Encouraging attended births in India:
Ethical pitfalls of Conditional Cash Transfer

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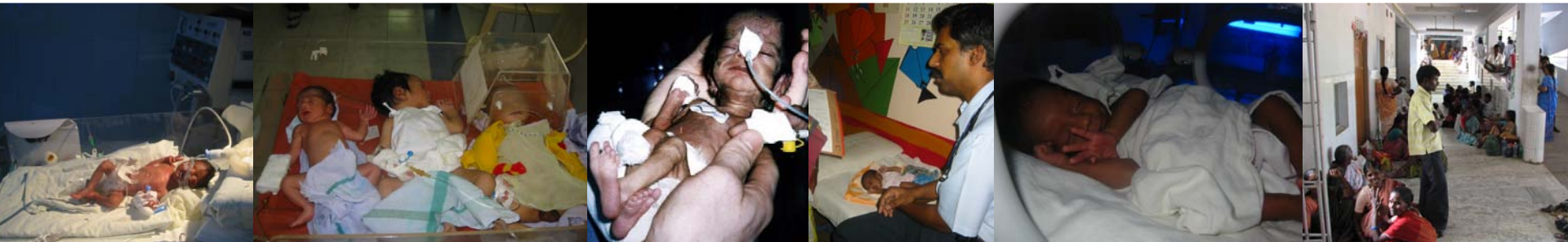
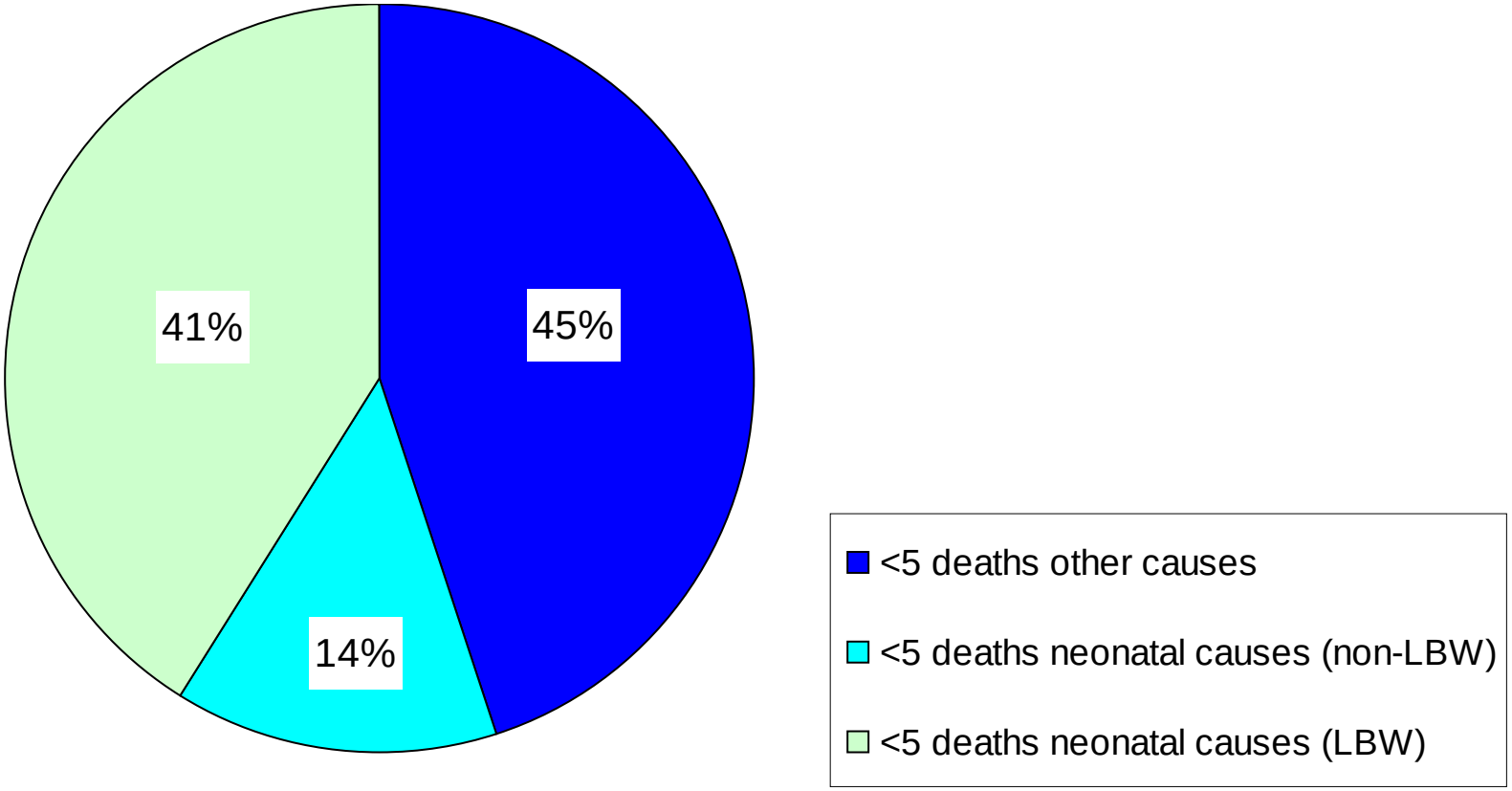


