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PREGNANCY AS A DECISION! THE ECONOMIC QUESTION OF AGENCY FOR WOMEN IN INDIA?

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Introduction

The latest Nobel prize in Economics awarded to Prof. Claudia Goldin has renewed interests pertaining to women's role in labour markets. In one of her seminal works, which is broadly referred to as the 'Quiet Revolution' article[i], she argued that there are four phases of women's involvement in the economy. The first three phases, as she describes to be 'evolutionary', largely comprises of three elements. First element being 'horizon' of time (women's perception regarding the duration of participation in labour market vis-à-vis creation of human capital investment). Second element comes with 'identity' (whether individuality of a woman is present in the labour market). Thirdly, in the evolutionary phase comes: decision making.

This last component of the evolutionary phase is a subtle one and forms a backdrop of this note. In Goldin's own word: "...whether labour force decisions are made fully jointly, if a woman is married or in a long-term relationship, or, on the other hand, whether the woman is a "secondary worker" who optimizes her time allocation by taking her husband's labor market decisions as given to her". Why reiterating this? In the contemporary context, marriage and child bearing requires further examination in India. This prized-Motherhood often limits women to further enter workforce after a few years of pregnancy: as the literature would suggest as attrition of women.

Every year in India, approximately 30 million women experience pregnancy[ii]. It has been noted that the incidence of pregnancy varies significantly across regions and across socioeconomic groups.
Beyond India, in the context of global south the decision of pregnancy and the health outcome literature often emphasises on the role of public health system (especially roles played by health workers such as ASHA and Anganwadi Workers). These public provisions have improved the conditions of both newly born and the pregnant women's health.

However, there lies a crucial question around the decision of pregnancy? Is it homogeneous across classes, across rural and urban India?

Claudia Goldin, Nobel Laureate

According to past research [i], women from non-Hindu and non-Muslim backgrounds, as well as those belonging to the Other(non-scheduled) Castes, faced exorbitant maternity care expenses compared to their counterparts. Notably, private healthcare facilities were associated with a significantly higher proportion of households experiencing mounted financial strain. Factors such as place of residence, women's education, social group, economic status, healthcare facility type, and regional location were identified as statistically significant indicators for predicting maternity care expenses in India.
With this in the background: this note aims to bridge a gap.

How heterogeneous is the incidence of pregnancy across different socio-economic groups? Furthermore, we need to explore whether there are significant divergences observed in terms of maternity care availed by the households, in terms of costs and choices.

Nomenclature of Pregnancy: 101

Pregnancy care is often subdivided into two parts: prenatal care helps monitor and address potential complications during pregnancy and postnatal care continues this support by monitoring the health of both the mother and child after childbirth. For households in India, expenditure on prenatal and postnatal care represents a significant intra-household economic decision in the health and well-being of both mothers and newborns.

Since choice of healthcare facilities and associated costs can pose a financial burden: proper prenatal care can help prevent complications during pregnancy and childbirth. Therefore, it is essential for pregnant women to have access to good-quality healthcare facilities. Additionally, the utilisation of Postnatal Care (PNC) observed to be linked to the education levels of both parents, urban residence, exposure to mass media, and the presence of any pregnancy complications[iv].

While attention in research is taking up on the impact of public health systems on pregnancy care, fewer studies have thoroughly investigated the decision of pregnancy. Is there a significant difference across classes with regard to the qualitative nature the decision of bearing a child? Does choice of (or lack of it) healthcare facility, the associated expenditures, and quality of healthcare during the prenatal and postnatal periods differ across caste, class, and location of the household?
Given the substantial divide between rural and urban areas in India, which reflects a profound socioeconomic contrast within the country's diverse landscape, it is pertinent to analyse pregnancy while focusing on these crucial dimensions.

We have analysed three features that emanate from caste, class, and location of residence (rural/urban) with regard to the incidence and cost of pregnancy in the contemporary Indian context.

We have used the NSSO 75th Round (2017-18), Expenditure on Social Consumption of Health data to elaborate on these features. In parallel, although NFHS data does provide better information on pregnancy related issues, but the last round (NFHS-5) was partly a phone-call survey during the COVID-19 pandemic. This could jeopardise the quality of the data. Therefore, we have used the NSSO-75th round as a near alternative.

Limitations and a Cautionary note on the Database

Before delving into the details, let us jot down a few precautions of using NSSO 75th Round data on “Social Consumption in India: Health” data.

