin lady. Before her, there was a SC gram Pradhan and prior to him, there was also a Brahmin Gram Pradhan. This shows that the village is Brahmin dominated and that they are very influential people of this village. Though it is a Brahmin dominated village, some other upper caste people also live there mainly: Thakur, Kayastha and

Vaishya. On the other hand, within SC- Mehatar, Dhobi, Ravidas, Jatav and in OBCs -Yadav, Gupta, Soni, Lohar subcaste people are living in that village.

Household's settlements: The house settlements in the village vary from basti to basti. This village is categorized and separated into three colonies (basti) which are given below:

1. Brahmin colony (Brahmin Basti)
2. Rajbhar colony (OBCs Basti)
3. Dalit colony (SC Basti)

Dalit Basti is located at the outskirt of the village, whereas, Brahmin Basti is in the centre and Rajbhar Basti is located at the back side of the Brahmin Basti.

As mentioned above, the Brahmin is the dominant caste and also the most affluent as majority of them having their own agricultural lands. Most of the houses in the Brahmin colony are pucca houses, which are located in the central part of the village, from where all the facilities are easily accessible in terms of schools, health centers, medical and grocery shops, means of transportations etc. On the other hand, the rest of the two colonies (Rajbhar and Dalit Colonies) houses are mostly made up of mud and their roofs are thatched roofs. There are some concrete houses too in these colonies.

Religious establishment: In terms of religious establishments, only temples are situated there because of the existence of vast number of Hindus in that village. There are four temples in the village, out of which, two are of God Hanuman, located in Brahmin Basti; one is of Goddess Durga and one is of Daitra Baba. These two temples (Goddess Durga and Daitra baba) are in the Dalit Basti. People of Dalit basti do not go to the temple of Brahmin Basti. They generally avoid visiting Brahmin basti's temple and worship in their own temple.

Transportation services: Auto rickshaw and local buses are the main modes of transportation in the village. The Village's road network consists of pucca road, concrete and muddy roads. The transportation facilities are connected to the main Pucca road of the Tilmapur. This pucca road is about 6 and 3km far away from the Dalit and Rajbhar basties respectively whereas it is on side of Brahim Basti. Thus, the majority of the pucca road comes on the way of Brahmin basti of the village.

Water resources: Tilmapur village is being benefited with the water by the Jal Nigam, through government water resources and about seventy to seventy five (70-75%) percent people are connected to this water network. Rest twenty to twenty five (20-25 %) percent people are dependent on well, hand pump and their own sources of water. Each and every basti has its own hand pump facilities. In the village, most of the Brahmin families have their own tube well, submersible motor as well as hand pump.

Sanitation: This village has a sewage facility from Municipal Corporation. This sewage facility is provided to those people, who have toilet facilities in their houses. In Tilmapur, it is found that there are thirty percent (30%) people having toilet facilities and these facilities are mostly in the Brahmin basti. The SCs and OBCs go for open defecation.

Electricity and telecommunication services: Tilmapur has been connected to the public electricity (City Belt) network. Approximately ninety percent (90%) of the housing units in the village are connected to the network and rest ten percent has no source of electricity. It has been observed that one of the problem faced by the villagers, is the irregularity of the electricity supply.

Economic activities: The economic condition of Tilmapur village is not so good. They highly depend upon the government/ private services and MNREGA scheme. Only around ten percent (10%) people work on agricultural land of others. There are many other economics activities in Tilmapur mainly: woodwork, leatherwork, laundry work and a small number of grocery shops where people work and earn money.

Education: With regard to educational institutes and schools, Tilmapur village greatly lacks in the number of government schools and colleges. There is no government primary school but only one government high school in the village. Barely one government Inter-college named “Sampurna Nand Inter College” is running there. However, there are five private schools, in which, two are girl secondary schools, one is for boys and rest two are nursery co-education schools and these private schools are situated in the new colony of Tilmapur. In addition to this, it has been observed that, no infrastructural facilities are provided for Angadwadi centers and this center has been running in the empty space of the village, especially beneath the shades of the trees.

Health services: Tilmapur village has some 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.

The condition of the health infrastructure and health facilities in the village

Like every village, in this village too PHC is located at a distance of around six (6) km. in Chiraigaon block from the village Tilmapur. This PHC covers eighty six (86) villages (including this village). Based on my field visits, it was also observed that there have been shortages of human resources. Though two doctors were posted, there was no ANM or trained dai at the PHC. Only one untrained dai attends to many deliveries in the absence of ANM. After interviewing the doctors at PHC, it was revealed that there is a pathology centre in the village but rarely a diagnostic test would be conducted there because of the lack of necessary equipments due to which patients have to go to private for the diagnosis of their illness. As per the norms, every PHC should have one male and one female health assistant but in the Chiraigaon PHC, laboratory assistant is doing the work of health assistant too. In case of transportation, PHC does not provide any transportation facility. One ambulance is there which is only used for the doctor's field visits. Lack of punctuality of the doctors posted in the PHC is another issue due to which villagers face a lot of problems.

