Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 7, Issue, 09, pp.20808-20815, September, 2015

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

ISSN: 0975-833X

RESEARCH ARTICLE

JANANI SHISHU SURAKSHA KARYAKRAM AND ITS REPERCUSSIONS ON OUT OF POCKET EXPENDITURE

***Dr. Suresh Sharma**

Institute of Economic Growth, Delhi University Enclave, Delhi, India

ARTICLE INFO

Article History:
Received 06th June, 2015
Received in revised form
23rd July, 2015
Accepted 18th August, 2015
Published online 30th September, 2015

Key words:

JSSK,
Out of Pocket Expenditure,
Diagnostic,
Beneficiaries and Delhi.

ABSTRACT

This paper primarily focuses upon the repercussions of Janani Shishu Suraksha Karyakram (JSSK) scheme on the out of pocket expenditure incurred by the beneficiaries. This paper examines the pattern of spending by the beneficiaries on various components of JSSK at aggregated and disaggregated levels that is analyzing the expenditure incurred on diet, diagnosis, transportation and medicines separately and collectively on maternal and child health. The primary survey conducted across various districts of Delhi unveils that beneficiaries are still incurring huge costs on health and the larger share of the expenditure is on diagnosis mainly because of infrastructure bottlenecks. Diagnosis was followed by medicine which is because of lack of timely availability of drugs. The scheme also guaranteed free transportation services to the beneficiaries but due to lack of ambulances and narrow inaccessible lands beneficiaries were still incurring costs on transportation. Diet also constituted an important part of the health care scheme but provision of raw food items like eggs breads etc defeated this component of the scheme as well. Thus this paper shows the presence of various infrastructure and other bottlenecks which are defeating the ultimate aim of the scheme that is to reduce the out-of-pocket expenditure of the beneficiaries.

Copyright © 2015 Dr. Suresh Sharma. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

***Citation*:** Dr. Suresh Sharma, 2015. "Janani shishu suraksha karyakram and its repercussions on out of pocket expenditure", *International Journal of Current Research*, 7, (9), 20808-20815.

INTRODUCTION

Janani Shishu Suraksha Karyakaram as a scheme was introduced on 1st June, 2011 to improve the health outcomes in India since health has always remained an important concern for the policymakers and researchers in India. High levels of morbidity and mortality still prevails despite various attempts and initiatives taken by the Government of India from time to time. Maternal Mortality rates in India have declined from 220 to 190 per 1, 00,000 live births from 2005-09 to 2010-1014. (World Bank data.worldbank.org) and Infant Mortality Rate have dropped from 56 in 2005 to 41 in 2013(World Bank data.worldbank.org) but huge scope still remains. JSSK as a scheme was introduced to provide cashless services to the beneficiary thereby aiming at reducing out-of-pocket expenditure of the beneficiaries. Prevalence of various loopholes and lack of proper infrastructure and human power have reduced the overall effectiveness of the scheme. Private players undoubtedly provide better services both in terms of quality and quantity but they are driven by the profit motive and hence cannot be relied upon especially by the low income group categories since the costs incurred in availing private services is beyond what they can afford.

****Corresponding author: Dr. Suresh Sharma,***
Institute of Economic Growth, Delhi University Enclave, Delhi, India.

It is for this reason that government institutions are called upon to take charge so as to improve the overall health outcomes and reduce the burden of spending on these services. But this does not solve all the problems as even at the government level, infrastructure and other bottlenecks prevail at central, state or local governments' provided health services. Further, this is not just limited to physical and financial resources but also goes beyond that from deployment of doctors to non clinical services thereby resulting in inducing the beneficiaries to avail services provided by the private institutions, thereby, increasing their out of pocket expenditure.

Keeping this view in mind, and the fact that India is spending considerably low on health as compared to other developed countries and some of the developing countries, NRHM (National Rural Health Mission) was launched in April 2005 by Government of India to address the health needs of the disadvantaged women and children. It aimed at strengthening the health facilities to provide services by enhancing and improving infrastructure, by increasing availability of equipment and essential supplies and by promoting demand through community level processes. Under this, Janani Suraksha Yojana (JSY) scheme was introduced for a period of 2005-12.

