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Financing Reproductive Healthcare and its Impact on Economic Development of India

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Abstract:
Poor reproductive health outcomes such as early pregnancies, unintended pregnancies, excess fertility (when actual births exceed desired fertility) and poorly managed obstetric complications would have negative effects on overall health and development of the country. (Wardlaw, 2004). Present situation of reproductive healthcare in India can be evaluated by some important reproductive health indicators like Total Fertility Rate (TFR), Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Crude Birth Rate, Crude Death Rate (CDR), and Life Expectancy Rate. These rates are often used as an indicator of the level of health in a country. To start with the discussion we first through the light on the broad view of present demographic and reproductive healthcare status of India. Via this study paper the author wants to highlight/point out the impact of the Financing Reproductive Healthcare on the Economic Development of India.

Keywords: Economic Development, Fertility rate, Financing reproductive *Healthcare, Mortality rate, WHO*

1. Reproductive health, economic growth and development

There is a direct and positive link among reproductive health, economic growth and development of a country. It has been widely recognized that investment in the reproductive health of the poor can enhance growth and reduce poverty. Access to health care especially reproductive healthcare is critical for improving health status of the country and good health is necessary for empowerment. It minimize absenteeism, enhance labour productivity and prevents misery. There is strong empirical evidence suggesting significant correlation in between reproductive health, economic growth and development. Some studies have concluded that healthier people are more productive.

According to the World Health Organization (WHO) 'Health is a state of complete physical, mental and social well being. It is not merely the absence of disease or infirmity'. Good health is one of the most precious assets of human resource in the country. A good healthcare system would be one that raises the status of the people and promotes their well being by enabling them to access quality and affordable healthcare.(WHO,2005). Amartya Sen in his study focused health as an important component of human development. Empowerment of people comes from the freedom they enjoy and this includes, among others, freedom from poverty, hunger, malnutrition, freedom to work and lead a healthy life. (Sen, 1999). The Alma Ata Declaration (1978) which emerged from the international conference on primary healthcare argued that health is essential to social and economic development. It identified primary health care as the key to the attainment by the year 2000, by all people, of a level of health that will permit them to lead a socially and economically productive life (WHO, 1978). Investment in the health of the poor raises their educational ability and productivity. It gives them both the assets they need to lift themselves from poverty and the immediate welfare gains of relief from physical sufferings (Wuensch & Poteat, 1998).

Vol. 2, Issue: 2, February 2014
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Improvements in the health indicators of the country have a positive influence on economic growth. For instance rapid improvement in health in East Asia in 1940s created conditions for a favourable demographic transition. An initial reduction in infant mortality swelled the youth population and after a time lag, the working age population began growing faster than the dependent population. This change in demographic structure of the population intern created an opportunity for higher rates of economic growth and can explain perhaps a 1/3 to 1/2 the "Economic Miracle", experienced by East Asia during 1965 to 1999.(Bloom and Williamson 1998).

Another study focused at elucidating relation between investment in health, economic growth and household productivity undertaken by Pan American Health Organisation/Inter-American Development Bank, found that life expectancy at birth alone is one of the strongest explanatory variables and economic growth are sufficiently significant in the long run to justify sustained national commitment to invest in health Bank. (WHR ,1999).