The condition of the sub-centre which is the first contact point between PHC and the community is also not good. As we know that there is a provision of providing free medicines and drugs for minor ailments, but it was found that there was a lack of essential drugs and medicines at the CHC. ANM is not available every time especially during the nights.

Community health centre (CHC) which is the topmost tier of the health centre and referral centre of the PHC, is not functioning in the village. Patients are usually referred to the district (Pt. Deendayal Upadhya and Kabeer Chaura) hospitals from the PHC, whenever necessary. Though the building of CHC has been made at the distance of 15 km from the PHC but it does not function.

Less number of health personnel and lack of health facilities in the public health institutions and absence of government hospitals in the village is the prime cause of rapidly expanding private health institutions, private clinics and hospitals in the last four-five years in the village which is too costly to afford for the poor. These private institutions are providing the large number of health services for both outpatients as wells inpatients.

Sampling and tools for data collection

For this study, purposive sampling has been used. This sampling method is used because the research targets all the 22 (twenty two) households which had deliveries during last one year. These twenty two households include seventeen institutional and five home deliveries. In the Purposive sampling, researcher did an in-depth investigation to gain deeper understanding of the problem.

Firstly, the researcher met the Gram Pradhan and collected data. She (researcher) also met the MO of the PHC and gathered data, which was further cross checked by conducting interviews of various other key informants such as Angandwadi workers, ASHA etc. All the 22 interviews that were taken were in-depth, out of which 13 were institutional births at PHC, five home deliveries and 4 private deliveries. These interviews included, respondent's socio-economic background, their living and working conditions, experiences and costs of hospitalization which they bear (doctor's fee, drugs and diagnostic test fees, bed charge etc) as well as other indirect charges during hospitalization such as, loss of income, accommodation, boarding and lodging cost etc. To understand the socio-political condition of the village, the researcher also interviewed the caste leaders and the former Gram Pradhan. She also consulted local money lender who provided loan to the BPL households for their delivery in the village.

Methods

All twenty two households were interviewed by in-depth interview with the help of a schedule.

Data Analysis

In this study, in-depth interview were taken from the respondents and the key informants. It has also been recorded with the help of a recorder. Then all interviews were translated and transcribed from Bhojpuri, Hindi to English language. On the basis of translation and content analysis, the key issues were identified. Some findings were arrived after a rough calculation on OOPs on households' consumption.

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.

Chapter 3

Experiences of institutions and home births among households below poverty line in the village

The present chapter aims to highlight experiences of the women who had delivered in institutions and at home. It examines the various targeted conditional cash transfer and insurance schemes that have been introduced by the State and the Central governments. In addition, it focuses on quality of service, reimbursement of funds, direct & indirect expenses for child birth and the behavior of providers in the health services.

Through in-depth interviews primary data was collected to meet the above mentioned objectives. This information was used to assess advantages of conditional cash transfer schemes which have been implemented in Varanasi district.

Our study shows that there are several schemes initiated by the state and the central government. These include the Janani Suraksha Yojana initiated by the central government and the Mahamaya Garib Balika Ashirwad Yojana by the erstwhile government. It is well known that the overall cost of institutional births in the public as well as private sector is very high (Ray et al. 2002). Therefore, some conditional cash transfer schemes, like JSY have been launched in the state for improving and enhancing the efficiency of delivery cases in government hospitals. In order to successfully implement these schemes, regular check up of patients is carried out as it improves the health indicators and working conditions of the poor.

In this study, when the researcher asked patients about the schemes and their experiences with PHC at the time of birth, most of them complained about the insufficiency of the amount given under JSY (Rs.1400). Reason quoted for this was the commission which is to be given to the health care attendants for using their services.

Study points out the fact that several schemes are not managed well and working inappropriately in government hospitals, under which BPL patients get free-of-cost treatment including drugs, ambulance, good quality of diet etc. Poor patients have to buy their own medicines as drugs are unavailable in hospitals. Ambulance is

inaccessible to the villagers because the village is located in very interior areas and this ambulance facility is accessible only for those villages, which come within the range of two kilometers, but it is easily available for Gram Pradhan of the village or politically strong people of the village. Thus patients are compelled to arrange a private vehicle. Patients get disheartened too, as many a time doctors do not examine them properly due to the lack of appropriate facilities and long queues. Thus, people are unwilling to visit government hospitals as doctors are either not available on time or are non co-operative.

In the following section we present case profiles of women who had availed the benefits from the schemes for institutional births and the direct and indirect expenditures incurred despite the scheme being in place; the quality of interaction between the provider and beneficiary.

"Chanda Devi, 25years old, who belongs to the Dhobi sub caste, was admitted to the PHC for her child birth. She went there along with her husband and ASHA. Her husband hired an auto rickshaw, which charged him Rs 200 to reach the PHC. This was because the ambulance could not reach the village and mostly it was used for doctor's field visit. She further told, the cost of the delivery was around Rs.2000, and she got only Rs 1400 which was inadequate to bear all the expenses of delivery charges. At the time of her delivery, medicines were also not available and thus they had to pay for medicines from their own pocket. They also had to pay charges to other staff as well, such as to ANM, ASHA etc. Even after her successful delivery she had to stay with her husband for an extra day in the PHC. ASHA also stayed with her and her husband had to spend additional Rs 30-50 for ASHA's food. Because of staying for one day extra at the PHC, her husband's job got affected, as he was a daily wages worker. Overall, they faced lot of problems in terms of money expenditure. Due to her above mentioned experienced, she is convinced that home delivery is a better option if there is no complication".

