Abortion economics - cost and expenditures

RAVI DUGGAL

Seminar, 532, December 2003, pp.47-52

ACCESSING abortion services of a wide-ranging variety is not difficult, even in the remotest areas of the country. This assortment of providers of abortion services range from *dais* and herbalists at one end of the spectrum to government paramedics like auxiliary nurse midwives, compounders and other health workers, unqualified private providers, qualified but uncertified doctors, to the gynaecologist at the other. This despite the fact that the practice of abortion has been legal since 1971 for those certified under the Medical Termination of Pregnancy Act. With certification under the act available to all allopathic doctors who meet the requirements and no dearth of providers who can be certified, yet unregistered and illegal abortions continue in overwhelmingly large numbers. Why is this so?

The answer lies in the political economy of modern health care and specifically abortion care. Traditionally, birth attendance and abortion were very much in the domain of the local dai and/or an equivalent practitioner like a herbalist or often even a local abortionist. Usually a woman, this provider was part of the *jajmani*[1] relations and provided services to all within her community. While not much has been written about abortions in pre-colonial India there is also no evidence of abortion being illegal in India, notwithstanding Kautilya's *Arthashastra*, which specified severe punishment for aborting a slave woman.[2] In fact, unlike the Hippocratic oath (*I will not give to a woman a pessary to produce abortion*),[3] the code of ethics as perthe*Charaka Samhita* does not mention abortion.

The ban came into effect only with the establishment of the Indian Medical Service in 1763 (initially as the Bengal Medical Service) under the British,[4] subsequently codified in the Indian Penal Code of 1860. With the establishment of modern medical

education and practice came values as understood under western medical practice, including criminalization of existing abortion, which continued in the code of ethics of the Indian Medical Council established in 1956 (*I will maintain the utmost respect for human life from the time of conception*). This medicalization of abortion completely changed the political economy of abortion, threatening the traditional dispensation. However, because regulation of medical practice was grossly wanting, abortion services continued to thrive even during this period of criminalization.

Given the above reality, the need for feminists and women's organizations to struggle for legal abortion as elsewhere in the world was not a priority. The Indian government in its dogged pursuit of population control adopted abortion as one more method of fertility control and legalised abortion under the Medical Termination of Pregnancy Act, 1971 (amended in 2002). This formal legalization provided the medical profession monopoly over abortion provision and worked as a further step in the medicalization of abortion. Legal abortion services began to expand but did not significantly threaten the traditional abortion providers. On the contrary, abortion was seen as a growing business and many unqualified and/ or untrained medical practitioners entered the fray. Since regulation of medical practice was weak, this put a further dampener on the expansion of legal abortion services.

While the state had promulgated the MTP Act to make abortion legal, it did not become a leading player in abortion provision unlike family planning services like sterilization, IUDs and other contraceptives. Thus abortion services remained predominantly in the private domain with the state playing a subtle role in keeping abortion within the family planning context by providing subsidies to private abortion

providers provided they linked abortion provision with sterilization or IUD.[5] In public health facilities the state pushed hard for acceptance of sterilization and IUDs for abortion seekers with the adverse consequence of turning women away.

An unmet demand for public abortion services further opened the floodgates for all sorts of private providers. In the eighties we saw huge advertising campaigns by private providers selling abortion services 'for Rs 70 only' – a clear message by the state that abortion could be practiced freely irrespective of the restrictions within the MTP Act. This attitude of the state and its failure to play a lead role strengthened the existing political economy of abortion practice, adding to the numbers of illegal and unsafe providers.[6]

In this trajectory of development the traditional abortion providers have got marginalized. Also with sterilization having wide acceptance in rural areas, the demand for abortions was partially affected, and the traditional abortion providers, as usually happens with the penetration of a new system or dispensation, become the first casualty. They only survive in remote pockets, *adivasi*and other under-served areas. Of concern in terms of safe abortion services is the growing number of non-traditional and unqualified practitioners of abortion services on the one hand and the absolute lack of ethics and self-regulation in medical and abortion practice among qualified professionals and their associations on the other.

Today, sex-selection and sex determination possibilities have catapulted the abortion business to newer heights and many unscrupulous players have entered the business. The massive decline in juvenile sex ratios has awakened the state into putting in place some vigilance and regulation. While the Pre Natal Diagnostic Techniques Act has been strengthened to control sex selection, the MTP Act has also been amended to make the process of registration and certification simpler and less bureaucratic with

the hope that registration and hence proportion of legal abortions will substantially increase.