The concept of reproductive health emerged from the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994.ICPD focused on Women's Sexual and Reproductive Rights and constituted the framework for the development of United Nations Millennium Development Goals (MDGs) in 2000. Several countries where low socio-economic development occurs have been observed to be characterised by an inherent infringement of the sexual and reproductive rights of women. Unsafe motherhood, unsafe abortion, traditional harmful practices as exemplified by early marriage, widowhood rites, female disinheritance and female genital cutting, gender inequality and violence against women are notable areas of women's sexual and reproductive rights abuses observed in these countries. It is perhaps against this background that at least four of the eight millennium development goals (MDGs) have a direct relationship with reproductive health, vis MDGs 3, 4 and 5. (United Nation's MDG, 2000). The MDG 3 aims to promote gender equality and empower women, represents a well-designed reproductive health and rights' violation remedial measure that could impact on economy and development either directly or indirectly.MDG 4 i.e. Reduce child mortality, represents a response to a very important component of reproductive health. Infant and child survival, growth and development, which continues to pose a great challenge to many countries of the developing world especially India with second largest populated country in the world where very slow improvements have occurred over many years. High maternal mortality statistics in India typifies the direct relationship between reproductive health and development. MDG 5 improves maternal health, has as its revised targets reduce maternal mortality by 75% by 2015 and provide universal access to reproductive health. Furthermore, its six indicators maternal mortality ratio, proportion of births attended by skilled health personnel, contraceptive prevalence rate, adolescent birth rate, antenatal care coverage and unmet need for family planning, all have direct bearing to reproductive health in general. This implies that very few meaningful development occur in India, until enough efforts have been made to address these reproductive health issues and in particular reduce maternal mortality to the barest minimum. (United Nation's MDG, 2000). Looking at the reproductive healthcare in India at present, we find that there is an evidence of large number of cases of maternal mortality, infant mortality, early delivery complications etc. It is indeed very painful for the poor and the downtrodden because of their inability to get medical care, die unnoticed. Poor reproductive health outcomes such as early pregnancies, unintended pregnancies, excess fertility (when actual births exceed desired fertility) and poorly managed obstetric complications would have negative effects on overall health and development of the country. (Wardlaw, 2004).

2. Present status of Reproductive Healthcare indicators of India

India, with 1,220,200,000 (1.22 billion) people is the second most populous country in the world, while China is on the top with over 1,350,044,605 (1.35 billion) people. India and China together

contribute to almost 40% of the world population. This means that 4 out of 10 people in the world are Indians and Chinese. India is containing 17.5% of the world's population, which means one out of six people on the earth lives in India. Population Growth rate of India is 2.4%, where as the population growth of china is falling it is estimated that India may overpass, the population of china by 2030 and would become a largest populated country of the world (WHO, 2011).

Table 1. Historical population of India

Historical population of India		
Census	**Population**	**%Increase**
1951	361,088,000	-
1961	439,235,000	21.6%
1971	548,160,000	24.8%
1981	683,329,000	24.7%
1991	846,387,888	23.9%
2001	1,028,737,436	21.5%
2011	1,210,193,422	17.6%

Source: Census of India 2011

Present situation of reproductive healthcare in India can be evaluated by some important reproductive health indicators like Total Fertility Rate (TFR), Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Crude Birth Rate, Crude Death Rate (CDR), and Life Expectancy Rate. These rates are often used as an indicator of the level of health in a country. To start with the discussion we first through the light on the broad view of present demographic and reproductive healthcare status of India.

Table 2. Demographic achievements of India

India-selected health indicators			
Parameters	**1951**	**1981**	**Current level**
Life Expectancy	36.7	54	64.6(RGI)(2000)
Crude Birth rate (CBR)(Per 1000 population	40.8	33.9	22.5(2009)
Crude Death Rate(CDR)(Per 1000 population)	25.1	12.5	7.3(2009)
Total Fertility Rate(TFR)per women	6.0	4.5	2.5(2010)
Maternal Mortality Rate(MMR)per 100,000 live births)	NA	437(1991)	212 per 100000 live birth
Infant Mortality Rate(IMR)per 1000 live births	146	110	46 (2009)
Child (0-4 years)Mortality Rates(per 1000 children)	NA	41.2	15.2(2008)
Sex ratio	946	934	933(2001)
Life Expectancy at Birth	37.2	55.4	69.89(2009)
Male	37.1	55.4	67.46(2009)
Female	36.1	55.7	72.61(2009)
Density per km square	117	216	324(2001)

Source: Census of India , National Commission on Population, Govt of India. 2010,Office of Registrar General of India(RGI)

Table 3. Population of India at present

Population of India	**1,210,193,422 (2011 est.) (2ndlargest population in the world)**
Total Male Population in India	628,800,000 (628.8 million)
Total Female Population in India	591,400,000 (591.4 million)
Age structure	
0-14 years	31.1% (male 190,075,426/female 172,799,553)

	(2009 est.)
15-64 years	63.6% (male 381,446,079/female 359,802,209) (2009 est.)
65-over	5.3% (male 29,364,920/female 32,591,030) (2009 est.)
Sex ratio	
At birth	1.12 male(s)/female (2009 est.)
Under 15	1.10 male(s)/female (2009 est.)
15-64 years	1.06 male(s)/female (2009 est.)
65-over	0.90 male(s)/female (2009 est.)