Based on in-depth interviews with all the women who had delivered during the last one year in an institution and at home, we present our findings across selected themes.

Casteism

In Tilmapur village, BPL cards are given to those who belong to certain social group. All BPL card holders are either Schedule castes (SCs) or Other Backward Class (OBCs), except one family belonging to the general category, who got a card by special request, since their economic condition was very weak. Usually, cards are not given to upper caste people even if they desperately need it on account of their poor economic conditions. Villagers have imbibed this fact that cards are meant for lower caste people only, no matter, whether upper caste people too, can come under BPL. Thus, it has been observed that only lower caste holds the cards. Although this caste system is hereditary in Hindu religion, which restricts the occupation of their members and affects their daily lives. Lower caste people also suffer from discrimination by upper caste society. A recipient of BPL card belonging to the lower caste group shared about his experience of discrimination by the Gram Pradhan, who is a Brahmin:

> *"When Gram Pradhan was making the list of BPL card holder, she asked me a number of times that are you from this village? From how long are you living here? Oh yeah….. You live in dalit basti, which is located at the outskirt of this village. That's why I (Gram Pradhan) didn't recognize or remember you. As, she knew everything about me like where and which place I live and from how long, then why she was asking me these questions repeatedly?* (Basant Kumar, 29, SC; 8 January).

(Jab Gram Pradhan BPL card banawat rehalin, tab hum logan se pachas baar puchale hoin ki tu logan yahi gaon ka hauwa. Accha tu logan us harijan basti me rahela na, waha hum jyada jaila to nahi aehi liye yaad nahi ba humke tu logan. Jabki ou (Gram Pradhan) sab kuch janat rehalin humre bare me ki humlogan kaha se hai aur kab se ee basti me rahat haee.)

Another woman also faced such discrimination and said that, the former Gram Pradhan had cut their name from BPL list.

Saroj has seven members in her family. Her husband Rakesh is the sole earner in family and works in a laundry in Surat. Earlier they were BPL card holders, as Rakesh's monthly income was Rs. 3000 which was insufficient for his family's

monthly expenditure. Her father-in-law too used to work in a small factory as a weaver, but he got paralyzed due to sudden attack and he stopped working. Thus, they started facing financial and other problems.

"Without any prior intimation, former Gram Pradhan cut their names from the list. The reason behind this was that Saroj and her family were dhobi by sub-caste and former pradhan, was Jatav, who believed cards were meant for Jatavs only. As Saroj has no BPL card, she used to buy ration from market which has drawn her into more financial crisis". (Saroj, 35, SC dhobi)

Bimala who is SC by caste related her experience with a Thakur lady:

"Once a Thakur women went to her house for woven rope on a wooden bed to earn money. Bimala offered a glass of water to that Thakur lady, but she refused to take it. After a moment that Thakur lady went outside of her house to take water from the hand pump to satisfy her thirst".

From above incidents one can see that lower caste people get discriminated by upper caste people, despite being of a better economic status.

Within the SC sub-caste, Mehatar sub-caste people suffer a lot of discrimination by the other castes as well as the same caste. People in their surroundings do not want to interact with them. People hate to eat in their houses and do not even like to be invited by them for any festival, party and marriage etc. They live in isolation in their own village. Thus we can see here that there is also a hierarchy within the Schedule Caste group.

Income

Income plays a dominant role in villager's health seeking behavior. BPL card holders, who are little economically better, do not prefer government hospital for their treatment. According to them, the quality of service is poor and they have to pay additionally for the treatment, so they prefer to go to private. In the study, it was found that most of the people treat themselves with home remedies. For major illness except delivery, they prefer private hospitals. Specifically, they opt for the government hospitals for delivery as they are aware of schemes (JSY, MAGBY etc.) which provide some financial security to them for their children's future.

In conclusion of the above, within BPL cardholders, who are in better condition usually, prefer to choose private hospitals.

In village, most of the BPL card holders are daily wages laborers. They earn in a range of fifty to three hundred rupees if they get job. Some time they become jobless and face a lot of problems to feed their families.

MNREGA, is a unique policy introduced by the state government for providing employment to poor people of rural area. Under this act, the government is legally bound to provide jobs to unskilled local villagers. During field visit, researcher found, majority of poor's were unemployed despite being MGNREGA in place.