This scheme was not able to achieve its targeted goals since mere cash incentives were not enough to attract people towards public institutions and this also encouraged corruption and furthermore people were spending on other service such as diet, diagnostic, transport etc. Thus, to enhance the overall effectiveness of the scheme, Janani Shishu Suraksha Karyakram (JSSK) was introduced in June 2011 with its major objective being to reduce out of pocket expenditure in utilization of antenatal care, institutional delivery, post natal care and neonatal care. It also aimed at providing free services like medicine, diet, diagnostic and transport to the pregnant women and the new born baby up to 30 days after delivery. But even after the JSSK scheme it was observed that beneficiaries still incur some costs i.e. their out of pocket expenditure was not reduced and thereby defeating the key objective of the scheme. Expenditure was carried out by the beneficiaries because of lack of awareness of such services, poor coverage in areas where the lanes are narrow and the ambulance cannot reach, etc.

This study will focus on implementation status of JSSK scheme in the Delhi state through districts of North, South, East, West and South-East. The prime objective of this paper involves an in-depth analysis of "Impact of JSSK Scheme on out-of-pocket expenditures" incurred by the beneficiaries. The study was aimed at examining the pattern of spending on diet, diagnosis, medicine and transport by the beneficiaries at aggregated and disaggregated levels. Scrutinizing the socio-economic differentials in the pattern of spending and reviewing whether the services are reaching the targeted population or not, thereby analyzing the overall effectiveness and prevalence of various loopholes existing in the scheme thus devising various policy actions and recommendations for ameliorating the scheme. The basic rationale of this paper is to investigate whether the huge spending by government under NHM in general and JSSK in particular is able to reduce the out-of- pocket expenditure incurred by the beneficiaries.

MATERIALS AND METHODS

The data was extracted from the primary survey conducted across various districts of Delhi by means of the questionnaires at the district, facility and the beneficiary level. The target population for the study included women who have delivered in past six months to one year and have availed the benefits of the scheme. The geographical survey included North, South, East, West and South-East districts of Delhi. From each district four facilities were taken along with the discussions with the district level officials. From each facility, sample of 22 beneficiaries were taken to evaluate the effectiveness of the scheme. Multi stage random sampling has been used. The data was then processed and regressed along with careful examination using statistical tools to investigate the overall success and loopholes of the scheme at implementation level.

The information obtained from beneficiaries includes their socio-economic and demographic attributes along with other factors such as: Awareness about JSSK, Availability & utilization of free referral transport services, Availability & utilization of free Diagnostic services, Quality and Quantity of food provided, & Availability of drugs, Health problems & redress of Sick-Neonates.

Beneficiaries were also questioned about the expenditure incurred overall and separately on diet, diagnosis, medicine and transport and their satisfaction level regarding each component of JSSK services. The information obtained from JSSK service provider includes provision of providing Food, free transport & diagnostic, Availability of drugs, Reasons of Maternal Deaths, Flaws in JSSK implementation, Yearly performance, Fund sanctioned and utilized.

RESULTS

The survey unveiled that the beneficiaries were still incurring a substantial cost on the services even after the provision of free services under JSK. While there was a difference in the pattern of expenditure on various components (diet, diagnosis, transport and medicine) but overall beneficiaries were still incurring significant expenditure on the services. Lack of awareness was a major policy loophole. But interestingly, despite so much unawareness about JSSK or its other basic concerns, majority of the beneficiaries reported being satisfied and that this scheme has proved to be beneficial to them. The funds allocated to health facilities by JSSK during 2013-14 were around 40 per cent for drugs, 53 per cent for diagnostic and 8 per cent for blood transformation in all health facilities. However, even after such an allocation, we observe from Fig 1 that spending on diagnosis constitutes a larger proportion of total expenditure incurred by the beneficiaries. 39 per cent of total expenditure is incurred even when 53 per cent of the total funds were allocated for diagnosis; this may be due to lack of basic equipments. Medicine and informal payments also constitutes a larger share of the total expenditure incurred by the beneficiaries which may be due to shortage of drugs. However diet and transport constituted a smaller proportion to total expenditure. Thus it can be asserted that people are still incurring costs from their pocket.

The Table 1 shows the average maternal health expenditure according to the socio-economic characteristics of the beneficiaries. Average expenditure on maternal health, medicine, diagnostic transport and informal payment is high among the age group of 35-49 years. Informal payment is relatively higher in this age group as compared to others. Cost incurred on diagnostic services was comparatively higher than the other services across all age groups. Expenditure incurred on diet was relatively higher for the beneficiaries under the age of 20 years. Spending on maternal health was high amongst highly educated beneficiaries, general caste, unemployed, low income class and RSBY (Rashtriya Swasthya Bima Yojna) card holder. At the educational level, spending on medicine, diagnostic, transport, diet and informal payment were high amongst highly educated beneficiaries. Across the religion, spending on medicine, diagnostic, diet, and informal payment is high amongst Sikh. Expenditure on medicine is high amongst general caste, skilled worker, income Rs 2000-Rs 5000, and RSBY card holders. Overall, the average expenditure on medicine was Rs. 776, Rs. 1129 on diagnostic cost, Rs. 150 on transport, Rs. 291 on diet and Rs. 595 on informal payment. Thus as noted above diagnostic costs were a significant part of the total expenditure incurred by the beneficiaries.