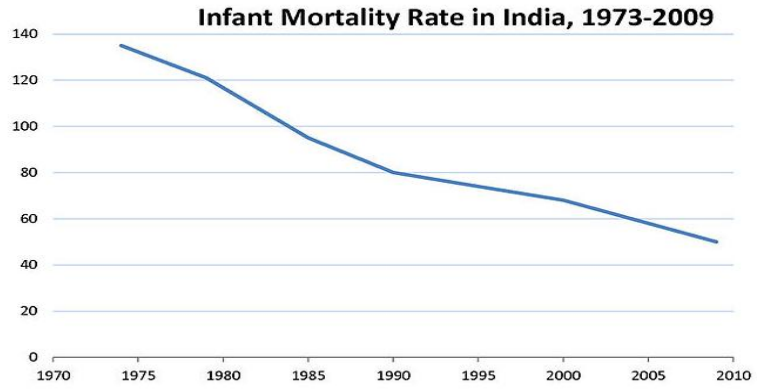
Source: National Commission on Population, Govt of India, 2010, Census India SRS Bulletins. Registrar General of India, Govt of India. 2011.

Each year in India, roughly 30 million women experience pregnancy and 26 million have live birth. With an estimated 77,000 deaths per annum, India contributes to a majority of maternal mortality burden in the region (WHO, 2009). Maternal Mortality Rate is the number of women who die during pregnancy or within 42 days of the termination of pregnancy. High fertility is positively associated with maternal mortality because each pregnancy increases woman's life time risk of dying due to pregnancy related causes. Every year, more than half a million mothers in low and middle income countries die giving birth, more than 9 million suffer pregnancy related illnesses and 10-20 million develop long term disabilities as a result of complications related to delivery and poor obstetric management. Most of these deaths and disabilities are preventable, but in many instances, the interventions are either not available to poor women or are too low-quality to be effective. Global, regional, and country-level estimates of maternal mortality show a clear connection between high rates of maternal mortality and poverty. More than 99 percent of maternal deaths occur in developing regions and more than 85 percent occur in the poorest countries of Sub-Saharan Africa and Southern Central Asia (Zahr & Wardlaw, 2004).

Another study stated that India recorded around 57,000 maternal deaths in 2010, which translate into a whopping six every hour and one every 10 minutes. In every two minutes a woman dies of pregnancy-related complications like severe bleeding after childbirth, infections, high blood pressure during pregnancy and unsafe abortion. However there has been some progress in providing improved healthcare to pregnant women which has resulted in the deaths being cut by half over the past two decades (UN Population Fund, World Health Organisation, 2012).
Maternal Mortality Rate (MMR) of India at present is 212 per one lakh live births, while the country's target is 109 per one lakh live births by 2015. India has reduced MMR significantly from 437 per one lakh live births in 1999 to 212 now, but needs to hasten the pace under the National Rural Health Mission to achieve the related Millennium Development Goal. Major causes of maternal mortality in India remain haemorrhage (38%), sepsis (11%), abortions (8%), hypertensive disorders (5%), obstructed labour (5%) and other conditions including anaemia, medical disorders during pregnancy contributing to 34% of all maternal deaths (RGI-SRS, 2006).Regional disparities in maternal and neonatal mortality are wide with states like Kerala having an MMR of 110/100,000 live births and others like Uttar Pradesh with 517/100,000. It is also recognised that delays in accessing specialised maternal care happen at all levels leading to maternal mortality and severe morbidity (Economic survey, Government of India, 2012).

Another indicator of reproductive healthcare is Infant Mortality Rates (IMR) i.e. the number of infant deaths (one year of age or younger)per 1000 live birth. There has been continuous improvement in IMR which has now reduced to 46 as shown by following data. Relatively recent data are available for IMR in Indian states, it is highest in Bihar, Madhya Pradesh, Odisha, Uttar Pradesh, Assam, Rajasthan and Chhattisgarh. Kerala by far the best performing state, way above Tamil Nadu and Maharashtra (Economic survey, 2011). Following Figure and Table show the achievement of India in reduction of IMR.

Fig 2. Trend of infant mortality rate in India



Source: National Commission on Population, Govt of India, 2010 and Census India SRS Bulletins. Registrar General of India, Govt of India

Table 4. Infant mortality rate in India

Year	Infant Mortality Rate
2000	64.9
2002	61.47
2004	57.92
2006	54.63
2010	49.13
2012	46.07

Source: National Commission on Population, Govt of India,2010 and Census India SRS Bulletins. Registrar General of India, Govt of India, 2011.

