ORIGINAL ARTICLE

Out of Pocket expenditure among beneficiaries of Janani Shishu Suraksha Karyakaram

Jyoti Tyagi[1], Jayanta K. Das[2], Pushpanjali Swain[3]

[1]Consultant, [2]Director, [3]Professor & Head, Department of Statistics and Demography, National Institute of Health and Family Welfare, Baba Gangnath Marg, Munirka, New Delhi-110067,India

Abstract | Introduction | Methodology | Results | Conclusion | References | Citation | Tables / Figures

Corresponding Author

Address for Correspondence: Dr Jyoti Tyagi 158-B2 Shaktikhand-2 Indirapuram Ghaziabad-201014
E Mail ID: tyagijyoti2302@gmail.com

Citation

Tyagi J, Das JK, Swain P. Out of Pocket expenditure among beneficiaries of Janani Shishu Suraksha Karyakaram. Indian J Comm Health. 2016; 28, 4: 331-336.

Source of Funding: Nil **Conflict of Interest:** None declared

Article Cycle

Received: 24/11/2016; **Revision:** 22/12/2016; **Accepted:** 23/12/2106; **Published:** 31/12/2016

Abstract

Background: About 67,000 women in India die every year (MoHFW, 2011), due to pregnancy related complications. Similarly, every year more than 13 lacs infants die, within 1 year of the birth and out of these approximately 9 lacs i.e. 2/3rd of the infant deaths take place within the first four weeks of life (1).Out of these, approximately 7 lacs i.e. 75% of the deaths take place within a week of the birth and a majority of these occur in the first two days after birth (1). In view of the difficulty being faced by the pregnant women and parents of sick new-born (MoHFW,2011), along with high out-of-pocket expenses incurred by them on delivery and treatment of sick new-born, Ministry of Health and Family Welfare has taken a major initiative, to provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30 days after birth) in Government health institutions in both rural & urban areas. **Material & Methods**: In this community based descriptive cross-sectional study, data was collected from 100 mothers, who had delivered in last one year at District Hospital Maternal Wing situated at Morar Block of Gwalior District M.P and MO, ANM's, ASHA's, using Semi structured close ended Interview schedule and an open ended questionnaire respectively. Data were compared by using SPSS (ver. 22.0) **Result**: Expenses were divided under two heads, medical and non-medical. 15% of the total beneficiaries incurred the medical expenses in the form of medicines, diagnostics etc. and almost 99% of all the respondents incurred the non-medical expenses in the form of transport, food etc. **Conclusion**: Based on the outcome of the study the overall impression was that 59% of the beneficiaries were not aware of the JSSK scheme. Only during pregnancies through the initiatives of the ASHAs the beneficiaries came to know about the free entitlements of the scheme. There was unavailability of ambulance when required and delay in the services.

Keywords

Pregnant women; Delivery; Medicines; Blood; Maternal mortality; Infant mortality

Introduction

Women and children are the greatest asset of a nation. Their health is the basis for the better health of the family as a whole and also of the nation. The health of families and communities are tied to the health of women – the illness or death of woman has serious and far reaching consequences for the health

of her children, family and community. According to WHO, maternal death is defined as, "The death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental cause"(2). According to UNICEF, infant mortality rate is defined as, "probability of dying between birth and exactly one year of age expressed per 1,000 live births" (3). Maternal Mortality Ratio of India is 178 per 100,000 live births. India accounts for one in every seven maternal deaths around the global every year (4). The current Infant Mortality Rate (IMR) of India, as per the Sample Registration System(5), is 40 per 1,000 live births while the Under-5 Mortality Rate (U5MR) as per SRS 2012 is 52 per 1,000 live births"(6). Majority of women die because they have inadequate antenatal and postpartum care and are attended at delivery (mostly conducted at home) by untrained and unskilled persons who are unaware of signs of an obstetric emergency. Madhya Pradesh registered the highest infant mortality at 52, and Manipur the least at 11 (7) and maternal mortality at 221 with least MMR at Kerala as 61(8). Several initiatives have been launched by the Ministry of health and Family Welfare (MoHFW). NHM launched in year 2005 with an intent to provide accessible, affordable, accountable, effective reliable primary health care particularly focusing on needs of woman & children among the rural population. Janani Shishu Suraksha Karyakram (JSSK) was launched by government of India from MEWAT district of Haryana state on 1st June 2011. (1)

The initiative entitles all pregnant women delivering in public health institutions. The scheme aims to improve the quality of care and treatment for the mothers and thereby decreasing maternal mortality and morbidity, by eliminating out of pocket expenses incurred by the pregnant women and sick newborns while accessing services at Government health facilities free and no expense delivery, including caesarean section.