Lack of proper infrastructure could be a possible reason for such high levels of expenditure on diagnostic services. The survey revealed that the percentage share on child treatment out of total expenditure on neonatal cases is high amongst age 35-49 years, Hindu, secondary education, general caste, other occupation of beneficiaries husband, high income class, and BPL card holder. But in cases of child referred, percentage shares is high amongst the beneficiaries 20-34 years age, illiterate, Hindu, SC, skilled worker, income more than Rs. 5000 to Rs. 10000, no BPL family, and RSBY card holder. Share on child medicine is more than 50 per cent amongst primary educated beneficiaries, Muslim, OBC, unskilled worker, and income Rs. 2000-Rs. 5000. Overall a share of 34 per cent is spent on child treatment, 23 per cent on referred child cases and 43 per cent on child medicine (Table 2).

There were also evidences of the fact that those who went to private clinics for ANC incurred higher amount of out of pocket expenditure as they paid huge informal payments. It was also found that spending on diagnostic was high amongst C-section as compared to normal deliveries. It was also seen that the expenditure incurred on child after delivery, including child treatment, neonatal expenditure and child medicine, was high amongst the age groups 20-34. Neonatal expenditure was high amongst Hindus, SC, skilled worker, high income class and BPL family. This expenditure is also high amongst the BPL card holder families as compared to other socio-economic characteristics. Expenditure on child treatment is also high amongst BPL families followed by general caste. In referred child cases, expenditure is highest among skilled workers and income category between Rs. 5000-Rs. 10000.

Fig 1: Percentage of Average Expenditure On The Services

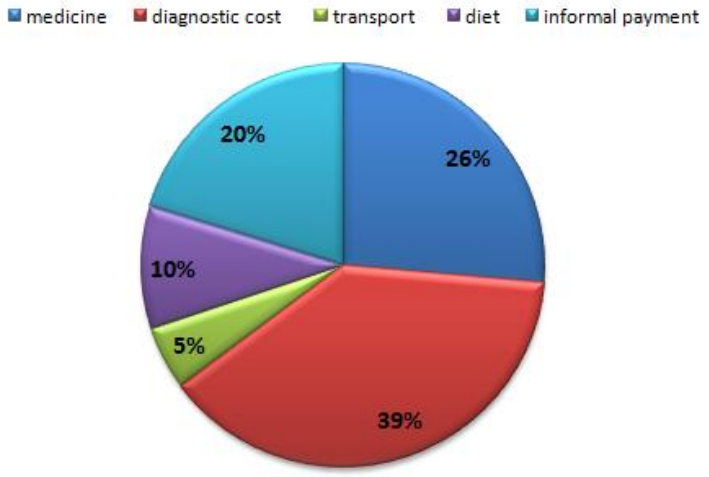
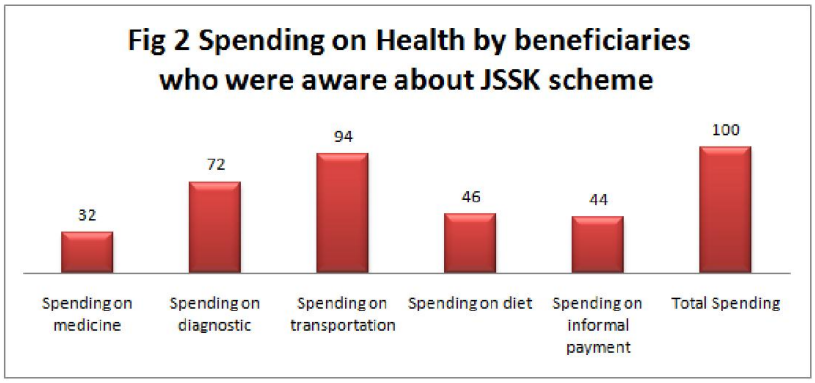