Given the above political economy and the stigma and secrecy that often accompany abortions, the cost to the seeker of abortion services is likely to be determined by supply side economics. The cost of abortion services vary considerably depending on factors such as the number of weeks since conception, the method used for abortion, the client's marital status, the kind of anaesthesia used, whether linked to acceptance of some contraception, whether it is a sex-selective abortion, whether any diagnostic tests like pregnancy test, sonography, lab tests and so on are carried out, medications given, the location of the clinic, whether the provider and/or clinic is registered, whether hospitalisation is required, the nature of competition and so on.

Since India's health care systems are not organized and regulated there are no standardized costs for services or components of services. Further, since health insurance in India does not normally cover abortions, the pricing of abortion services remains unregulated.[7] In the USA in contrast, insurance does cover abortion, though state programmes like Medicaid (for the poor) have major restrictions in that only abortions following rape, incest and if a woman's life is endangered, are covered.[8] Given the organized nature of the health sector in the USA abortion costs are reasonably well documented. Depending on the procedure used and the gestation of pregnancy the rates vary from $350 to $500 for an early abortion going up to $1000 for a late one.[9]

But even with relatively fixed rates, other factors may vary the price. For instance, women under 17 years are likely to pay higher rates for the same procedure as are women who are forced to opt for abortion due to genetic indications.[10] For medical abortions (RU-486) the rate is $525.[11]Similarly in Britain, private abortion providers

have more or less standardized rates. For instance the Marie Stopes clinics charge £450 for RU-486, £420 for surgical abortion up to 12 weeks without anaesthesia, £480 for 14 weeks with general anaesthesia and £650 for pregnancies between 14-19 weeks.[12] In a developing country like Vietnam where menstrual regulation is a popular method, a study of 800,000 MRs showed that it cost only $11.5 per MR, of which the woman had to bear three-fourths of the cost.[13]

In India such data is not available, except through small studies of providers and household-based studies researching health care utilization patterns. Recently, a multi-centric study of abortion providers in six states attempted to obtain costs from private and public providers of abortion services. In Kerala the costs ranged from an average of Rs 1266 for under 12 weeks to over Rs 5000 for over 20 weeks in the private sector, which were free in the public sector.[14]In Haryana, the public sector costs ranged from Rs 9 to 80 for under 12 weeks and over 12 weeks respectively, while in the private sector the range was from Rs 300 to 3000.[15] In MP the public sector cost was much higher ranging from Rs 209 under 12 weeks of pregnancy to Rs 775 for up to 20 weeks, and in the private sector from Rs 389 under 12 weeks to Rs 1583 for over 20 weeks.[16]

A number of other studies in the last few years have looked at what clinics charge or what clients pay for use of abortion services. CORT conducted studies of providers in rural UP, Maharashtra, Gujarat and Tamil Nadu and also interviewed a few clients to collect information on the fee paid. These ranged from Rs 135 to 534 (average Rs 370) for public providers and from Rs 394 to 649 (average Rs 497) for private providers. Of this the doctor got 42% and 21% was spent on medicines.[17] A similar

study in Maharashtra in 1999 computed the average cost of abortion at Rs 991.[18] And in UP and Rajasthan in 1998 the average cost to the user was between Rs 200 and 500 in a government facility, Rs 700 to 800 in private hospitals and Rs 1000+ in Marie Stopes clinics.[19]

All the above studies indicate that early abortion is available on the average between Rs 500 and 1000 and late abortion averages between Rs 2000 and 3000 per case. The variation depends on the method used, with vacuum aspiration during early pregnancy costing much less than other surgical procedures like dilatation and curettage, since the latter procedures use general anaesthesia adding to the cost. Manual vacuum aspiration (MVA) use is still very low in India and its larger use could substantially bring down the cost of abortion. The experience in many developing countries of Africa, Asia and Latin America provides clear evidence for an expansion in the use of MVA, not only because it is cheap[20] but also because it would encourage early abortion. This in turn would make abortion safer, even if trained paramedics provide such services as is being done in Bangladesh and South Africa.[21]