Notably, in the previous health-survey round, namely NSS 71st round (2014), information pertaining to major sources of prenatal and postnatal care did not include records for NGO and charitable trust hospitals. It did not include informal healthcare providers as well. While in the NSS 75th round, the survey schedule included these sources among the major providers of prenatal and postnatal care. Furthermore, it is worth noting that the NSS surveys on health has not incorporated government-provided benefits specifically designated for pregnant women during their pregnancies, which is another important consideration in the analysis of maternal healthcare.

On the methodological caveat: we have used the Monthly Per Capita Consumption Expenditure (MPCE) quintiles from the household block of the unit level data. These quintiles are used as a proxy for class. We are well aware of the problem with the collection of consumption data in health rounds. The usually expected detailed consumption schedule is not canvassed, instead, only total monthly consumption expenditure is reported. This might lead to certain inappropriate estimations, and could lead to certain problematic benchmarks of class.

However, without any other variable that could refer to income, we stick to the consumption quintiles while acknowledging it's limitations. The comparable database of NFHS (Family Health Survey) was conducted during 2019-21, due to COVID, some states were surveyed over non-physical (read: telephonic) manner. Hence, we are sticking to good old NSSO.

Incidence of Pregnancy: The Myth about Poor in India

The data from the NSSO 75th round in India reveals a noteworthy disparity in pregnancy rates among women aged 15-49, depending on their place of residence. Women who are aged between 15-49 years,:6.9 per cent among them reported being pregnant. In rural areas, this incidence is slightly higher 7.5 per cent, while in urban areas the reported incidence was roughly 5.4 per cent.

Although this finding underscores a pattern where rural regions consistently exhibit a higher percentage of pregnant women across various social groups compared to urban areas, however when we further break this down across the 'economic location' (or class) of the households, we observe an interesting puzzle. This puzzle remains the crux of our note. In rural areas, more than 60 per cent of pregnant women are in the bottom two quintiles of Monthly Per Capita Consumption Expenditure (MPCE), while in urban areas, it is the top two quintiles which contributes to a similar range (See table 2).

In the top-most quintile (Q5), urban areas show a substantially higher percentage (34.7%) in comparison to rural areas (3.4%). When examining the entire population,

Table 1: Proportion of Pregnant Women Aged Between15-49 Years, in per cent, by Sector, All India, 2017-18

Sectors	Proportion of Women Pregnant (%)
Rural	7.5
Urban	5.4
Overall	6.9

Source: Authors' Calculation from NSSO 75th Round.

However, our primary interest emanates from Table (2). In popular forums this has been often identified that a marker of backwardness often comes from larger incidence of pregnancy among the women hailing from socially and economically marginalised sections. We observe (from the report), that in both rural and urban areas for the socially marginalised households (SCs and STs) the incidence of pregnancy is not strikingly higher than that of other forward castes. While in rural India, 7.4 and almost 9 per cent women are pregnant from ST and SC households respectively, the incidence is at par with the overall incidence rate of 7.5 per cent for all groups combined.

it becomes evident that the incidence of pregnancy among rural populace is substantially contributed by the bottom expenditure quintiles (Q1 to Q3), while in the urban population the top quintiles predominate the incidence of pregnancy(Q5).

This then becomes a myth breaker?
Poorer sections or socially marginalised sections in the contemporary Indian context are not the only contributor of the incidence of pregnancy.
What remains of further query? Why this disparity?

Table 2: Distribution of Pregnant Women Aged between 15-49 Years across MPCE Quintiles, By Sector, in per cent, 2017-18

MPCE Quintiles	Rural	Urban	Total
Q1	33.2	8.3	27.1
Q2	28.6	12.7	24.7
Q3	21.8	16.8	20.6
Q4	13.1	27.6	16.6
Q5	3.4	34.7	11.0
Overall	100.0	100.0	100.0

Source: Authors' Calculation from NSSO 75 Round unit level data

Is there a regional dimension to this class-wise differences in the incidence of pregnancy? If yes, what reinforces this? Anecdotally one might expect that rural households with larger size of the household (members) often get to reduce the burden of pregnancy care through the unpaid domestic work provided by other women in the household. Meanwhile for urban India, a strictly higher cost of living and small size of the household might make it more of an economic decision within the household.