Nakhadu a 32 year old man, belonging to the Ravidas by subcaste, narrated his experiences with MNREGA. He said:

> *"I used to work under MNREGA some time back, but the administrative officers of the program were very corrupt. I was frequently either not paid or half paid for the work done. My brother in law was unemployed and willing to work under MNREGA but the officials use to force him to pay some money or give bribes for getting job. That's why he is jobless, since there is no money to give to the MNREGA officials".* (Nakhadu, SC; 12 January)

Places of birth

In-depth interviews revealed that people select the place for birth based on their previous experiences, knowledge or convenience. In Timalpur village, during the past one year, there have been twenty two live births. . Out of 22, eighteen were institutional births. Five were in private and thirteen in government facilities. The remaining four were home births. These births were conducted with the help of ANM and ASHA, as there were no Dai in the village. They lived in the same village and hence could easily attend to delivery cases. The PHC was situated 5.2 km away from the village while private hospitals were located within the range of 2 km which led the villagers to opt for private institutional birth.

"When I was having labor pain, I went to the primary health centre with my mother. After my formal check up, the doctor said to me that I still have to wait for delivery as right time hasn't come yet. So, we went back to home. An hour after we reached

home, I again started getting severe labor pain but this time my mother had decided not to go to the PHC, as it was located 5.2 km far from my home. So, she called ASHA and thus, the delivery was done at home."(Sharda. 21 year old; 15 January)

Experiences with institutional birth

Comparison of Doctor's Behavior in PHC, District & Private hospital: According to the villagers of Varanasi district, PHC's doctor's behavior in comparison to district hospital is good. At the PHC, doctors listen to their patient's problems politely and calmly. They provide them with proper advice and consultation as per their disease.

In district hospitals, doctor's behavior is completely unbearable. They never pay proper attention and care to their patients. They become silent and rude when patients ask questions related to their problems. Sometime they even scolded them for their questions.

In private hospital, doctor's behavior varies according to the patient's standard of living. If patients belong to an economically well off family, then doctors take them as first priority and devote all their time and attention for their care and treatment. If patients, who cannot afford bill and hospital charges, approach doctors for concession in the bill, then doctors' becomes very rude.

Hari Prakash shared his experience with researcher about refusal to his wife's operation due to insufficient finance:

"He took his pregnant wife Radhika to the private hospital with severe labor pain. After the doctor examined his wife, he told him, that his wife should undergo for cesarean and instructed him to first complete all the formalities (including paying charges) only then she will start operating his wife. As he enquired to the concerned hospital staff about the formalities and charges of operation, he came to know that the operation charges cost Rs. 8000, but he had only Rs.6000 with him. So he requested to the staff to start the operation with Rs. 6000 and rest of the money will pay after the delivery. Staff refused but advised him to consult the doctor. If she agrees, then only, they admit his wife. As per staff's suggestion, he went to the doctor to request her for the same. But the doctor was completely against this, angrily scolded him in spite of his repeated requests; and later directed him to take his wife to another affordable hospital (Hari Prakash, SC; 2 February)".

Experiences in a public hospital

Quality of services: In the public hospital, the quality of services is very poor with regard to water supply, equipment availability, cleanliness (in terms of hygiene and sanitation), nurse support etc. As per one woman who underwent delivery in a government hospital, doctors' unavailability and lack of punctuality was the big issue to deal with. Majority of people believed and experienced better facilities and services in terms of doctor's support in a private hospital as compared to a government hospital. Though private hospital costs more in comparison to the public hospital but their quality of service is quite appreciable.

Corruption: In due course of the study, researcher found that bribe plays a vital role in availing benefits under the government schemes (JSY and MGBAY) as well as getting patients' admitted into hospital. Villagers are mostly deprived of these schemes whenever they failed to pay money.

People reported to have to pay bribes to ASHA, Angandwadi worker, Gram Pradhan, village secretary etc., for availing benefits guaranteed under above mentioned schemes. One poor respondent Meera Yadav, 26 years old, who failed to avail MGBAY scheme due to the lack of money narrated to the researcher about her experience:

"My husband is a daily wage worker who used to drink daily. When he failed to earn money due to unavailability of work, then he used to sell some home's articles for his drink. At the time of my baby's birth, my husband was not working. Somehow we managed to afford charges of ASHA and other attendants but we failed to arrange Rs. 500 for MGBAY scheme for my baby. We requested Anganwadi didi to pay later but she refused and said "We too have to give the commissions to the higher authority for further formalities, so until you give the money, we can't do anything for you regarding this scheme." My husband doesn't allow me to save money. Sometimes I managed to save, but somehow he gets to know and snatched it from me for his drink. 5months have been over and still we are unable to arrange Rs 500 and get the benefit from the scheme." (Meera yadav, OBC; 18 January)

(Didi humar aadmi roz ka khudara kaam karelan. Jab koi kaam na milat unke aur unke paas paisa na rahela peene (sharaab) ke liye tab wo ghare ka saman bech kar pi

jaayelan. Hume baccha hoe ke samay per, unke paas koi kaam na rahel. Jaisan taisan karke humlogan thoda paisa ikattha kar le las rahali jo ki ASHA aur sab ke aspatal me de kar khattam ho gal rahel. Humre paas itna (500) rupaya na ho ki hum Angadwadi didi ke de saki taki hume bhi balika yojana wala scheme mil sake aur upper se humar aadmi itna piyelan ki kuch bhi na bach pavat hamare paas).