Another reason for cost variation could be undertaking of sex-selective abortions. A qualitative study of women in Maharashtra showed that while regular abortion cost between Rs 100 to 1200 depending on whether it was a public or private facility, the cost went up to Rs 5000 for a sex-selective abortion.[22] Further, the legality of the provider could also be a factor that affects cost. An exploratory study in Delhi showed that in middle and lower class localities the charges for abortion services were higher for illegal providers, further increasing for unmarried girls.[23]

Expenditure data has also been collected at the household level from women who have undergone abortions. Again, national level studies like NFHS, RCH and NSSO have failed to collect such data when recording pregnancy outcomes, and thus it is

only a few small studies that have gathered some data on out-of-pocket expenditures for seeking abortions. Also in public budgets, abortion related expenditures are not indicated separately, except when there is a separate plan scheme for upgradation of services or other such new provisions. For instance, in the Maharashtra health budget of 2003-04, a sum of Rs 2.5 million has been allocated under the MCH programme for expansion of MTP services, and in the year 2001-02 Rs 2.23 million was spent for expansion of MTP services.[24]

As part of the abortion assessment project, household level studies have been carried out in Maharashtra and Tamil Nadu. Preliminary data from the Maharashtra study suggests that during the last five years the average expenditure incurred by women was Rs 1460 per induced abortion.[25]

A study in West Bengal[26] in 1998 calculated median expenditures by women for each induced abortion as follows: private hospitals and nursing homes Rs 1000; private clinics Rs 500; government hospital Rs 356; primary health centre Rs 335; RMP Rs 400; and traditional healers Rs 200.

A study on health expenditures in 1987, which also recorded pregnancy outcomes, showed that the mean expenditure for seeking induced abortions was Rs 300 per abortion, of which 41% went to the doctor and hospital and as much as 36% for medicines and tonics. Data from this study also revealed that the share of abortion expenditures in total household health care out-of-pocket expenditures was 0.21%.[27] A similar study in 1990 recorded Rs 1258 as the mean expenditure per induced abortion and this was 0.54% of total household health expenditure.[28]More recently, two studies on women's reproductive health by CEHAT recorded mean expenditure for induced abortion as Rs 640[29] and 989[30] (latter only private) per abortion. In these studies the share of abortion in household health expenditure was 0.16% and 0.28% respectively.

For Rajasthan a larger study in 1998-99 using the national health accounts framework estimated expenditures on abortion state-wide for both public and private health sectors.[31] This study recorded mean household expenditure on abortion as Rs 925 per abortion with a small public/private variation – for government services it cost women Rs 873 out-of-pocket and for private services Rs 977 per abortion. This study estimated the value of the entire health economy of Rajasthan at Rs 30,034 million in 1998-99 with the public sector share being 29% (Rs 8673 million). This amounted to 5.95% of the state domestic product with the private sector accounting for 4.23% of SDP. Of this the RCH expenditure (maternity, immunizations, antenatal and postnatal, abortions, contraception etc.) was Rs 6424 million, and of the latter abortion was Rs 160 million. Thus the share of abortion works out to 0.53% of total health expenditure. Out of the total abortion expenditure, 82.5% (Rs 132 million) was out-of-pocket expenditure and the rest by the public health sector. In the public sector the share of abortion in total health expenditure worked out to 0.32% and in the private sector 0.62%.

In recent years, medical abortion as an option has been gaining momentum. Mifepristone is today used widely across the world; its use in India was legalised in February 2002 by the Drugs Controller. While obtaining data on the pharmaceutical market is difficult as selected consultants control this information and sell it at exorbitant prices, an estimate from *IMS Health*(August 2003) shows that mifepristone sales in India stood at Rs 174 million over previous12 months (at Rs 320 per dose this translates into a whopping 540,000 medical abortions). It is worth noting that mifepristone was being used in India even prior to its legalization and hence there is also a grey market and the above figure could be an underestimate. Further, the legalisation of its use by the drug authorities is restricted to only gynaecologists

directly or to hospitals which are recognised for abortion services. But the reality is that mifepristone is available over the counter and misuse of this drug cannot be ruled out because recent evidence shows that doctors as yet do not seem to be using medical abortion as a significant option.