However, one observation still remains as a puzzle: with increasing public health care provisions in India do we still observe burdens (economic and otherwise) that persists in urban India which might reduce the vagaries and costs associate with incidence of pregnancy among poorer women? We further investigate this concern in two ways: First we disaggregate to what extent (proportion) women receive pre-natal and post-natal care from the public agencies vis-à-vis the private agencies? Is increasing occurrence of private health care in urban areas increasing the cost of pregnancy care for general masses?

Paid Cost of Pregnancy: Region Matters!

In prenatal care, as shown in Table (3): urban areas consistently allocate greater resources across all quintiles compared to their rural counterparts.

For instance, within the lowest MPCE quintile (Q1), rural areas expend an average of Rs. 1581 in prenatal care, whereas urban areas demonstrate a more substantially higher expenditure with an average of Rs 2397. In the highest income quintile (Q5), rural areas allocate an average of Rs 4548.5, while urban areas dedicate significantly more, with an average of Rs 6767.2, to prenatal care. On an average, urban areas expend twice as much on prenatal care (Rs 4633.1) as rural areas (Rs 2407.9).

Turning to postnatal care, a similar pattern emerges. Urban areas consistently exhibit higher average expenditures across all MPCE quintiles compared to rural areas. Within the lowest MPCE quintile (Q1), rural areas invest an average of Rs 1044.3 in postnatal care, whereas urban areas allocate more, with an average of Rs 1884.7. In the highest income quintile (Q5), rural areas allocate an average of Rs 2932.7, while urban areas allocate more, with an average of Rs 2941.8 for postnatal care.

Table (3) represents the urban advantage in allocating greater resources for both prenatal and postnatal care across all income quintiles when compared to rural areas. For example, within the lowest income quintile (Q1), rural areas spend an average of Rs 2321.2 on maternal care,

Table 3: Average Prenatal and Postnatal and Total Expenditures by MPCE Quintiles, across Sectors, In Nominal Rs., All India, 2017-18

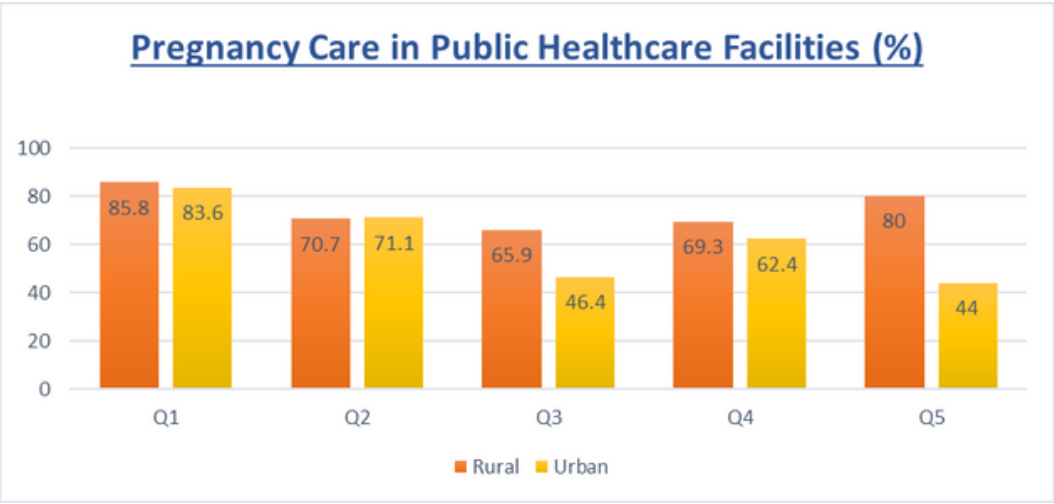
	Prenatal Expenditure			Postnatal Expenditure			Total Expenditure		
MPCE Quintiles	Rural	Urban	India	Rural	Urban	India	Rural	Urban	
Q1	1581.1	2396.8	1641.8	1044.3	1884.7	1107.8	2321.2	3768.5	2428.7
Q2	2022.1	2615.4	2096.1	1353.8	1468.5	1368.5	2953.2	3674.3	3042.7
Q3	2826.7	3330.6	2925.5	1375.5	1855.5	1480.9	3739.2	4759.4	3939.2
Q4	4004.3	4268.4	4109.5	2155.9	1873.8	2044.8	5565.1	5588.2	5574.3
Q5	4548.5	6767.2	6253.4	2932.7	2941.8	2939.8	6809.9	9057.9	8536.4
Overall Average	2407.9	4633.1	2951.3	1423.1	2213.8	1624.2	3398.6	6281	4100.1