Ram Prasad, 28 years old, Ravidas by subcaste had to pay bribe to get his wife admitted to the hospital for her delivery. Entire experience as shared by him is stated below:

"Rita suffered from labor pain in a cold midnight of winter season. Her husband faced a lot of problems in order to admit his wife. First, he failed to get transportation facility immediately, but fortunately, after an hour of his continuous search, he found one rickshaw in which he took his wife to PHC. Second, doctor declined to admit his wife as he declared it a complicated case of twins after examining her. He advised him to take her to the district hospital which was very far from the PHC. Third, he doesn't have any transportation facility at that time as well as his wife's condition became more critical due to severe pain. So, he requested and begged to the doctor and then ANM for his wife's delivery. Fourth, at last he paid a bribe of Rs 200 to ANM who later insisted doctor. Upon ANM's request, her wife finally got admitted in the PHC for her delivery". (Ram Prasad, SC; 7 February)

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 (Rashtriya Swasth Bima Yojna), 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.

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.

"Munni was a diabetic patient who took her pregnant daughter Kalavati to the district hospital for her child birth. She stayed with her for a week there, as she had a caesarian section. She told that the sanitation was the major problem of that hospital. Because of diabetes, she used to go for toilet in every short span of time which later led her to a urine infection. In this way, she came back home with another health complication".

Direct and Indirect expenses: 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)

Choice of institutions: In the village, the researcher had found that, most of the villagers prefer to go to private hospital for major and minor ailments. They have conditioned their mind that the government hospital doesn't provide better health services and treatment. They preferred government hospitals only for their normal birth but for rest other ailments they chose private institutions. One of the patient's husband Pancham who belongs to OBC, shared his experience of opting private in place of government hospital for his wife's delivery, is described below:

"He admitted his wife into the private hospital, as he lost trust in the government institution. His first child was not safely delivered at PHC. The death of his child occurred during the birth and this is the main reason for his loss of faith. Thus, he took his wife into a private institution where his second child was born. His second girl child was totally fit and fine which further strengthened his belief in private hospitals. He then stated that he is an illiterate who can't read and understand and if government hospitals give wrong or expiry medicines then he can't do anything. Therefore, he believed private hospital treated well and properly as they charge for the whole treatment".

Researcher also encountered that casteism too plays a vital role in the choice of an institution. The majority of upper caste people preferred to choose private hospitals for their treatment as well as for delivery, as it was a matter of reputation and ego for

them. Upper caste people have a belief that government hospitals are meant for lower caste people only.

This study also reveals that even the lower caste people from BPL households also wanted to opt private in place of government hospitals, if they have had money. Villagers were aware of some schemes which state finances in the form of cash transfers to patients who give birth in the government institutions. Therefore, only for delivery cases villagers preferred government institutions.

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 autorickshaw. 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 subcaste 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)

(humlogan ke ghare chahe koi mar hi na gail hoi koi, har haal me humlogan ke har guruwaar ke thik saade saath baje paisa leke pahuche ke hi padela aur agar samay se na pahuch li to ajaiyan takada kare).

Syama Devi's son Ajay, whose net daily income of INR 250-300 with a rented autorikshaw 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.

Experiences with home birth: In the study, 4 months ago one lady delivered her son at home. Researcher asked her "why she did not go to the government hospital for her baby birth where several facilities and schemes were available for poor like them."? She replied-

"All my five children were born at my mother's house with the help of Dai. All five children were fit and healthy. The dai who helped to delivered the babies was an expert, familiar and trained. She was doing this profession from a long time. The good thing was that, whatever she was given she happily accepted. According to her, home delivery was very convenient. My delivery and stay at home helped me in looking after the rest of my children. My husband's job also did not suffer and he earned money on daily wages. I believed that the schemes which have been implemented in the government hospitals are meant for convenience and these are on papers only. The fact is that, one needs to pay for their services at any cost no matter whether it's in private or government hospital." (Malti, 32 years old, SC)

(dekha humar paancho bacchan ghare per hi paida bhail rehalan, dai ke madad se, sab thik thak hauwan. Dai bahut hi pehale se ei kaam karat hai aur kaafi jankaar hoilin aur sabse acchi baat to ei hola unke saath ki unke job hi de dila wo le let hain chahe u ghar ka ration hau ya bhir purana kapada. Ghare per baccha howe se, aur bacchan ka bhi dekh bhaal ho jaaye la aur humre aadme ka bhi kaam bhi nahi chutela. Sarkar jitna

bhi scheme chale ye sab khali paper per hi reh jayela, hum gariban ke to paisa dew eke hi padela chahe wo sarkari ho ya private aspatal).

> Usha, 21 years old OBC, has delivered her child at home, as her moth-in-law didn't send her to the hospital. Upon enquiring with her mother-in-law, she stated "I don't believe in government deliveries as there is no privacy and in addition to this, we either need to carry or arrange all the required materials (like blade, soap and clothes etc.) for delivery which I have already experienced during my neighbor's daughter-in-law's delivery. Thus, I completely believe in home delivery and my grand child who was delivered at home is fit and fine now and moreover it saves our money and time. "

(humke sarkari haspatal pe bilkul bhi bharosha nahi hau, kahe ki sarkari haspatal me koi bhi gopniyata hi nahi rahela, koi bhi aaye-jayela. Aur waha per jab saara saaman jaise blade, saboon, kapada sab apne aap hi se lekar jay eke padela aur paisa lagave ke hi padela tab ka jaroorat hau haspatal me jaaye ke).