Aims & Objectives

1. To study the functioning of Janani Shishu Suraksha Karyakram with regards to assess the extent to which out-of pocket expenses made by beneficiaries for institutional delivery.
2. To study the difficulty faced by the beneficiaries to avail the free entitlements.

Material & Methods

Study Type: It was a cross sectional descriptive one point analysis with both quantitative and qualitative research methods being used in the study. ***Study Area:*** The study has been carried out in District Hospital Maternal wing situated at Morar block of Gwalior District Madhya Pradesh, after obtaining permission from institutional ethical committee. As Madhya Pradesh is a low performing state. ***Study Duration:*** carried out between 29th April to 31st May 2015 ***Study Population:*** included the providers of JSSK which includes MO, ANM and ASHA's. The study also included the beneficiaries of JSSK scheme and their attendants.

Out of 147 villages in Block Morar 5 villages were randomly selected. From the selected villages 20 beneficiaries were selected randomly for the interview from each village, who delivered in District Hospital Morar. ***Inclusion Criteria:*** A woman who had delivered in last one year in the selected area and had been covered under the scheme had been included in the study. Villages and beneficiaries had been chosen randomly and entirely by chance, such that each individual has the same probability of being chosen at any stage during the sampling process. Because of the time and financial constraints the selection was done randomly.

Semi structured questionnaire was administered to the beneficiaries and their attendants after taking prior consent from them, for data collection. Which had been pre tested before using.

Interview with the Medical Officer, ANM's and ASHA's.

The study being exploratory in nature, data collected by interviewing the health providers and the beneficiaries had been tabulated and analyzed as per the objective of the study. The data was entered in SPSS version 22.0 and analyzed.

Results

A total of 100 beneficiaries participated in the study from 5 selected villages.

Expenses divided under two heads, Medical and Non-medical.

Medical expenses constitute of Medicines, Blood and Diagnostics while Non-Medical expenses constitute of Diet, Transport and Accommodation.

Out of total 89 normal deliveries, 13 respondents paid out of their pocket for the medical expenses while 76 didn't have to pay anything.

Out of 11 caesarian sections 2 respondents bear the cost of medical expense while 9 didn't pay any-thing. 88 out of 89 respondents who had normal delivery paid for non-medical costs while all the respondents i.e. 11 mothers who underwent caesarian section bear the non-medical costs.

15% of the respondents were not satisfied by the services of JSSK.

Interview schedule also included a Medical Officer, 2 ANM's and 3 ASHA's.

As per the Medical Officers views the scheme was running since 2011 in the hospital with 600 actual numbers of institutional deliveries being conducted and covering a population of 10,50149 under this scheme. There had been a remarkable increase in the number of institutional deliveries since the programme was being implemented. They were providing free diet, medicines, blood and diagnostic facilities to the patients. Earlier Janani Express was being used to provide free transportation to the patients, However the services were withdrawn since November 2014 because of several complaints against the drivers for kickbacks. Since then the ambulance (108) is being used for the same. The proposal of dropping the pregnant mothers of the same locality at the same time could not be implemented and was not feasible too, which was also a factor for discontinuation of Janani Express services. Therefore the only out-of-pocket expense the patients had to incur was for transport. Also, the number of ambulances was less as compared to the population the hospital was catering, Hence putting burden on patient's pocket. The staff nurses and ANM's were imparted regular training for effective implementation of JSSK. The grievances of the mothers were tackled through feedback forms. The availability of budget was on time through cheques but was sometimes lesser than what was demanded. The hospital owned a kitchen and pathology they were neither rate contracted nor outsourced so as to provide good quality food and diagnostic facilities respectively.