Above figure shows that there has been reduction in the infant mortality rate in India which can be consider as a major achievement in the field of reproductive health sector in India. Another indicator of reproductive healthcare is Life Expectancy at Birth (LEB) indicates the number of years a new born infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life. The value for life expectancy at birth, total (years) in India was 65.13 as of 2010 from 42.45 in 1960 (Government of India survey, 2011). Crude birth rate is also one of the important indicators for reproductive healthcare in India. There has been decline in birth rate from 40.8 in 1951 to 22.5 in 2009. Birth rates in 2008 were lowest in Kerala, while UP had the highest rates, followed by Bihar, Madhya Pradesh, and Rajasthan. While death rates did not show large variation across the states, the worst performer in this regard was Odessa followed by Madhya Pradesh, Assam and Uttar Pradesh .(Government of India survey,2011).

Figure 3. Trend of Crude birth rate in India (per 1000 people, national average)

Source: Ministry of Health and Family Welfare report on maternal mortality rate in India, 2012

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Total Fertility Rate is other determinant indicator for reproductive healthcare in India. It is the average number of children that would be born per woman if all women live to the end of their childbearing years and bore children according to a given fertility rate at each age, it shows the potential for population change in the country.

Table 5. Total fertility rate in India

Years	Total fertility rate in India
2000	3.11
2002	2.98
2004	2.85
2006	2.73
2008	2.76
2010	2.65
2012	2.58

Source: MOHFW report on maternal mortality rate in India, 2012.

High fertility rates have been found to hamper investments in child health and education in some developing countries. Poor child health is likely to reduce physical work capacity when the children turn into adult. The impact of health indicators such as Adult Survival Rate (ASR) on growth rates would depend on the level of GDP. The interaction between ASR and GDP is found to be significant predictors of economic growth. ASR would significantly affect economic growth at low level of GDP, because of the contribution of labour in prime years. For the poorest countries, a 1% change in ASR was found to be associated with an approximately 0.05% increase in growth rate whereas, a similar increase of 1% in investment/GDP ratio was associated with a 0.014% percent increase in growth rates thereby implying significant positive impact of ASR on growth rates. The positive effects were also found to be significant for India (Bhargava, et al., 2001).

To improve maternal and new-born infant health by reducing mortality and morbidity related to pregnancy and child birth, it is essential to build continuum of care that increases access to and use of skilled care during pregnancy, birth and the post par took period. The continuum of care need to extend from care in the household to the care provided by a skilled health professional at the primary care level, to that provided at the referral facility for those women and new-born's with complications. Having a pool of skilled manpower for provision for this continuum of care is a major challenge for India towards improving its maternal health situation (WHO, 2011).

3. Present status of reproductive healthcare financing in India

There is a need to focus on reproductive healthcare financing in India. There are however, varied sources of health care financing in India. These include budgetary allocations from the government at all levels of the federal structure (local government, state and federal); loans and grants obtained from multilateral and bilateral agencies in the form of international aid; private sector contributions and the out of pocket payment which is the part of private healthcare expenditure (WHO, 2000). At present the government of India has launched large number of programmes and schemes as follows to improve the condition of healthcare in general and reproductivehealthcare programme in particular under government funding which are as follows:-

3.1 National Rural Health Mission (NRHM)

It was launched in 2005 to provide accessible, affordable and accountable quality health service to rural areas with emphasis on poor persons and remote areas. It is being operational throughout the country, with special focus on 18 states, which includes 8 empowered action group states (Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Uttar Pradesh, Uttrakhand, Odisha & Rajasthan), 8 north-eastern states, Himanchal Pradesh and Jammu and Kashmir. The NRHM aims

to provide an overarching umbrella to the existing programme of Health and Family Welfare including the Reproductive Child Health Project (PHC-II). (Economic Survey , 2011)

3.2 ASHAs/Link workers

So far 8.33 lakhs accredited social health activist (ASHAs) have been selected. Of these 7.82 lakhs have received training in at least the first module and 5.7lakhs have been provided with drug kits in their respective villages.(Economic Survey, 2011)

3.3 Mobile Medical Units (MMUs)

About 381 MMUs are functional under the National Rural Health Mission (NRHM) so far.