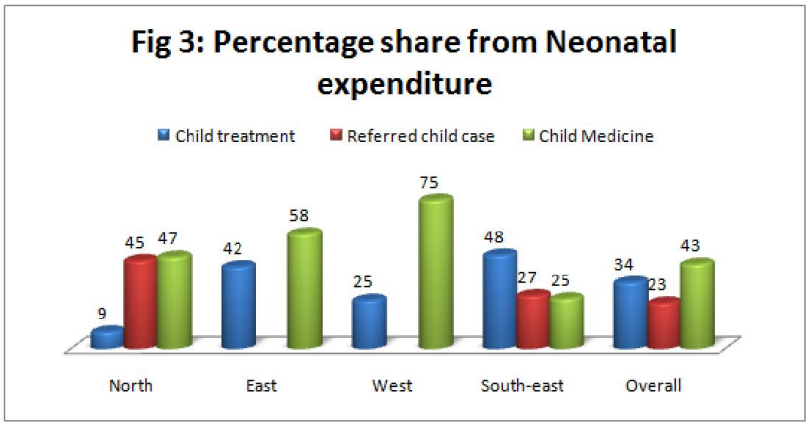
Table 1. Average Expenditure on maternal health by Socio-economic characteristics

Characteristics		Medicine	Diagnostic	Transportation	Diet	Informal payment	Total Medical Cost (in Rs.)
Age	<20	343	500	212	600	387	1258
	20-34	784	1132	145	289	583	1472
	35 and above	921	1300	266	230	1500	2239
Education	Illiterate	771	992	143	263	512	1219
	Primary	505	858	136	293	431	1081
	Secondary	781	1095	148	295	670	1595
	Above Secondary	985	1583	194	333	819	2341
Religion	Hindu	764	1150	152	296	570	1519
	Muslim	777	1001	114	263	656	1298
	Christian	633	800	633	300	450	2467
	Sikh	1130	1444	48	325	1017	2026
	Others	0	600	200	0	0	400
	No respond	550		258	200	367	858
Caste	General	908	1202	156	313	698	1676
	OBC	677	1262	130	291	514	1645
	SC	800	978	158	276	544	1271
	ST	75	350	135	100	150	255
	No respond	567	550	120	200	488	1143
Occupation of Husband	Skilled	875	1187	140	299	662	1637
	Unskilled	740	926	151	247	539	1237
	Unemployed	600	1233	700		975	2317
	Others	465	1552	162	415	544	1980
	No respond	0	2700	0	0	0	2700
Income	<2000	0	3075	0	0	0	3075
	2000-5000	973	850	126	246	439	1071
	>5000 to <10000	732	923	141	295	508	1295
	>10000	778	1478	177	295	768	1942
Cards	BPL	894	968	113	220	516	1311
	RSBY	1350	700	175	100	1600	1870
Overall		776	1129	150	291	595	1493

Table 2. Share of Neonatal Expenditure by Socio-Economic characteristics

		Share of Neonatal expenditure (in %)			Share from Total expenditure (in %)			
		Child treatment	Referred child case	Child Medicine	Child treatment	Referred child case	Child Medicine	Neonatal expenditure
Age	20-34	30	28	43	1	1	1	2
	35-49	56	0	44	5	0	4	8
Education	Illiterate	2	57	41	0	1	1	2
	Primary	0	0	100	0	0	1	1
	Secondary	48	3	49	1	0	1	2
	Above Secondary	47	18	35	2	1	2	4
Religion	Hindu	34	27	39	1	1	1	3
	Muslim	29	1	70	1	0	2	2
Caste	General	48	12	40	1	0	1	2
	Other backward class	47	0	52	1	0	1	2
	Schedule Caste	20	40	40	1	2	2	4
	No respond or do not know	0	0	100	0	0	1	1
Occupation of husband	Skilled	32	37	32	1	1	1	3
	Unskilled	35	8	56	1	0	2	3
	Others	100	0	0	0	0	0	0
Income (in Rs.)	2000-5000	16	0	84	1	0	3	4
	>5000 to <=10000	14	46	40	0	1	1	2
	>10000	57	9	34	2	0	1	3
BPL	Yes	59	8	33	4	1	2	7
	No	19	32	49	0	1	1	2
RSBY	Yes	0	100	0	0	2	0	2
	No	34	22	44	1	1	1	3
	Total	34	23	43	1	1	1	3





On the whole, it was seen that it was the transportation services which were lagging behind and which added to the out of pocket expenditure of the beneficiaries. The ambulances were not available on time to the beneficiaries. But a possible reason for this could be that the lanes where the beneficiary resides are too narrow for any ambulance to enter which is why the beneficiary was required to travel on their own. Thus transportation costs formed the major part of their costs.