Abortion economics in India thus has to contend with specific peculiarities. Despite early legalisation of abortion the problem of illegal providers and unsafe abortion looms large. This translates into a political economy of abortion which is controlled by providers of various kinds. The unqualified and unregistered exploit the vulnerabilities of the abortion seekers and contribute to widespread post-abortion problems and mortality. This does not imply that those qualified and certified do not exploit, but at least they are open to monitoring by the authorities.

The responsibility of this mismanaged political economy falls squarely on both the state agencies and qualified medical professionals. The former because they have failed miserably to institutionalize services for safe abortions[32] and have not regulated private providers; the latter because they completely lack in ethical medical practice and have failed to self-regulate professional conduct. Seen in conjunction with the social dynamics determining abortion seeking behaviour and the social restrictions in access which women face,[33] we have a political economy that thrives on vulnerabilities of the very clients who are the source of the providers' survival.

Analysis of expenditure data shows that women have to spend substantial amounts in accessing both private and public abortion services. Until recently they were free of charge, even though women reported out-of-pocket expenses (usually non-medical expenses like travel or on prescription drugs) in the various studies mentioned earlier.

Presently, abortion services in the public sector are free only if the woman or her husband opts for some form of contraception, usually sterilization or IUD, after the abortion. This conditionality existed even prior to user fees being introduced in 2000 and was the main reason which distanced women from using public health facilities. The addition of a user fee has made access to public abortion services for women even remoter. Estimates from various studies referred to above lead one to conclude that induced abortions in public health facilities cost on an average between Rs 300 and 500.

The private sector shows substantial variation in charges for abortion services. On average early abortions cost women around Rs 1000 for an induced abortion while late abortions cost close to Rs 3000 per abortion – a substantial expense for the poor or even lower middle class women. Given that a larger number of providers are unqualified and/or uncertified, the cost of unsafe abortions has to be factored in and hence post-abortion costs due to botched-up abortions and various complications could be even higher. This is one unexplored area in abortion economics; what we know well is that 15-20% of maternal deaths are due to unsafe abortions.

Another dimension in abortion economics, especially in the private sector, relates to the methods used for abortion. The obsession with curettage even in very early abortion, including check curettage after vacuum aspiration, is overwhelming among both certified and non-certified providers, adding to the cost as well risk of post-abortion infections and problems. This is clearly borne out in the recent studies undertaken under the aegis of the Abortion Assessment Project – India.

The overall share of abortion related expenditure in total health expenditure ranges between 0.25% to 0.62%. The Rajasthan study cited above provides a fairly comprehensive accounting of various health expenditures. If we go by their figure of

share of abortion expenditure in total health expenditure, then for a national health expenditure (public and private) of about Rs 1500 billion (Rs 1250 billion private) the abortion economy would be valued at Rs 8 billion. Of course, Rajasthan is not representative for the country as a whole, but what is evident is that the above figure for abortion expenditure is probably an underestimate for the country because in many other states the private health sector is much larger than in Rajasthan.

Finally, the above analysis makes imperative that regulation of the abortion economy, both by the state and the medical profession, is critical for rationalization of costs as well as assuring safe abortions for women. Learning from experience in a number of African, Latin American and Asian countries, it would make good sense to expand the legal base of abortion providers. As mentioned earlier, Bangladesh and South Africa, among other countries, have used paramedics like nurses, midwives and auxiliary nurse midwives to provide early abortion services using menstrual regulation methods.

This is a choice worth pursuing because training and legalization of ANMs, LHVs and other women paramedics in India to conduct early abortions would eliminate many of the quacks. This is easier said than done because it involves large scale investment in training of these paramedics in the face of strong resistance from the medical profession, strengthening support systems in public health services, changing the state’s perspective of viewing abortion as a family planning method, as also building confidence in women to rely on paramedics. Such an option in terms of financing would not only be cost-effective but simultaneously increase the credibility of the public health system.

Footnotes:

1. The *jajmani* system was a set of economic interrelations across caste groups in the local community which had social sanction and was linked to mandatory social obligations. This also kept intact the economic basis of the caste system. Today, though is largely destroyed, it survives in pockets in most states, especially the Hindi heartland.