Table 6. Healthcare infrastructure in India

Facilities	Number
Sub-centres/PHC/CHC*(2009)	1,73,795
Dispensaries and hospitals (all)	35,071
Nursing personnel(2009)**	16,52,161
Doctors (modern system)2009**	7,57,377

*Source:*RHS:RURAL HEALTH STATISTICS in India 2000*
***National Health Profile, 2009.*

Following programmes have been launched by the Government of India for strengthen of primary health infrastructure and improving service delivery:

3.4 Janani Suraksha Yojana (JSY)

It was launched with focus on demand promotion for institutional deliveries in states and regions it integrates cash assistance with delivery and post-delivery care. It targets lowering of maternal mortality rate(MMR)by ensuring that deliveries are conducted by skilled birth attendants. The JSY scheme has shown rapid growth in the last three years, with the number of beneficiaries reaching 100.78 lakh in 2009-2010. The strengthening of infrastructure, coupled with improvement in manpower and training, has resulted in significant improvement of institutional deliveries in all major states. A mid-term evaluation of the RCH II programme also confirmed the increase in the number of JSY beneficiaries.(Economic Survey, 2011).

Thus, in India Public health expenditure has increased substantially since independence, but this has not been enough to secure a minimum decent standard of healthcare services in the country. As a consequence, the private health sector has seized the opportunity and established its market in the profitable sub sector of health, namely, curative care and drug manufacturing and distribution. The public healthcare sector has been saddled with preventive and primitive services, medical education and urban hospital services; the former mainly in rural areas and the latter in urban areas. (Duggal, et al.,1993). The ratio of Central Government spending to total State Government spending is currently around 1:2. In the past decade, Central Government expenditure on health and related areas has been relatively flat at around 0.35 per cent of GDP. It is also significant that a greater proportion is taken up by revenue expenditure (essentially, the payment of salaries) rather than capital expenditure for creating much-needed basic physical infrastructure. (Mahal, Srivastav and Sanan, 2000). This in turn resulted in increasing household expenditure on healthcare. In 2009, India's total expenditure on health was 4.13% of GDP (out of which 1.10% was public). Two-third of healthcare expenditure is on out-patient and the rest one-third is on hospitalization (Selvaraj, 2009).Government is only spending one-fifth, rest 70 per cent is being spent by the households as their out of pocket expenditure on healthcare. Out-of-pocket expenditure on health reached as much as 80% of personal expenses, mostly for outpatient treatment (74%) and drugs (72%) (Ministry of Health and Family Welfare, 2009).Thus, among all the sources of healthcare financing, the worrisome picture is the heavy out of pocket expenditure

on reproductive health which adversely affects access to reproductive healthcare in India and which is one of the important causes of poverty in India as well. (WHO, 2000).

At present, Government of India is spending only 1.2 percent of the total budget on healthcare. However, the Planning Commission of India has recommended the government to increase public spending on health by central and state governments from the current level to 2.5 per cent of GDP by the 12th Five-Year Plan, i.e., 2012-2017 and to 3% per cent of GDP by the next 13th Five Year Plan, i.e. 2017-2022).(12th Five Year Plan of India).On the other hand the official figure shows that in 2009, India's total expenditure on health was 4.13% of GDP (out of which 1.10% was public), while at the same time out-of-pocket expenditure on health reached as much as 80% of personal expenses, mostly for outpatient treatment (74%) and drugs (72%) (Ministry of Health and Family Welfare, 2009).

Another study states that India spends 4.2 per cent of its Gross Domestic Product (GDP) on health care. Out of this, the government is only spending one-fifth, rest 70 per cent is being spent by the households as their out of pocket expenditure on healthcare. While, Two-third of health care expenditure is on out-patient and the rest one-third is on hospitalization (Selvaraj, 2009).

4. High out of pocket expenditure on reproductive healthcare in India

Out of Pocket expense is the amount of money the patient has to pay from their own funds for things like deductibles, co-insurance and (possibly other expenses) not paid by the insurance company. These out of pocket expenditure are direct outlays of cash which may or may not be later reimbursed. Household out-of-pocket expenditure on health comprise cost-sharing, self-medication and other expenditure paid directly by private households, irrespective of whether the contact with the health care system was established on referral or on the patient's own initiative. Out of pocket expenditure is direct outlay by households, including gratuities and in-kind payments to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individual or population groups. It is a part of private health expenditure. It is estimated that out of pocket payment dominates the bulk of reproductive health care financing in India. The immediate effect of this method of health care payment is catastrophic to poor households and further impoverishes them (WHO, 1999).