It was seen that spending on transportation was the highest amongst all the age groups and education categories. Hindus, Muslims and Sikhs were spending highest on education but Christians were spending highest on medicine, diagnostic and transportation. Considering caste, husband's occupation, family income and cards holding, it was seen that the highest proportion of spending was on transportation. Thus, transportation needs to be strengthened as this would bring down the expenditure incurred by the beneficiaries

considerably. The district wise segregation of the data reveals that in the North, South and West districts, majority of the expenditure was being carried out on transportation but in East district, high amount of expenditure was incurred both on diagnostic and transportation. In South-East district, beneficiaries were spending more on drugs and transport, while among other facilities most of the beneficiaries were spending on transport.

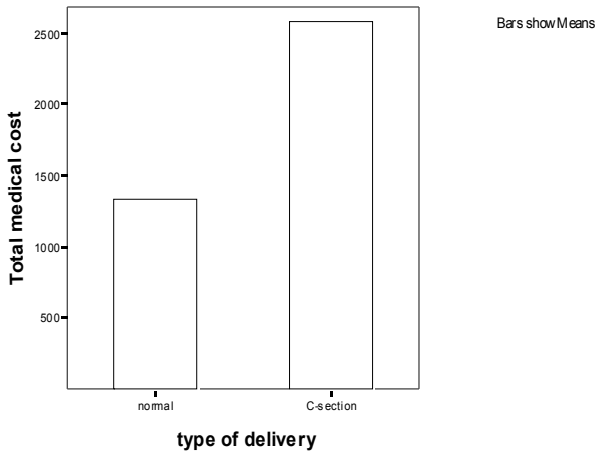
Taking into account the socio-economic characteristics, it was observed that spending on medicine is high among age 35-49 years, and RSBY card holder which is more than 60 per cent. Further spending on diagnostic test is also more than 50 per cent in all groups. Diagnostic was one of the factors where all the groups spent more than the other facilities. Lack of proper lab services has proven to be one of the hurdles in smooth implementation of the program. More than 90 per cent beneficiaries among all categories were spending on transportation. Spending on diet is also more than 50 per cent among the age group of 35-49, secondary and above secondary educated, Sikh, skilled workers and income category of more than Rs. 5000. It was also observed that more than 30 per cent of the beneficiaries pay informal payments went to the hospital staff.

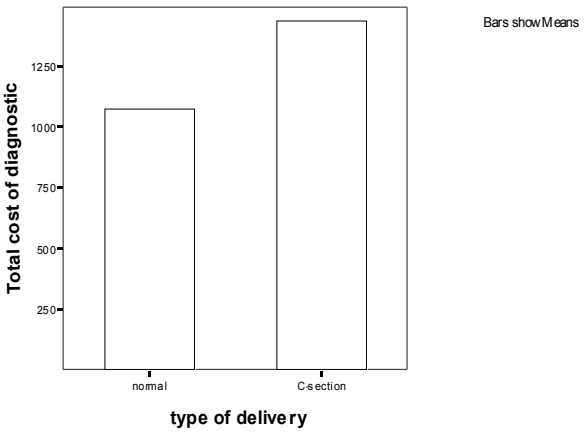
Figure 2 reveals that apart from the beneficiaries who were unaware about the JSSK scheme and its benefits, there were the ones who were aware and both these categories were spending considerably on healthcare which increases the total spending to 100 per cent. Spending on transportation was too high followed by spending on diagnostic. There were also evidences of the fact that those who went to private clinics for ANC incurred higher amount of out of pocket expenditure as they paid huge informal payments. It was also found that spending on diagnostic was high amongst C-section as compared to normal deliveries. Similarly informal payment is also high in case of delivery at CHC.

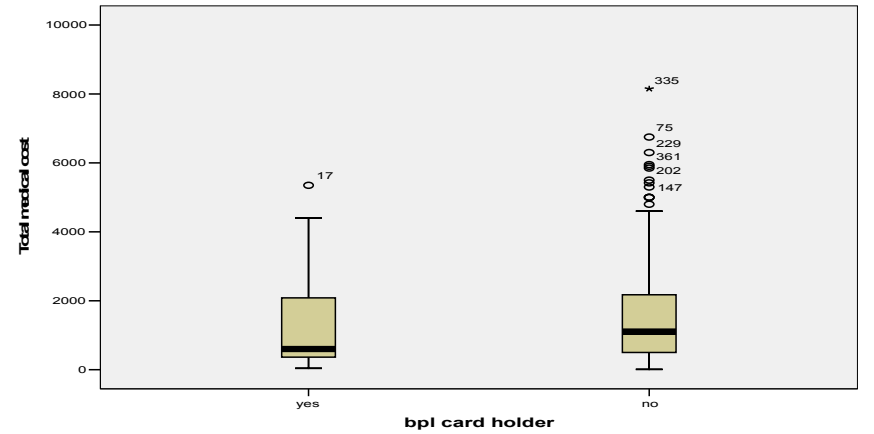
It was also seen that the expenditure incurred on child after delivery, including child treatment, neonatal expenditure and child medicine, was high amongst the age groups 20-34. Neonatal expenditure was high amongst Hindus, SC, skilled worker, high income class and BPL family. Figure 3 The date also reveals that expenditure on child healthcare is highest amongst those who were unaware on JSSK. Also, those who spent high on child medicine also spent high on child treatment. This kind of expenditure was highest in West followed by East. It was further observed that percentage share on child treatment was high amongst beneficiaries of South-East districts.