Thus we can find that there are various reasons, because of which people suffered a lot and that is why people opt for the home delivery.

This chapter has drawn attention towards various health care and insurance schemes launched by government for the betterment of underprivileged's health. These schemes have proved to be of benefit to few, as most of the time, they are not fully aware of such schemes. Sometimes in spite of being aware of particular scheme they do not get the benefits because of innumerable paper formalities and lack of money to be given as bribe to service providers. OOPs of households of rural areas, has grown up day by day. Indoor and outdoor treatment cost also gets increased due to the continuous rise in privatization in health services like doctor fees, medicines, diagnostic and other miscellaneous (Duggal, 2005).

Chapter 4

Discussion and Conclusion

A number of empirical researches on out-of-pocket expenditure have focused on the direct cost of accessing health care and have given a number of suggestions to reduce these direct expenses. But in this study, the researcher has attempted to study the indirect expenditure incurred on institutional and home deliveries. According to this study it is estimated that indirect expenditure incurred by poor households accounted for around thirty percent of the total medical expenditure.

Despite the efforts and initiatives of the Government in India, it has been found that scarcity of basic facilities continues to be widely prevalent in government hospitals leading to increasing dependence on private facilities. There is also evidence that majority of government hospitals are largely underfunded. The lack of human resources such as doctors and staff and irregularity and unpunctuality is another big issue in public hospitals (Macroeconomics Commission Report, 2005). Apart from inadequate infrastructure and human resources, irregular drug supply compounds the problem. My study showed that around ninety five percent women who had institutional births had purchased the drugs from a chemist located just outside the hospital and paid for it out of their pocket. It was also seen that the chemist shop had links with the doctors in the Primary Health Centre (PHC) based on commissions. Based on interviews with patients, it was clear that they had to buy expensive medicines from a private chemist because of the shortage and unavailability of the drugs in the public hospitals. In addition to drugs, other facilities were found wanting in basic diagnostic amenities at the primary health (PHC). This resulted in patients being referred to private facilities for diagnostic testing.

From the study, the researcher found that most of the women who had delivered in institutions during the last one year, had taken loans from a private money lender (Micro - Finance Company). These micro finance companies provide money especially to poor women in order to generate income. Loans are given to the women for enlarging their business which is profitable for the company but detrimental for the woman who has to borrow. This leads to negative consequences on her living conditions, food security and the education of her children. The promoters of the

company argue that by lending money to these poor women they are actually helping to prevent poor households from a catastrophe. According to the respondents, when people require money urgently for any emergency which their neighbors/relatives are not interested or willing to provide them on time, then they have no other options except to take loans from micro-finance companies which they think are more reliable and affordable. But the rate of interest is not as low as poor innocent people think. The researcher found that interest rates of these types of finance companies is around 4% monthly (Source: researcher) which is a not small amount for the underprivileged. As we know that in India, there is still around thirty two point five (32.5) million people who are under the poverty line (Garg and Karan, 2005) this kind of interest rate is unreasonable and unaffordable for them. The reason people trust these companies are that a big amount is easily available without too many formalities. Poor access to formal finance is another reason why the poor prefer the micro finance companies. The villagers have to face a lot of difficulties in accessing the organized bank since they have no savings and also face difficulties in understanding the formalities of bank and future risk such as illness, accident etc. The coverage of the government insurance schemes is very poor and has little positive impact if any, the vulnerable, to avail health services. The non co-operative nature of higher authorities such as Gram Pradhan and Secretary of the village combined with huge formalities of the schemes is another cause for non -accessibility of the insurance schemes. It was found that some of them have no knowledge of the schemes and other few names were not updated in the BPL list. Thus for bear the delivery cost as well as hospital expenses they were highly dependent upon the micro -finance companies. These types of unorganized finance companies are very dominating in the rural areas and through these informal finance agencies poor people meet their health expenditure, whose reliability and validity is in itself a question mark.

The findings show that utilization of the health services is usually dependent upon the quality of services, accessibility and ability to pay or affordability of the people. There are lot of factors which have an impact on the perception and needs of the people with regard to medical care and facilities. Accessibility is the one important problem in the health services of the rural people. Unavailability of government hospitals in rural areas forces poor people to use private facilities. Around seventy five percent (75%) poor people use private sector facilities due to the lack of

government institutions, poor quality of services, inadequate drugs and medicines and rude behavior of doctors towards poor patients in public hospitals.

With regard to the choice of hospitals, this study shows that high socio-economic status people opt for private hospitals whereas those belonging to the lower economic class use public hospitals, where no or less charges for the treatment. It reveals that there is strongly association between particular types of health (private and public) facilities and socio-economic condition.