According to the ANM's and ASHA's, majority of them stated that there had been an increase in institutional deliveries since JSSK was launched, but they lack IEC material in form of flip charts, posters and banners to bring awareness about the institutional deliveries. Only 2 of them were aware of the name of the scheme while others just had the information regarding the free entitlements. There were no charges for the diet, medicine, blood, diagnostics and bed as well but sometimes be-cause of unavailability of beds patients had to lie down on mattresses placed on the floor. 1 ANM and all ASHA's mentioned that the beneficiaries were charged fully for transport from home to hospital and dropping back to home. Because of the unavailability of ICU , during complications the patients were referred to higher centers through ambulance (108) for which the beneficiaries were partially charged. As per their opinion the new steps to be taken to increase institutional deliveries in JSSK were adequate healthcare facilities should be provided along with timely monetary remuneration.

Discussion

15% of the total beneficiaries incur the medical expenses in which the maximum out-of-pocket expense was for medicines. According to the respondents few medicines which were vital and costly too, were not available in the hospitals and henceforth after discharge they were told to buy those medicines from the market for which they showed their resentment as it was a costly affair to them.

40% respondents paid for diagnostics although these services are provided free by the government however upon interviewing the respondents facts came into account that in order to avoid inconvenience on account of long queues and other logistic reasons the respondents preferred to avail of diagnostic services at private centers at their own expense.

26% of respondents paid for blood because either required blood group was not available or the patients were not ready to donate blood for exchange.

Despite free transport services from home to health facility, and for referrals to higher medical centre, 94% of the respondents conveyed that they spent money from their own resources for transport charges to reach the district hospital Morar.

Only 7% respondents used ambulance for reaching hospital from home, out of which 2 respondents incur the cost by paying to the driver, thus only 5 out of 100 could actually avail the free service also 1 respondent went by foot because of the close vicinity of the hospital from her home.

13% mothers were referred from district hospital Morar to Kamla Raja medical college hospital out of which only 9 (69.2%) used ambulance for referring. Out of 9 respondents 4 had to incur the cost by

paying to the driver of the ambulance, henceforth only 5 could avail the free services.

5 sick new born were referred to higher facility out of which 4 (80%) were referred by ambulance as level 3 intensive care unit setup was not available.

Also in this study the ambulances were mainly being utilized for referrals this is why there is a huge difference in result of percentage of mothers and sick new born referred (69.2% and 80% respectively) as compare to those who were brought to hospital from home and dropped back (7% and 10% respectively).

Around 71% of these beneficiaries had out-of-pocket expenditure between Rs. 0-500 and this expense was solely for the mother who has obviously put burden on those who are daily wagers, labours or vendors who earn money on daily basis.

Conclusion

There were certain gaps found. The transport system for the beneficiaries was not streamlined. Main problem was unavailability of ambulance when required and delay in the services and thus fearing complications, beneficiaries were bound to arrange their own transport. Also the services of Janani Express were withdrawn since November 2014.

Most of the times the beneficiaries had to procure the medicines from outside, few of them were vital and constitute maximum out-of-pocket expense. Whereas under JSSK scheme it was envisaged that everything at a government institution is to be provided free.

Main cause of inconvenience for the patient was long queues due to which they had to unduly wait and to avoid this many of them preferred using private diagnostic services. Also this creates mistrust between ASHAs and pregnant mothers as they think that ASHAs were to solve all the problems for them.

At the programme level, the JSSK scheme management needs strengthening. This will entail attention to the following elements of the programme management.

Monitoring plan: JSSK guidelines provide detailed information about monitoring of scheme at different levels. Sorting out the issues related to transportation primarily, non-availability of medicines, blood, waiting time for patient etc. can be addressed largely through periodic monitoring visits by District Level Programme Managers. It is suggested that appropriate monitoring visits may be chalked out in advance.