Objective:

Identify potential ethical pitfalls of conditional cash transfer (CCT) aimed at encouraging mothers in India to deliver in facilities:

Describe key priority dilemmas with emphasis on relevant criteria for fair distribution of limited health care

Distribution of <5 death causes



Background

- 1 million neonatal deaths in India per year (3.6 mill. globally)
- 40-70% mortality reduction possible
- In India:
  - 82% of health expenditures are out-of-pocket
  - Public spending on health: 1→ 3% of GDP
  - Increased awareness and funding
  - Insufficient coverage of best standard of care

= **Priorities are made at all levels**

Sources: Paul V.K. et al 2010, Lancet; Kumar S.A.K. et al. 2011, Lancet; Darmstadt G.L. 2005, Lancet

State of newborn health in India

- Die due to prematurity, infections, birth asphyxia
- Lack of medical treatment for sick and premature neonates
- Variation in mortality and access to health care
- Special issue: Gender

Sources: The million death study collaborators, 2010, Lancet; Miljeteig et al. 2009, Pediatrics; Simmons L.E. et al. 2010, Sem in Perinatology

Janani Suraksha Yojana (JSY)

- "Safe Motherhood Scheme" (2005)
- Primary goal to reduce maternal and neonatal death
  - Accredited Social Health Activists (ASHA)
  - Incentive payment for institutional delivery and skilled attendant at home deliveries

Sources: Ministry of Health & Family Welfare. Government of India. Janani Suraksha Yojana - Guidelines for Implementation

Preliminary outcome data of JSY

- Increased in-facility deliveries
- Inclusion depends on multiple factors
- Large variations between districts and states Reduced mortality:
  - perinatal mortality reduction; 4.1 deaths /1000 livebirths
  - neonatal mortality reduction; 2.4 deaths/1000 livebirths
- No reduction in maternal mortality
- Variable quality, capacity problems, lack of equipment, infrastructure, skilled personnel, attitudes

Sources: Lim S.L et al. Lancet 2010; Khan M.E et al. Journal of Family Welfare 2010; Sharma MP et al. Indian J Public Health 2009

Critique of CCT to improve health

- Divert attention from other well documented programs
- Changing behavior for the wrong reasons
- Sustainability
- Lack of data on long term effects
- Targeting and stigma
- Increased corruption and administration
- Not reaching the worst off
- Increase access before quality

Sources: Lagarde M. Cochrane Database of Systematic Reviews 2009; Transparency International, "Corruption prevention strategies in cash transfer schemes", 2010

Ethical pitfalls of JSY

- ”New” patient groups:
  - premature and sick neonates
  - disabled
  - preventable stillbirths
  - (girls?)
- Consequences for mothers and families
- Workload on health workers
- Expanding decision maker roles
- Limits and standards in institutions with/without access to SNCU/NICU?
- Are these limits fair?

