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Estimating financial resources for universal access to sexual reproductive health care: Evidence from two states in India

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ABSTRACT

India has made insignificant progress towards achieving universal access to sexual and reproductive health (SRH). One of the key inputs for achieving universal access to SRH is financial resources. Given this, many international agencies including the UN are emphasising on monitoring the financial progress towards achieving SRH.

Objective: To generate evidence on spending on SRH from various sources – (government, household, international donors and NGOs) to improve the accountability of the government towards SRH goal.

Methodology: Adapting a sub account framework of the NHA, this paper investigated the SRH expenditure of the two divergent states of India. The data were collected from government, households (NSSO), and foreign donors and were classified as per the International Classification of Health Accounts (ICHA).

Results and Discussions: Total SRH expenditure is less than one percent of SGDP from all sources in each state. Among the sources, government's spending on SRH is more than household. A large part of household spending is on curative care which has implications for accessing services by the poor.

In spite of data constraints, this paper presents a comprehensive analysis on SRH spending, which is critical for monitoring the commitment towards universal access to SRH. This evidence can be used for further improving data quality for RCH account in LMICs.

Introduction

Poor reproductive health (RH) accounts for one-third of the global burden of illness and early death among women of reproductive age [1]. About 201 million married women in developing countries still have an unmet need for modern contraceptives and around 70,000 maternal deaths (13 percent of the total) occur every year due to unsafe abortions [2].

Realising the importance of RH towards improving maternal health, in the year 2007, universal access to RH was included under MDG 5. However, progress towards universal access to RH has remained elusive, both in India and globally. In India, widespread disparities in the age of marriage were observed across states and among different social groups. Nearly, 42.9 percent of women in the age group of 20–24 were found to have got married before the legal marriageable age of 18 years [3]. The unmet need for family planning (FP) was 21 percent at the national level with higher percentage observed in the rural areas compared to urban areas. This also varied significantly across income groups with 18 percent for the lower wealth quintile to 8 percent for the higher wealth quintile [4]. Another study reported of 28 percent of adolescent girls and young women aged 15–24 were practising contraception. The same study also reported that in 7 out of 29 surveyed states, contraception use was less than 20 percent resulting in unwanted early pregnancies [5]. Though efforts have been made to reduce maternal mortality, the current maternal death rate of 178 deaths/per 100,000 childbirths is compelling.

One of the key inputs for achieving universal access to sexual reproductive health (SRH) is the financial resource. Much international and national funding is politically driven with limited focus on equity and quality improvement. Financing remains a significant challenge in most developing countries and it demands creative responses [6]. Since the early 1990s, continuous effort has been made to increase access to RH services globally through greater resource mobilisation, but recent studies show that funding has consistently fallen short of the financial targets agreed upon at the International Conference on Population and Development (ICPD) in 1994 [7]. Several studies attribute this to the international community's shift in focus, both politically and programmatically, towards HIV/AIDS [8]. Limited integration of HIV/AIDS programmes and

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targeting RH/FP has also been cited as a possible contributing factor that limited funding. From 2000 to 2009, for example, donor assistance for FP dropped from 30 percent of the total population assistance[1] to 5 percent. This has significantly affected FP, and basic RH services including maternal health, abortion and information-education-communication (IEC). It also affected services related to sexually transmitted infections (STIs) and HIV/AIDS prevention programme, and basic research, data and analysis of policy on population and development. Funding for basic RH services other than FP and sexually transmitted infections (STIs) also witnessed a decline from 29 percent to 23 percent of total population assistance [9].

At the UN summit in 2008, world leaders also called for increasing spending to achieve the MDGs [10], setting targets and creating a high level task force to assess needs and funding gaps. Despite these efforts, in 2012, shortfalls were noticed. Official Development Assistance (ODA) had actually declined and in 2012, it was just 0.29 percent of the gross national income (GNI) of the donor countries, far short of the target of 0.7 percent set by the UN [11]. ODA to the low income countries was also less than the UN target of 0.15–0.20 percent of the GNI. There has been a sharp decline in grants to FP and RH. Within a span of 10 years from 2000 to 2010, funding for FP has declined from 9.3 percent of total ODA to health to 3.2 percent and RH funding has dropped from 8.4 to 6.2 percent [12].