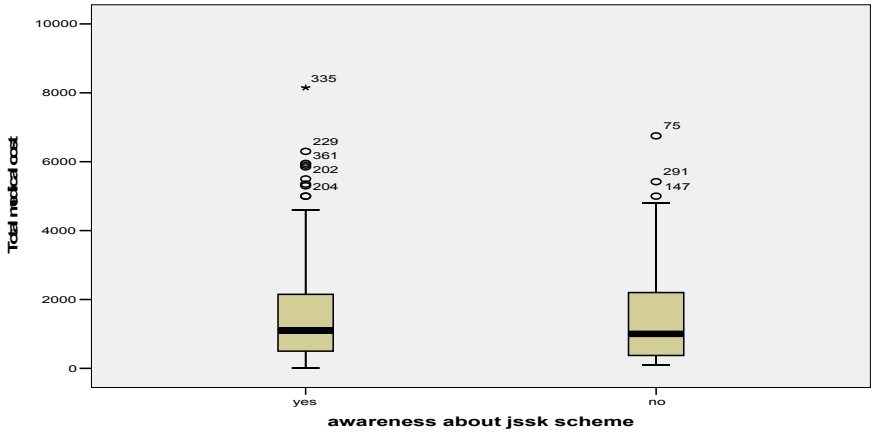
Further, characterizing the spending according to the components of JSSK the survey revealed that the percentage share of diagnostic cost was high as compared to others. The district wise segregation revealed that the highest spending (68 per cent) on diagnosis was in the South district. This was followed by the West district which spent 63 per cent of the total expenditure on the same. Moreover, on the whole 15 per cent was spent on medicine with the West district spending the highest at about 24 per cent followed by the South-east district which spent 16 per cent. On the other hand, spending on transportation cost is almost less than 10 per cent across the districts which is considered quite low taking into account the vast majority of beneficiaries who would want to avail the same. Similar kind of scenario was also observed in case of diet where spending was less than 10 per cent with the North district being an exception and spending 13 per cent. Concentrating on the informal payments made by the beneficiaries, the survey revealed that the West district maintained the highest record of 25 per cent. Further analyzing the socio economic characteristics, percentage share on medicine was highest at 24 per cent of the beneficiaries falling in the income category of 35 – 49 years, at 17 per cent for the illiterate, at 26 per cent for the Christians and in the income category of Rs. 2000 – Rs. 5000. It was also high amongst those who were not aware on JSSK, those who's ANC was at CHC, delivery at government hospital and the C-section cases. Transportation was spent on more by Christians, other religion category and ST. Diet constituted a less proportion of the expenditure as compared to other components with just 19 per cent of the beneficiaries spending on the same under the age of 20 years. However, more than 20 per cent were paying informally to the hospital staff.

On the whole, it was clear that despite the provision of free services under the scheme, the beneficiaries were forced to incur the expenditure which implies that their still exists some of the constraints which prevent 100 per cent coverage. Some of the constraints are genuine like lack of space for ambulance to enter the lane, lack of sufficient tools (gas, utensils etc.) to provide cooked food (in which case raw food is served), etc.









But even then, a majority of the beneficiaries reported that they were satisfied with the services on the whole and that these schemes have helped them in one way or the other. From the above graphs it can be concluded that mean out of pocket expenditure was high amongst the C-section as compared to normal deliveries and further bifurcation shows that diagnosis costs constitutes a major share of Total Medical costs incurred by the beneficiaries who had C-section deliveries thus the infrastructure and other necessary equipments needed for such complicated cases should be made available.

Expenditure incurred by BPL card holders

It was observed that the average cost incurred by BPL card holders was lower than those without BPL cards. However even the BPL card holders which was the major targeted population under JSY incurred costs even after JSSK 60% of the beneficiaries who were BPL incurred more than the mean cost of 1491, thus the scheme did not prove to be of much advantage even to BPL card holders which was the main attraction under JSY.