IEC Action plan: Districts should be encouraged to have a sound IEC activity plan for JSSK. The plan should identify key target groups and relevant communication messages so as to achieve better utilization of services. Study findings clearly indicate important knowledge gap in the community regarding features of this scheme which has affected the programme negatively

Recommendation

The main objective of JSSK is not only elimination of out-of-pocket expense burden and cashless delivery alone but also for reduction of maternal mortality and morbidity, which will be achieved when women coming to facilities receive quality delivery and postpartum care services. There is need of Intensive Care Units, additional operation theatre, wards, labour rooms, drugs and other supplies, quality of services, cleanliness and hygiene etc. Hence, it has been pro-posed to monitor the quality of facilities as an integral component of JSSK, so that service providers and programme managers also realize importance of the quality of services provided and don't see their role only as mere distributors of money.

Limitation of the study

The only limitation faced during the study was time constraint.

Relevance of the study

This study is relevant for policy makers, public health leaders in planning appropriate interventions required for the programme. The results and recommendations of this study may be utilized to bring about improvement in the implementation of the programme.

Authors Contribution

JT: Conception and design, acquisition, analysis and interpretation of data, drafting and revising the article. JKD: critically revising the article for intellectual content and final approval of the version to be published. PS: Final approval of the version to be published.

References

1. Guidelines for Janani-Shishu Suraksha Karyakram (JSSK). National Rural Health Mission, Maternal Health Division, Ministry of Health and Family Welfare, Government of India, Nirman Bhavan, New Delhi, June 2011. Available at : http://nrhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf Accessed on 30/04/2015

2. World Health Organization. Maternal Mortality Estimates developed by WHO, UNICEF and UNFPA. Geneva, 2004. Available at : www.who.int/healthinfo/statistics/indmaternalmortality/en Accessed on 30/04/2015
3. UNICEF- Definition of Indicators Available at: https://www.unicef.org/infobycountry/stats_popup1.html Accessed on 30/04/2015
4. Sample Registration Bulletin- Sample Registration Survey, Census of India, 2010-2012. Available at: http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_Bulletin-2010-12.pdf Accessed on 05/05/2015
5. Sample Registration Survey Statistical Report- Census of India, 2013, Chapter-4. Available at: http://www.censusindia.gov.in/vital_statistics/SRS_Reports_2013.html Accessed on 05/05/2015
6. Sample Registration Survey Statistical Report- Census of India, 2012, Chapter-4 Available at: http://www.censusindia.gov.in/vital_statistics/SRS_Reports_2012.html Accessed on 07/05/2015
7. Sample Registration Bulletin – Sample Registration Survey, Census of India, 2014.
8. Maternal Mortality Ratio Bulletin, Sample Registration Survey, Census of India, 2011-2013 Available at: http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf Accessed on 07/05/2015

Tables

TABLE 1 SHOWING MEDICAL OUT OF POCKET EXPENSES

MEDICAL EXPENSES		Frequency	Percentage	Normal delivery	Caesarian section
	YES	15	15.0%	13(17.9%)	2(18.18%)
	NO	85	85.0%	76(82%)	9(81.8%)
TOTAL		100		89	11

TABLE 2 SHOWING MEDICAL ITEMS CONSTITUTING MAXIMUM OOP

MEDICAL EXPENSES	FREQUENCY (N=15)	PERCENTAGE
MEDICINE ONLY	8	8%
DIAGNOSTICS ONLY	6	6%
BLOOD ONLY	4	4%
MEDICINE AND DIAGNOSTIC BOTH	1	1%
BLOOD AND DIAGNOSTIC BOTH	2	1%

TABLE 3 SHOWING NON-MEDICAL OUT-OF-POCKET EXPENSES

		Frequency	Percentage	Normal delivery	Caesarian section
NON MEDICAL EXPENSES	YES	99	99.0	88(98.8%)	11(100%)
	NO	1	1.0	1(1.12%)	0(0%)
TOTAL		100		89	11