The Out-of-pocket health expenditure (% of private expenditure on health)in India was last reported at 86.35 in 2010(World Bank report, 2012). India ranked 42nd in the list of countries with highest average of out of pocket expenditure. It holds the third rank in the South-East Asia region in the latest list of countries with highest out of pocket (OOP) expenditure on health (World Health Organization 2012).

Another study done by World Bank in 1995 states that in India 75% of total health spending was from private out-of-pocket sources. Analysis of that spending showed that 82%of primary health care spending was out-of-pocket, as was 92% of primary curative spending. In other words, primary healthcare spending is more private than overall spending, despite government's stated priority for such services. The study also showed that it was proportionately more private in rural areas and for lower income population, implying a significant burden on the rural poor. (World Bank, 1995).

5. Medical poverty trap phenomenon

"If a household spends more than 10 per cent of household expenditure on health care, then it is termed as a catastrophic expenditure. In India, 13.68 per cent of household expenditure is spent on health care." (Selvaraj, 2009).

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There is a close link between poverty and health is the medical poverty trap phenomenon. When analysing poverty with regard to income, it implies limited capacity and opportunity for making choices, it also implies that the poor have limited access to basic amenities and factors that are inherent in their health production function. Health production of an individual is a function of several variables (inputs), which include among others nutrition, income, general consumption of goods, education, consumption of health care services etc. Some of these inputs enter into the function directly while other enter indirectly thereby reducing their ability to produce health and obviously imply that they will have poorer health status and high burden of diseases(Grossman, 1972).

There has been continuous increase in the out of pocket expenditure of public on health. Many studies have shown that out of pocket spending on health care is one of the major reasons for pushing households into poverty (Selvaraj, 2011). The high medical bills cause 3.2 percent Indians to fall below poverty line(WHO,1999). Another study done by Gupta states that the out of pocket expenditure (OOP) accounts for an average increase in poverty by as much as 3.6 and 2.9 percent for rural and urban India respectively (Gupta, 2009).

There is predominance of out of pocket (OOP) payment for health care in most of the developing countries like India. The OOP payments in both public and private health care facilities are driving the households into poverty and further deepening the poverty levels of those already below the poverty line. Out of pocket spending is inefficient and inequitable for the poor who are more susceptible to disease and likely to be pushed into the poverty trap. Out of pocket has been identified to generate four major effects namely untreated morbidity, reduced access to health care, long term impoverishment, irrational drug use. This reinforces the well known vicious circle of poverty (Whitehead, et al., 2001).

There are about 70 percent Indians who spent their whole income on health care and medicines. The Planning commission also agrees that high out of pocket expenditure on health leads to poverty. It is recognized as a growing issue since 39 million Indians are pushed to poverty due to ill health every year. In 2004 around 30 percent people in rural India were unable to go for any treatments, restrained by financial difficulties while 20 percent of diseases were untreated in urban areas because of the same reason (WHO, 2011).

6. Importance of pre-payment plan in form of reproductive healthcare insurance

Reducing the burden of healthcare cost remains a big challenge for India at present. We spend nearly 6% of our GDP on health and the share of government expenditure is less than 1% as against the recommended rate of 5% by the WHO. A major share (75%) in this expenditure is that of private out of pocket expenditure (WHO, 2010). Keeping in view the State's constitutional obligation and its inability to fulfil the health care needs of the disadvantaged section (due to resource crunch, lack of political will etc), inefficient public health care system, problem of inflation in healthcare services, shrinking budgetary allocations for health and heavy out of pocket expenditure on health have created a strong need and desire for a relatively new concept for India ,that is,-'Insurance of Health' or Health Insurance based on the willingness to pay of the patients/households for reproductive healthcare services. Health insurance has been identified to play an important role in household's access to healthcare, it turns the unexpected health expenditures into predictable payment in the form of insurance which in turn encourages households to further invest in the wellbeing and further reduces the crunching effects of poverty(Asgary, et al., 2004). Health insurance aims at converting heavy out of pocket expenditure into prepayment schemes through insurance on the basis of willingness to pay.