Awareness about JSSK

From the above graph we observe even those people who are aware of JSSK scheme are incurring huge costs and on an average are incurring more than those who are not aware about JSSK thus indicates lack of infrastructure, and other basic facilities.

Thus not only there is a need to spread more awareness but also more work should be done to ensure smooth access to all the services, timely availability of all necessary drugs and other necessary perquisites should be there to ensure the overall effectiveness of the scheme.

DISCUSSION

In India, about 11.8 million or at least 6 households out of 100 are silently marching towards poverty every year due to huge costs incurred on health care.[1] Total health expenditure in India stood at 4.2 per cent of GDP which is more than its neighboring countries such as Pakistan and Sri Lanka but less than the European Union member states which spend about 9 per cent of GDP. Further, if we see the public health expenditure which is an inclusive term for the expenditure of centre, state and local governments, India spends only around 1 per cent of GDP. Though health expenditure has increased in absolute terms, the proportionately higher growth of GDP has resulted in a moderate increase in the share of health expenditure to GDP in recent years.[2] Though the Government has come out with a variety of schemes to provide affordable services and reduce the out of pocket expenditure but even after huge expenditure incurred by the government it was observed that beneficiaries still have to incur costs on health.

[1] Policy Brief Out-of-Pocket Spending on Health in Odisha, September, 2011
[2] J.V. Arun and Dr. D Kumar, Trends and Patterns of Health Expenditure in India, Vol. 13, 4 Apr 2013

Maternal and infant mortality rates are very high in India as compared to other countries primarily because of huge medical costs incurred to get the right treatment. Private players which do provide better services are mainly driven by profit motive and thus are not easily accessible by common man hence government has to step in to provide affordable health services. Janani Shishu Suraksha Karyakaram as a scheme was introduced mainly to provide the disadvantaged group with affordable health services. Government institutions are relatively less expensive but even here the problem persists, not in the monetary terms but in other aspects like the availability of beds in a hospital, adequate and timely provision of treatment, lack of basic infrastructure and human resources etc. thereby increasing the out of pocket expenditure of the beneficiaries who are referred to private hospitals, thereby defeating the primary goal of the scheme.

Various studies were conducted across the country in various states to reveal that in some states the expenditure in health sector is not very adequate. Some of the interesting results are summarized as follows[3]:

- Majority of deliveries in the states of Assam, Bihar, Chhattisgarh and Jharkhand were conducted at home without any medical assistance, whereas, in Kerala and Tamil Nadu, majority of deliveries were conducted with medical assistance.
- The proportion of deliveries at private health centres varies greatly among states being lowest in Jammu and Kashmir followed by Chhattisgarh and Orissa and highest in Punjab followed by Andhra Pradesh and Tamil Nadu.
- The mean out of pocket expenditure on a delivery was US$44 (2004 prices) with maximum in Kerala (US$149) and minimum in Chhattisgarh (US$17).
- Mean out of pocket expenditure for caesarean deliveries is four times that of normal deliveries.
- Transportation cost for rural women is high as compared for urban women and it is highest in Chhattisgarh.
- Our survey conducted in various districts of Delhi reveal similar results.

It was observed that the out of pocket expenditure was high even after the JSSK scheme under NRHM. This was mainly because Delhi was lagging behind in terms of proper implementation of the scheme. This was because of lack of basic infrastructure and human resources and inability to spread awareness among people about the benefits of the scheme. It was further observed that similar to Mohanty and Srivastava studies the mean expenditure on all the services was higher for C-section deliveries than the normal deliveries. Transportation was another issue. Ambulances were provided but sometimes it did not reach the concerned beneficiary on time or sometimes it failed to reach altogether. As a result, the beneficiaries had to arrange for their own mode of transport. Our results revealed less utilisation of referral transport which can be due to lack of awareness about the same or not wanting to use it because of delay in the arrival. The problem was further exaggerated by narrow lanes making them inaccessible to the beneficiaries.

The scheme also aims at providing free diet to the beneficiary to not only reduce any expenditure on the diet but also to improve the maternal and child health and provide the mother with sufficient diet but even in this case the results were not very fruitful. Most of the maternity homes were providing raw materials due to lack of infrastructure in the facility and this includes bread, milk, biscuits, and egg/cheese. Further all these items should come under Rs. 100 which was one of the drawbacks resulting in the spending on part of the beneficiary for a proper diet or a move to the district hospital where cooked meals were provided thrice a day. This was the case in all the districts surveyed, hence diet being a significant component of post-delivery care was lagging behind. Not only this, beneficiaries were also required to spend from their own pockets because they were referred to private screening centers due to lack of infrastructure and human resource. Thus overall beneficiaries had to incur huge costs on all the four components diet, diagnosis, transportation and drugs because of various loopholes of the scheme.