2. O.P. Jaggi, *Indian System of Medicine*, Atma Ram and Sons, Delhi, 1981.

3. O.P. Jaggi, *Western Medicine in India: Social Impact*, Atma Ram and Sons, Delhi, 1980.

4. D.G. Crawford, *A History of Indian Medical Service 1600-1913*, W. Thacker and Co., Calcutta, 1914.

5. Organizations like FPAI and many other NGOs get grants for conducting sterilizations and inserting IUDs, including incentive money. Often this is linked to abortion services which are provided free to acceptors of contraception. For instance, FPAI records reveal that 97% of abortions in 2001-02 in Delhi were dovetailed with sterilizations or IUDs (cited in Cost and Finance in Abortion by Ramamani Sundar – a paper done for the Abortion Assessment Project, India – under publication).

6. The first major study on illegal abortions by ICMR showed that 68.5% of all induced abortions were illegal. This study conducted in five states covering 44731 pregnancy outcomes recorded an induced abortion rate of 21 per 1000 live births and an abortion ratio of 1.98% of all pregnancy outcomes – ICMR, Illegal Abortions in Rural Areas, ICMR, New Delhi, 1989.

7. Social insurance programmes like ESIS, CGHS, Mines Acts, Maternity Benefit Act etc. do cover abortions and have fixed rates which are reimbursed for abortions and miscarriages.

8. Alan Guttmacher Institute, Revising public funding of abortion for poor women, Issues in Brief, 2000 Series, No. 5.

9. S. Henshaw and L. Finer, 'The accessibility of abortion services in the United States, 2001', *Perspectives on Sexual and Reproductive Health* 35(1), January/February 2003.

10. http://www.lrfps.com/fee.html

11. Ibid.

12. http://www.mariestopes.org.uk/uk/abortion-fees.htm

13. T.H. Vach et al., 'The potential impact of introducing pregnancy testing into menstrual regulation procedure in Vietnam', *International Family Planning Perspectives* 24(4), December 1998.

14. M. Ramanathan et al., Situational analysis of MTP services in Kerala: provider perspectives (draft report), AMCHSS, Thiruvananthapuram, 2003.

15. S. Barge et al., Situation analysis of MTP facilities in Haryana (draft report), SORT, Vadodara, March 2003.

16. A. George, An enquiry into provision of abortion services in Madhya Pradesh (draft report), CHSSS, Hyderabad, August 2003.

17. CORT, Situational analysis of MTP services in Gujarat (1995), Maharashtra (1996), UP (1997) and Tamil Nadu (1997), Centre for Operations Research and Training, Baroda.

18. S. Bandewar and M. Sumant, Quality of abortion care: a reality, CEHAT, Pune, 2002.

19. PSS, Abortion research phase II (final report) Parivar Seva Sanstha, New Delhi, 2002.

20. M. Jowett, 'Safe motherhood intervention in low income countries – an economic justification and evidence of cost effectiveness', *Health Policy* 53(3), 2000.

21. B. Klugman and D. Budlender (eds.), *Advocating for Abortion Access*, University of Witwatersrand, 2000, Johannesburg.

22. M. Gupte, et al., 'Abortion needs of women in India – a case study of rural Maharashtra', *Reproductive Health Matters*, May 1997.

23. R. Sundar, Cost and finance in abortion (draft paper for Abortion Assessment Project; under publication), CEHAT and HealthWatch, Mumbai 2003.

24. Government of Maharashtra, Civil Budget 2003-04 – Public Health Department, GOM, Mumbai, 2003.

25. Preliminary data generated from an ongoing abortion incidence study undertaken by CEHAT.

26. S. Mathai, Study on prevalence of abortion in West Bengal, unpublished.

27. R. Duggal and S. Amin, Cost of health care, FRCH, 1989, Bombay.

28. A. George, et al., A study of household health expenditure in Madhya Pradesh, FRCH, 1992, Bombay.

29. N. Madhiwala, et al., Health households and women's lives, CEHAT, 2000, Mumbai.

30. S. Nandraj, et al., Women and healthcare in Mumbai, CEHAT, 2001, Mumbai.

31. IIHMR, et al., Financing reproductive and child healthcare in Rajasthan, IIHMR, 2000, Jaipur.

32. For instance all PHCs and rural hospitals (that is one facility per 20000 population) are certified by default to provide abortion services. But the government's own study, the RCH Facility Survey Phase 1, shows that only 13% of PHCs and 28% of rural hospitals had qualified persons to conduct abortions.

33. Op cit., fn 22.