Medical expenditure is another key issue of the health services in the government hospitals. It is found that poor people have to pay in the government hospitals despite the fact that the government has been running lot of schemes for the poor, for instance JSY, RSBY, MGBAY etc, under which there is provision that poor people will get treatment without any charges. But it is found in most cases, patients spent money from their pocket for the treatments. It indicates that, these schemes and programmes are not working properly and due to this patients have to bear the expenses, for which they borrowed money through loans, selling their assets and securities. Under the JSY scheme, there is a provision that mothers stay in the hospitals for at least 48 hours post delivery but the researcher observed that due to the increase in institutional deliveries, doctors discharge the mothers after some hours of delivery. This duration of the stay in the institutions remains a cause of concern.

My study shows same finding as Narayana (2008) study shows. Unofficial or informal payment (bribes) to personnel in public institutions for the utilization of health care is very prevalent. These informal additional payments make the health services unaffordable especially for the poorer households. In the public hospital it is compounded by the high expenditure on drugs/medicines as well as tips which are given to the various health staff and members of the hospitals for their services. It is then quite apparent that the provision of the free health services is not completely free as the vulnerable group has to pay for the seeking treatment from their pocket. This has negative impact on the vulnerable group of people. These difficulties (direct and indirect cost) are the major reason which people turn towards for home delivery.

The findings of the study also indicate that almost all households suffered a lot due to the catastrophic health payment which further negative effects on their living conditions, their consumptions, children educations as well as adult's treatment.

My study reveals the same findings as the study of Bonu et al. (2005) which based on the analysis of NSSO data, noted that poor households are more likely to face the catastrophe compared to others. Rural agricultural and daily wage labors have higher probability to be trapped in catastrophe net and it is also high among SC and OBC as compared to upper caste people. In the case of inpatient care people have greater chances of catastrophe. Those who are poorer, have low possibility of catastrophe because of their low ability to pay for medical care (Bonu et al. 2005).

In economic theory it is well known that the goods or services which are costly will not be purchased by the consumer because of the expensive cost. There is a negative relationship between price and demand. But in the case of health services it is totally the opposite of the above. . When person falls severely ill, they immediately go for the treatment without thinking of the cost of the treatment. This is because medical care differs from other commodities. The rational choice of the consumer does not work in this case because of the vulnerability that is produced because of ill health in an individual. As a result, even in the case of inadequate money, they take loan from the various sources to avail medical care.

For the food security, the government has given a facility of Public Distribution System (PDS) for the below poverty line. In this scheme poor people get the ration at a cheaper cost and a fixed amount but the finding emphasizes that, more than seventy percent of the total beneficiaries of the BPL card holders suffered from the corruption in this department also. The providers do not distribute the real quality and quantity of the ration. Providers generally buy the ration and thus feed their family.

A similar problem is faced by the poor with the MNREGA scheme as well. This scheme is also for the unemployed poor, where the laborer gets the wage daily for their daily work. But this scheme is also misused by the higher author authority (Gram Pradhan, officers of MNREGA) as they make fake entries of working days and keep the money for themselves. The worker does not get full wages or is half paid by the officers and this is another problem.

Experiences with the targeted schemes for institutional births: The study shows that to deliver a child in the institution is not an easy task for anyone and it is more difficult for the poor. However, central as well as state governments have sponsored many schemes (JSY and MGBAY) to reduce the burden of birth cost but these

schemes still pose many challenges. For instance late payment of JSY and MGBAY, unavailability of drugs, inadequate accessibility of doctors, lack of transportation etc factors make it problematic to access and for these various reasons women still prefer home birth in spite of government financial schemes. The cost of caesarian section in the private hospitals is beyond the reach of poor households and hence they have to arrange money from loans or end up selling their assets to fulfill their medical needs.

The findings also demonstrate that, in the rural areas, those who suffered a lot are lower castes, i.e. scheduled castes or other backward castes. They face discrimination in availing various services which is actually meant for them. They are still discriminated by the upper caste of the village, despite the government talking about equality. Contrary to the claims of equality, these castes face discrimination and have hardly got any services without being targeted by the upper castes.

Income and caste are very important components which determine the choices of institutional delivery. The higher income as well as higher caste group people prefer, institutional delivery, and often have a choice of which private institutions they prefer whereas the low income and low caste generally opt for public institutions, but it is found these lower caste people had bound from their income therefore they have opted for the public. Otherwise most of them were in favor of private institutions.

The findings show that the women, who have delivered babies in the government hospitals, have not taken the full coverage of immunization and have also not taken the complete doses of iron folic acid tablets. The ASHA also complained that these necessary drugs and injections are never available in the PHC. Therefore she does not give these complete doses to the pregnant lady.

Usually, the mother should take rest after delivery, which is called confinement period. This confinement period is a time in which the mother and baby are protected from various infections and it helps the mother to recover from the tiredness of child birth. This confinement period usually depends upon the various regions. In northern parts of India, this period lasts about 45 days in which mothers are restricted to stay at home. Mothers are given body massage regularly. But in the study, it is found that poor women, who had delivered baby, returned at their work after a week from their delivery due to the loss of daily wage if they don't work after delivery.