Key priority dilemmas following giving incentives for in-facility births in India

Relevant equity dimensions for fair distribution of limited health care

- Area of residence
- Unfair distribution of wealth/income/education
- Ethnicity
- Gender
- Imposing catastrophic health expenditures

- Severity of conditions
- Effectiveness of intervention
- Cost-effectiveness
- Equality in lifetime health

Sources: Daniels N. 2008, ”Just Health”; Daniels N. 2000, Bull World Health Organ; Norheim O.F. 2010, Am J of Bioethics; Persad G et al. 2009, Lancet; Baltussen R et al. Tropical medicine & international health 2011

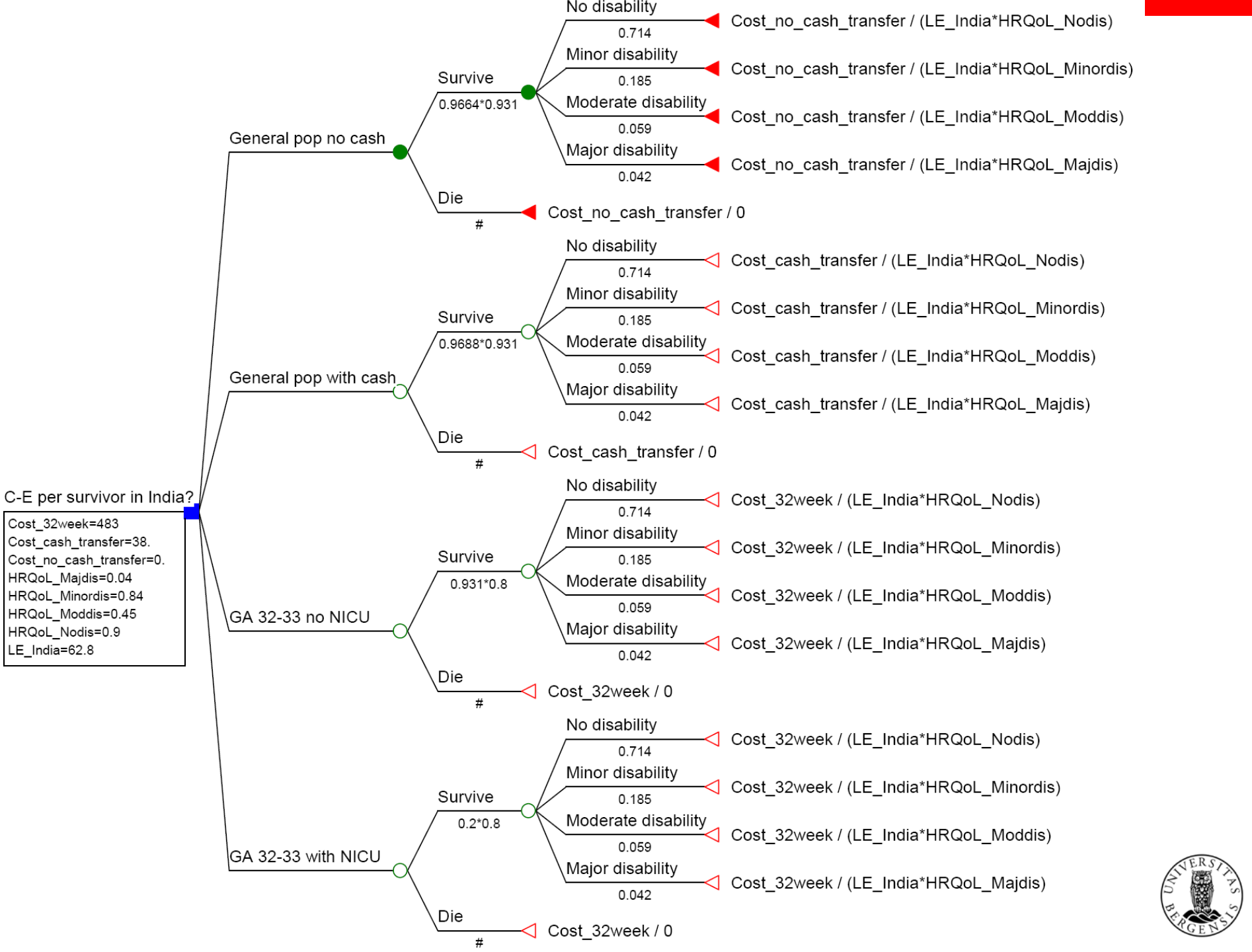
Equity dimensions in JSY

- Urban>rural
- Inequality in JSY implementation according to:
  - Poverty level, caste, education level, age and parity mother, religion
- Catastrophic health expenditures

Sources: Das A et al. Lancet 2010; Kumar AKS et al. Lancet 2011; Paul VK et al. Lancet 2011; Bhal R et al. Semin in Perinatologiy 2010; Khan M.E et al. Journal of Family Welfare 2010

Evaluation of two interventions aiming to reduce NMR according to:

- Severity (lifetime prognosis no intervention)
- Effectiveness (health benefit from intervention)
- Cost-effectiveness


C-E per survivor in India?