Conclusion

Overall, the above study shows that the services provided under JSSK scheme are not able to meet the desired outcome that is to reduce out of pocket expenditure of the beneficiaries. Although the scheme provides cashless services but due to lack of infrastructure, human resource and constant shortage of drugs beneficiaries still have to incur huge costs on their own thereby defeating the main goals of the scheme. It implies that the total government expenditure on the scheme is not adequate and lot more needs to be done to improve the overall efficacy of the scheme. Moreover, many of the beneficiaries are still not aware about the JSSK scheme and its benefits, so it becomes important at the first place to create awareness about the same. This will not only help in reaching the concerned beneficiary in a more efficient way but will also help in achieving the intended objectives of the scheme. Thus there is a strong need to run campaigns and other forms of spreading awareness among the lower sections of the society so that they can benefit from the scheme. Free medicine is also provided under the scheme which includes medicines given during ANC, INC and PNC up to six weeks which includes management of normal, C-section delivery and child birth. Furthermore immunization drugs, vaccines etc are also provided for better health of the child even in future but due to lack of availability of sufficient drugs the overall benefits of the scheme are curbed. The scheme also claims to provide free diet to the beneficiary which is an important step since post delivery the mother needs proper diet which they may not get at their homes because of poverty or gender biases engraved in Indian culture but the upper limit of Rs 100/- in the era of growing inflation is not enough furthermore the meal should include more nutritious food like cooked meals, soups etc. unlike the raw eggs, breads which are served due to lack of kitchens and other constraints to improve the overall efficacy of the scheme.

Transportation is another component of JSSK to provided free transportation facilities from home to health centre and drop

[3] Sanjay K Mohanty and Akanksha Srivastava, Out of pocket expenditure on institutional delivery in India, 17 June, 2012

back facilities to the beneficiaries. But some bottlenecks still persist behind under utilisation of transport services such as stigmas attached to ambulance services, lack of awareness, and irregularity of ambulance services. The already poor are forced into an aggravated state of poverty due to the expenditure that they have to incur on health thus not only government but other Non Profit organizations needs to step in to provide the disadvantages groups adequate services to improve the overall health outcomes. Government must take initiatives to raise awareness about the benefits and various measures of family planning and also ensure the timely availability of necessary drugs and other infrastructure needed to improve the overall efficacy of the Janani Shishu Suraksha Karyakaram scheme.

REFERENCES

Arun, J.V. and Dr. Kumar, D. Apr 2013. Trends and Patterns of Health Expenditure in India, Vol. 13, 4. National Rural Health Mission. Implementation status of JSSK Report. Government of Nagaland, Nagaland 2012 (Available at-www.wbhealth.gov.in/NRHM/pdf/JSSKReport)

Goyal1 R. C., Priya L. Singh2, Abhay Mudey3 2014. Assessment of implementation status of Janani-Shishu Suraksha Karyakram (JSSK) for free referral transport services at selected Public health facilities in Wardha district, of Central India.

Himanshu Bhushan. Janani- Shishu Suraksha Karyakram-Review. Ministry of Health and Family Welfare, Governmentof India, Nirman Bhawan, New Delhi, September2012.

http://data.worldbank.org/indicator/SP.DYN.IMRT.IN

Indian Institute of Health Management and Research. Janani Shishu Suraksha Karyakram- Report; Rajasthan Oct. 2011 to March 2012.

Ministry of Health and Family Welfare (2011). Guidelines for Janani-Shishu Suraksha Karyakram (JSSK). National Rural Health Mission, Maternal Health Division, Government of India, Nirman Bhavan, New Delhi June 2011,.

Ministry of health and Family Welfare, UNICEF & Government of India 2009.Coverage evaluation survey 2009 All India report 2010; PP: 68,73. (Available at-http://www.unicef.org/india/health.html)

National Health System Resource Centre. Janani-Shishu Suraksha Karyakram- Review New Delhi, Quarter report 2012-2013

Policy Brief Out-of-Pocket Spending on Health in Odisha, September, 2011

Sanjay K Mohanty and Akanksha Srivastava, Out of pocket expenditure on institutional delivery in India, 17 June, 2012

Sharma Suresh, (2014-15): Evaluation of Janani Shishu Suraksha Karyakaram in Delhi, Population research Centre, Institute of Economic Growth, Delhi University Enclave, Delhi

****