Health insurance turns unpredictable health expenditures into predictable insurance payments. It allows them to "prepay" through premiums on the basis of their willingness to pay so that they do

not have to live with the risk of large and unpredictable health care bills. Premiums are paid voluntarily and often depend on the risk category of the buyer of health insurance. (Rexford, et al., 2001). Thus, system of prepayment will share the financial burden of medical expenses with the people, enabling access and protecting them from the economic ruin caused from high health expenditure. It increases the likelihood that those who need health care will be able to obtain it in an affordable and timely way. It also encourages longer term investment in the wellbeing of the households. It is generally accepted that insurance against large and unpredictable health expenditure is a key component of social protection and a significant factor in the economic development of India.

The insurance penetration in India has increased from 2.32% to 5.51% over the period 2000 to 2010. (IRDA, 2010). With just 5.5% of health insurance penetration in the country, a large part of the sum is poised to be paid out-of-one's pocket (OOP). Justification for promoting-health insurance is to assume protection of the poor from bankruptcy, upgrade quantity of healthcare and open avenues for resources required to sustain the system (WHO, 2000). Therefore, reproductive healthcare insurance aims to convert the out of pocket expenditure into reproductive healthcare financing as payment of insurance on the basis of the willingness to pay. Given the importance of such prepayments schemes, it is important for us to know the amount households are willing to pay to establish prepayment schemes among the different income groups, to know if there exist any difference between how much households are willing to pay (WTP) and the actual cost of treatment.

7. Present status of maternity healthcare insurance in India

When planning a family, it is wise to consider taking out a reproductive healthcare insurance policy before the mother is actually pregnant. Mediclaim policies in India such as maternity insurance are offered by insurance firms as a component of group insurance policies to corporate houses. India has a number of insurers- few government and many private players. But none of them offers individual coverage for pregnancies. In India none of the general insurance firms provide complete insurance policy for pregnant women. Moreover, there are no particular parameters or consistency among the various pregnant women insurance benefits, either in its inclusions or in its omissions. Female employees are entitled to maternity benefits, but when it comes to pregnancy insurance, the chances of obtaining it are dim. However, there are few firms offering maternity insurance policies but they rarely cover maternity expenses that take place within the nine months of buying the scheme as they consider insurance is usually meant for unexpected risk and pregnancy is not regarded as such a risk in India. Once a woman is pregnant, it is very difficult to get life insurance cover in India. Many insurance companies are reticent about allowing life cover for a woman who is already pregnant due to all the possible complications that could occur. Insurance companies advise mothers to wait until her baby is three to six months old before trying to get cover. If a pregnant woman has managed to get life insurance cover she can expect to pay up to 50% more on her premiums. Any complications recorded during pregnancy will increase the premiums when cover is available.

The most common types of complications are gestational diabetes ,gestational high blood pressure, hypertension, risk of post natal depression immediately after the birth although there are no statistics concerning the suicide rate amongst post natal depression sufferers, insurers feel they are at higher risk. Gestational diabetes is one such condition and it has been known for a company not to pay out on a critical illness claim when gestational diabetes was not declared - even though it was not connected to the critical illness. If a first pregnancy has shown signs of complications, then insurance cover whilst pregnant for a second time is unlikely. High blood pressure is a common complaint of pregnancy and can lead to hypertension and even toxaemia (pre-eclampsia), this condition can bring on fits, strokes and even death. Already existing medical conditions can advance rapidly during pregnancy and conditions not already picked up will become more

dominant and detectable. Women with these conditions during pregnancy will have a hard time getting insured. But the majority of women enter pregnancy healthy and remain so until delivering the baby. Insuring these women is easy, unless they had complications with a previous pregnancy. In this case, most carriers will not make an offer of life insurance to the prospective buyer. All these or a previous caesarean birth will prevent pregnant women in India from purchasing life insurance while they are pregnant.

An added problem to secure life insurance for pregnant women is that we are now seeing a new generation of higher risk pregnancies i.e. pregnancy at the older age of women, being made available by the advancements in medical technology. Pregnancy is increasingly possible in older women with in-vitro-fertilisation treatment. They are also more at risk from the complications of higher blood pressure. This treatment itself carries a high risk of multiple births, again putting a strain on the woman's health. The advice from insurance companies and financial advisers is to take out a life insurance policy before getting pregnant wherever possible. After the event, always be upfront in declaring medical history.