Cost_32week=483
Cost_cash_transfer=38.
Cost_no_cash_transfer=0.
HRQoL_Majdis=0.04
HRQoL_Minordis=0.84
HRQoL_Moddis=0.45
HRQoL_Nodis=0.9
LE_India=62.8
General pop no cash
Survive
0.9664*0.931
No disability
0.714
Cost_no_cash_transfer / (LE_India*HRQoL_Nodis)
Minor disability
0.185
Cost_no_cash_transfer / (LE_India*HRQoL_Minordis)
Moderate disability
0.059
Cost_no_cash_transfer / (LE_India*HRQoL_Moddis)
Major disability
0.042
Cost_no_cash_transfer / (LE_India*HRQoL_Majdis)
Die
#
Cost_no_cash_transfer / 0
General pop with cash
Survive
0.9688*0.931
No disability
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Cost_cash_transfer / 0
GA 32-33 no NICU
Survive
0.931*0.8
No disability
0.714
Cost_32week / (LE_India*HRQoL_Nodis)
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Cost_32week / (LE_India*HRQoL_Moddis)
Major disability
0.042
Cost_32week / (LE_India*HRQoL_Majdis)
Die
#
Cost_32week / 0
GA 32-33 with NICU
Survive
0.2*0.8
No disability
0.714
Cost_32week / (LE_India*HRQoL_Nodis)
Minor disability
0.185
Cost_32week / (LE_India*HRQoL_Minordis)
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Die
#
Cost_32week / 0

Mean individual health			
	QALE NO-intervention	QALE +intervention	Net benefit
CCT	46.7	46.8	0.1
NICU GA 32-33	8.3	38.6	30.3