Rationale of the study

Growing concern for achieving universal access to SRH added to the problem of low financial resources, is propelling the international agencies, including the UN, to emphasise on monitoring financial progress and designing strategies for achieving maternal, new born, and child health, at both the global and country levels. In this environment, information on how much a country spends on specific health programmes, on population sub-groups, on whether resources are adequate to meet targets and on determining the financial shortfalls will be vital to policymaking. It could also be used to strengthen the accountability and holding governments to their commitments.

Allocating financial resources for comprehensive SRH programme, as mentioned in the ICDP, though assumes significance, expenditure data for the disease specific accounts are limited in India, except for a few state-specific studies done to examine the financing of reproductive and child health. One study [13] in Rajasthan reported comprehensive and disaggregated health expenditure on reproductive and child health. Another study, in Odisha, examined the pattern of resource allocation and spending on publicly funded reproductive and child health programmes [14]. This is further constrained by limited attempt at the national level to examine resource flow to health sector comprehensively using the National Health Accounts framework. Till date, India has produced only two National Health Accounts (NHA) reports, which systematically examine where money comes from, who provides health care services and what type of goods and services are created within the health systems. According to the last NHA report, India's public spending on health care was below 1 percent of gross domestic product (GDP) and more than 70 percent of the total spending on health care was borne by individual households [15]. In 2011–12, the public expenditure rose to just 1.04 percent of GDP [16].

These evidence point towards a need to examine India's commitment to SRH spending through data collection and analysis. Adopting a NHA framework, this study has investigated the pattern of financing SRH in two states i.e. Karnataka and Bihar. It has examined the SRH expenditure by source, agent, and function within the NHA framework during the year 2010–11.

Methodology and data sources

In the Indian union, the state government has a larger responsibility for improving health status of the people. In order to know the country's progress in health care, it is important to examine the situation at the state level. Keeping this in view, this study was conducted in two states of India namely Bihar and Karnataka. The two states were selected on the basis of their contrasting socio-economic characteristics. Karnataka, located in the southern part of India is relatively an advanced state with better health and socio-demographic indicators whereas Bihar located in the eastern part of India is a poor state with low social development indicators. For instance, the maternal mortality rate (MMR) of Karnataka was 144 for 100,000 live births against 219 in Bihar. The infant mortality rate of Bihar was 43 in comparison to 32 in Karnataka. Apart from health indicators, Bihar lagged behind Karnataka in most of the SRH related indicators. The unmet need for family planning was 35.9 in Bihar against 14.9 in Karnataka and Bihar had the lowest number of users in modern family planning methods among the major states of India [3]. The two states selected for this study represented more or less the scenario that is prevailing in India where the southern states – Kerala and Tamil Nadu have witnessed larger improvements in health and social indicators in comparison to eastern states – Bihar, Odisha and northern states of Uttar Pradesh and Rajasthan. The variations in health outcomes including the SRH indicators makes it an apt case to study the pattern of resource flow and financial commitment towards universal access to SRH in two divergent states of India.

Currently, most countries use the National Health Accounts (NHA) framework to examine resource flows in the health sector. NHA is a tool used to analyse the financial flow and transactions from the allocation of resources to the actual outputs in the health sector. This framework was adopted in the context of SRH here.

Based upon the NHA framework, this study identified the different sources of financing for SRH; government, households, NGOs, external donors and corporate firms. Household and government being the two major players, their contribution was captured comprehensively in this study.

Defining SRH expenditure is crucial as this is influenced by many factors. As suggested in the (ICDP), this study included a comprehensive definition where, RH is "a state of mental and social well-being and not merely the absence of disease or infirmity in all matter relating to the reproductive system and to its function and processes." This implies people have the capacity to reproduce and have the freedom to decide when and how often to do without any form of coercion, discrimination and violence.

Given such a comprehensive definition, this should include: family planning counselling, information-education-communication (IEC) and services; prenatal care, safe delivery and postnatal care, prevention and appropriate treatment of infertility; prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; treatment of sexually transmitted diseases and other reproductive health conditions. However, in many cases it is difficult to include all the activities required by ICPD either due to non-availability of disaggregated data on expenditures or due to difficulty in separating the joint nature of expenditure benefiting both mother and child.

Based upon this, this study included expenditure on adolescent health, family planning, antenatal care (ANC), post natal care

[1] Funds for population assistance divided into family planning; basic RH services consisting of maternal health, abortion, information, education, and communication about RH, among other services; sexually transmitted infections (STIs), HIV/AIDS, and basic research, data and population and development policy analysis.