TABLE 4 SHOWING NON MEDICAL ITEMS CONSTITUTING MAXIMUM OOP

NON MEDICAL EXPENSES	FREQUENCY N=99	PERCENTAGE
TRANSPORT	94	94.9%
TRANSPORT_BACK TO HOME	91	91.9%
FOOD	26	26.2%

TABLE 5 SHOWING FREQUENCY DISTRIBUTION OF FREE TRANSPORT USE

	FREQUENCY	PERCENTAGE	TOTAL
FROM HOME TO HEALTH INSTITUTION	7	7.0%	100
REFERRAL FROM ONE HOSPITAL TO ANOTHER	9	69.2%	13/100
FROM HEALTH INSTITUTION TO HOME	10	10.0%	100
SICK NEW BORN REFFERED FROM HOSPITAL TO HIGHER LEVEL FACILITY	4	80.%	5/100

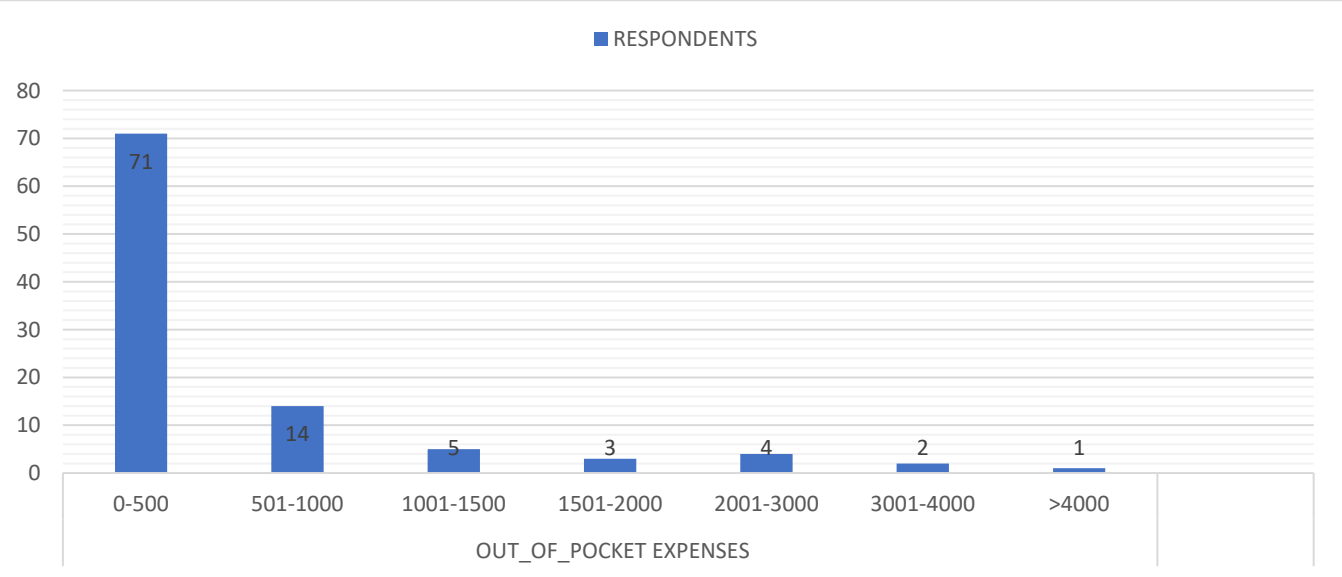
TABLE 6 SHOWING FREQUENCY DISTRIBUTION OF DIFFICULTIES FACED BY THE BEN-EFICIARIES TO AVAIL THE FREE ENTITLEMENTS UNDER JSSK

DIFFICULTIES FACED	FREQUENCY (N=100)	PERCENTAGE
UNAVAILABILITY AND/OR DELAY OF TRANSPORT	99	99%
UNAVAILABILITY OF MEDICINE	8	8%

UNAVAILABILITY/DELAY OF TRANSPORT AND MEDICINE BOTH	5	5%
LONG QUEUES FOR DIAGNOSTIC CENTRES	10	10%

Figures

FIGURE 1 SHOWING FREQUENCY DISTRIBUTION OF OUT-OF-POCKET EXPENDITURE



X Axis = Out-of-Pocket expenses made in Rs.; Y Axis = No. of Respondents

FIGURE 2 SHOWING FREQUENCY DISTRIBUTION OF REASONS FOR DISSATISFACTION