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Aggregated public health

	cost ($) / QALY	n-persons annually
CCT	342	26 million
NICU GA 32-33	12	580,000

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Aggregated public health

	cost ($) / QALY	n-persons annually
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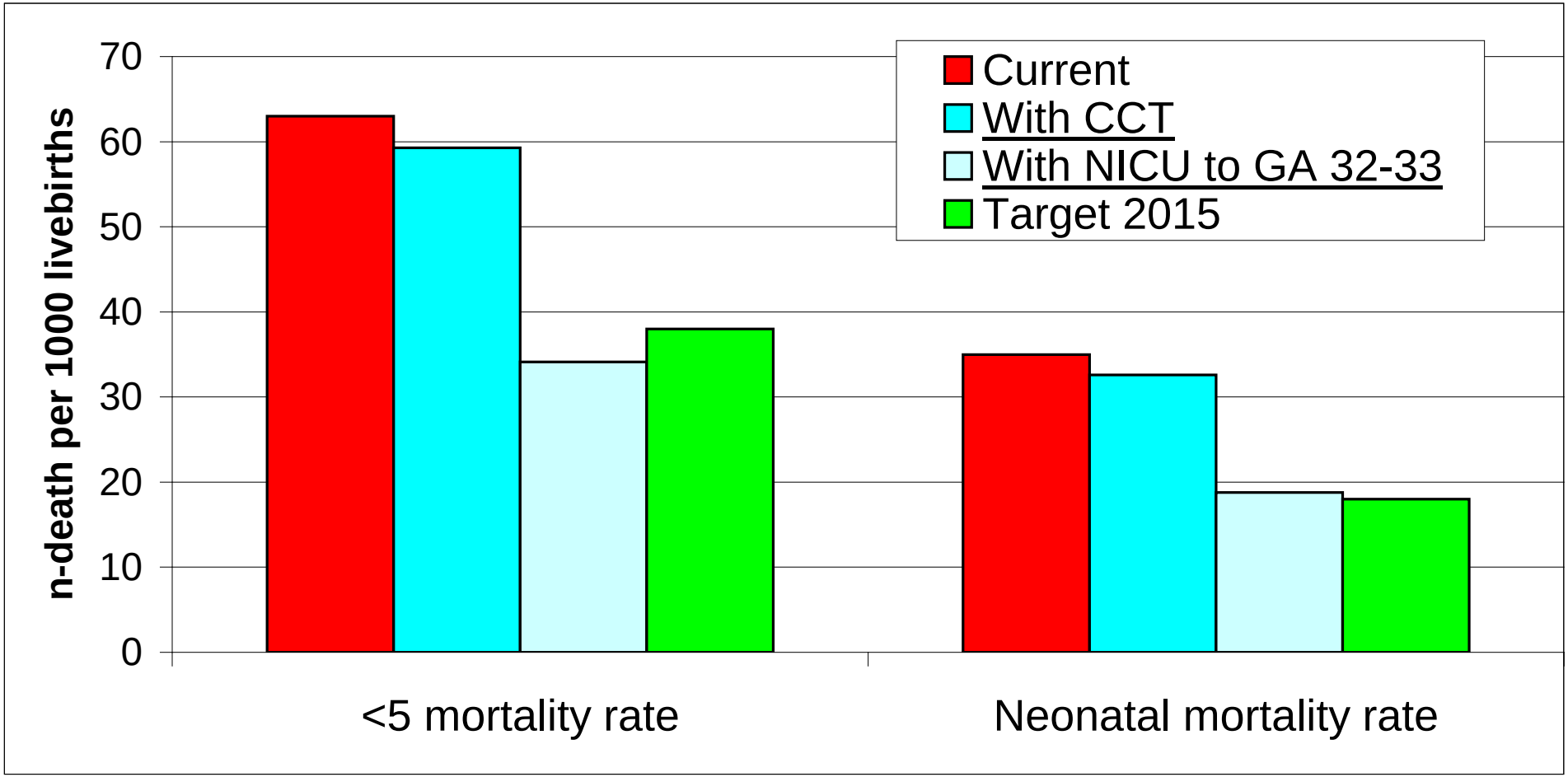
	total QALY	total cost ($)
CCT	2.6 million	990 million
NICU GA 32-33	17.5 million	280 million

In other words…



Summary

- JSY improves neonatal health for a large population and reach many of the poor
- Systematic evaluation of ethical pitfalls and JSY as a priority setting dilemma
- Access vs. quality and capacity
  - Access to what?
  - Capacity to whom?
  - Trust?