8. Inclusions under Insurance Policy for Pregnant Women in India

Maternity insurance available as part of group coverage stipulates that at least 100 employees be covered in the group. Pregnancy insurances cover all pregnancy-related hospitalization costs. The hospital where the insured employee can get treatment depends on her employer's group policy. The group pregnancy insurance covers costs of surgery, pre- and post-natal care and treatment of any complication arising due to the pregnancy. A number of group insurance policies offered by insurance firms for working women envelop maternity advantages and insurance. These policies includes all pregnancy associated hospitalization costs, before and after hospitalization costs for pre-determined number of days, surgeries and other pregnancy related complications, expenditures incurred pre- and post-natal durations.

9. Exclusions under Insurance Policy for Pregnant Women in India

Normally, neither medical checkups during pregnancy nor expenses incurred on medicines are covered under pregnancy insurance in India. Termination of pregnancy within the first 12 weeks is also excluded from insurance coverage. Pregnancies within nine months of taking the maternity insurance policy also are not covered. Many insurance policies neither incorporate expenses met during monthly medical checkups after pregnancy nor does it envelops costs incurred towards medications consumed during pregnancy. Insurance Policy for pregnant women in India also does not constitute unanticipated events resulting in the termination of pregnancy for the initial few weeks, medical costs for pregnancies taking place during nine months of purchasing the maternity insurance policy. The insurance firms offer these benefits under their group policies for corporate firm that is subject to the condition of inclusion of minimum number of individuals working in the organization.

Factors influencing the premium of insurance policy for pregnant women under group insurance policies offered by insurance firms depend on the company's profile which is being insured, the sector under which it is functioning and its related risk factors are also taken into consideration. In the 2007-08 around 3/4th of firms working in the sector of information technology, pharmaceuticals and manufacturing picked group insurance scheme with maternity benefits. Other aspects that influences the premium of maternity insurance is the employee profile, her age group, designation etc and earlier health insurance assertion ratios applicable to the firm. The last factor affecting premium is the frequency of utilization of maternity insurance and other health policies by the firm's employees. Pregnancy insurance stipulations vary from insurer to insurer. Some insurers may require the insured to inform them immediately of hospitalization for delivery or any pregnancy-related reason. Failure to comply with simple formalities could jeopardize a person's insurance benefits.

9.1 State Insurance Scheme

Female employees working with the government get maternity insurance coverage under the Employees' State Insurance Scheme (ESI). Under this scheme, an employee contributes 1.75 percent and the employer contributes 4.75 percent of the wages earned every month. In times of pregnancy, the employee becomes eligible for 12 weeks of confinement as well as for miscarriages and any complication arising out of pregnancy.

9.2 Group Pregnancy Insurance Coverage in India

A number of companies in India offer pregnancy insurance under their group coverage. Nearly 73 percent of pharmaceutical, manufacturing and IT companies provide group coverage that includes maternity insurance benefits. In fiscal year 2007-08, nearly 450 group policies were sold by insurance company Cholamandalam General Insurance. Out of those, 65 to 70 percent included maternity benefits. IT companies are the major buyers of group policies with maternity insurance.

9.3 Companies providing Insurance Policies for Pregnant Women in India

There are number of pregnancy insurance providers in India. The companies which offer Insurance policy for pregnant women in India are: Apollo DKV, ICICI Lombard, United India Insurance, Cholamandalam General Insurance and Star Health. Apollo DKV and Star Health being the major ones. ICICI is more liberal with its maternity insurance, as it covers prenatal tests and medication expenses. United India Insurance meets hospitalization and in-patient care expenses to a certain limit. It is vital for maternity insurance to incorporate all expenditures incurred during pregnancy, right from the delivery to post-natal care in Indian hospitals. Thus, the need is to improve the reproductive healthcare services for the overall growth and development of the country. There should be increase in expenditure on health facilities on part of the government, regulatory measures should also be taken to regulate the high price charged by the private healthcare providers and spread of reproductive health insurance specially within the lower income group by making them part of inclusive growth could help to improve overall health status of the country to achieve higher rate of economic growth and development of the India.

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