The present study indicates that the differences between the cost of public, private and home births are significant. For normal births, the cost of drugs and fee of Dai is the main components for which, the patient has to pay. The researcher found that this cost lies between the range of Rs. 500-1000 while in government hospitals, medical cost alone constitutes the major part of the expenses for normal births. In a few cases these expenses are less than the home birth cost. In the private hospitals, direct cost such as bed charges, medicines cost, doctor fees, diagnostic test etc are higher than the public hospitals for normal delivery. The indirect cost such as a loss of wages of the patients as well as care givers, transportation cost, commission to the staff, expenses on the food on the mother and other persons who stay with her for look after during hospitalization are almost same in the normal delivery whether in the public or private. But in the case of caesarian, it is found that, indirect costs are also high. As it is known that in the Caesarian Section, the mother has to stay a longer period of time in the hospitals. The other family members also stay with the mother to look after her. Therefore indirect cost especially loss of income increases.

The result of my study endorses the findings of the study carried out by Worrall et al which shows that indirect cost is regressive in nature and therefore, is a greater burden for the poor as compared to the rich. It means that the burden of indirect costs of delivery has a greater negative impact on the poor compared to the rich. While the direct cost is dependent upon the patient's socio-economic conditions, it has been observed that people from higher economic groups generally opt for the private hospitals while on the other hand poor people prefer the government hospitals and thus the direct cost of the medical care is progressive in nature. This study also found that the vast majority of births have occurred in the public institutions because the PHC was located within the range of six km and majority of the villagers were aware about the schemes sponsored by the government. But majority of them were not satisfied with the schemes and facilities which were provided in the government hospitals due to the lack of hygiene in terms of toilets and cleanliness of the ward, drinking water facilities, availability of drugs etc (Worrall et al. 2011).

Those births who took place in the private hospitals were caesarian cases or those who had bad experiences in the public hospitals. Few caesarian section deliveries were referred to the district hospital by the PHC located around eighteen to twenty (18-20)

km. Therefore, they had to go in the private institutions because of the private institutions were located closer to their homes.

There were no complications or maternal deaths found among the reported home births. Some issues though such as lack of antenatal checkups and lack of formal institutionalized training of Dais were noted. Yet, these Dais were doing their job in this field from the long time and women have faith on them.

Conclusion

The finding of this study has demonstrated the link between class, caste and choice of institutions for delivery. The study shows that the choice of institutions for births is highly dependent upon the financial status of the patients. From the analysis it is seen 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.

Suggestions

Based on this study I wish to highlight the importance of factoring in the quantum of indirect expenditure incurred by households while seeking medical care. Therefore it

is important that indirect cost should be included in health related economic evaluation. This would be important to estimate the economic burden of medical expenditure for poor families. In general it is identified that direct cost of the delivery is high but indirect cost is not negligible because it constitutes a considerable amount of the total expenditure incurred for institutional delivery. Therefore it is important that policy makers need to take steps regarding indirect expenses of poor households. We suggest that the government should generate resources for the poor to protect them from incurring debt and reduce the financial difficulties as well as burden due to medical expenditure. It is inferred from the study that the poor have trouble in accessing loans from the government. As a result they have to depend on the private or unorganized sectors. These loans have high interest rates as a result of which they are further impoverished. Hence the government should take some initiatives to make loans from the formal sector more accessible and also simplify the procedure easier.

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Annexure:

Tools

1. Full introduction of the respondent
   a. Name
   b. Sex
   c. Caste
   d. Occupation
   e. Education

2. How many members do you have in your family?

3. Who is the head in your family?

4. Monthly income of your family?

5. What are the other sources of income in your family?

6. Do you have any BPL card?

7. If yes, which one (red/white)?

8. Which facilities have been given to you, by the government?

9. Do you face any problem in availing these facilities?

10. Is there any delivery case in your house in last one year?

11. In which hospital (PHC, CHC, District or Private) she was admitted?

12. How far the hospital from your place?

13. What were the transportation costs to reach these various hospitals from your home?

14. What was the reason behind choosing the private hospitals?

15. Which types of facilities (free of cost) have been given in the government hospitals during hospitalization?

16. How many care givers had gone along with the mother during hospitalization and what were the means of transportation?

17. Did the hospital provide the treatment free of cost?

18. Have/had you given money from your pocket for treatment?

19. If yes, what were those items on which you have to pay from your own pocket?

20. Did you have sufficient money during the period of hospitalization to afford these expenses?

21. If no, how you managed it?

22. If you have borrowed money than what was the rate of interest?

23. Have you got the Rs. 1400 of the JSY scheme from the government hospitals?

24. Any inconvenient in getting this amount of money?

25. Have you got Rs. 20,000 from the public hospital (If the baby was girl)?

26. If no, what was the reason for not getting this amount?

27. Was there any kind of problems and complications to both the mother and the baby after discharge from the hospitals?

28. For the home delivery how much did you pay to the dai/ ANM/ASHA?

29. What is the reason for opting home delivery?