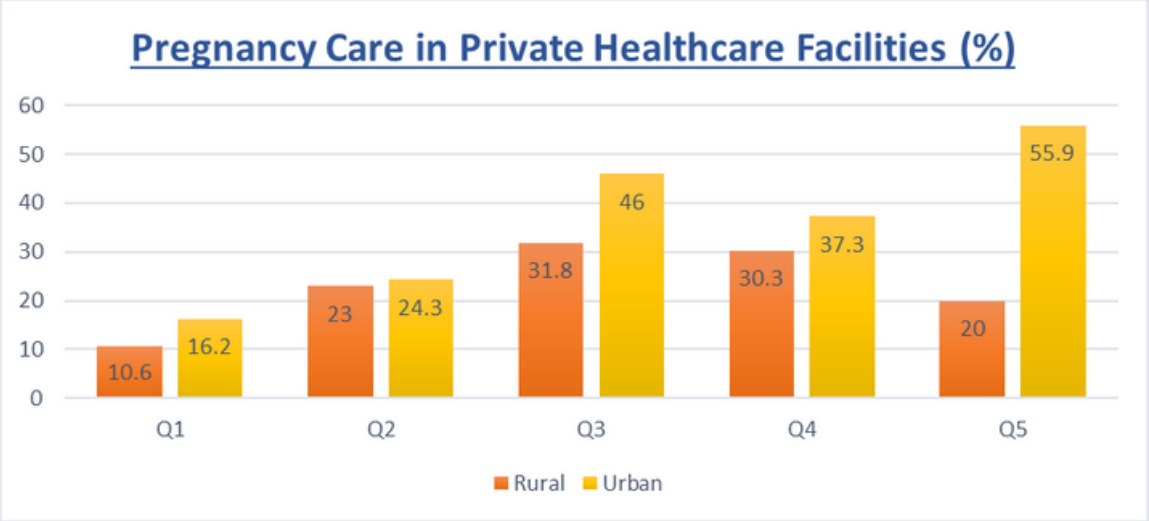
Source: Author's Calculation from NSSO 75th Round

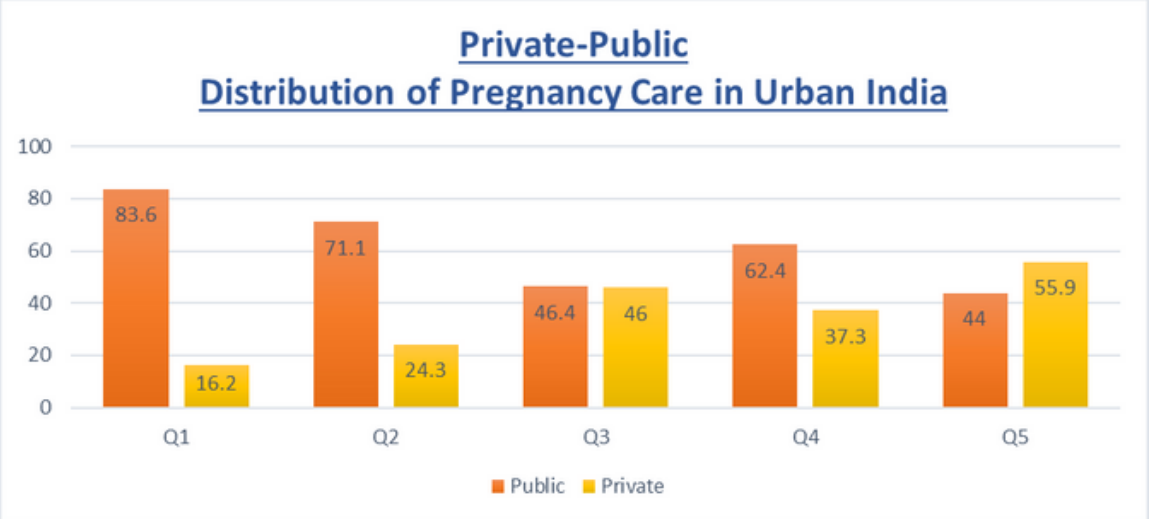
while urban areas allocate significantly more, with an average of Rs 3768.5. This pattern remains consistent across all quintiles, with urban areas consistently surpassing rural areas in maternal healthcare expenditure.

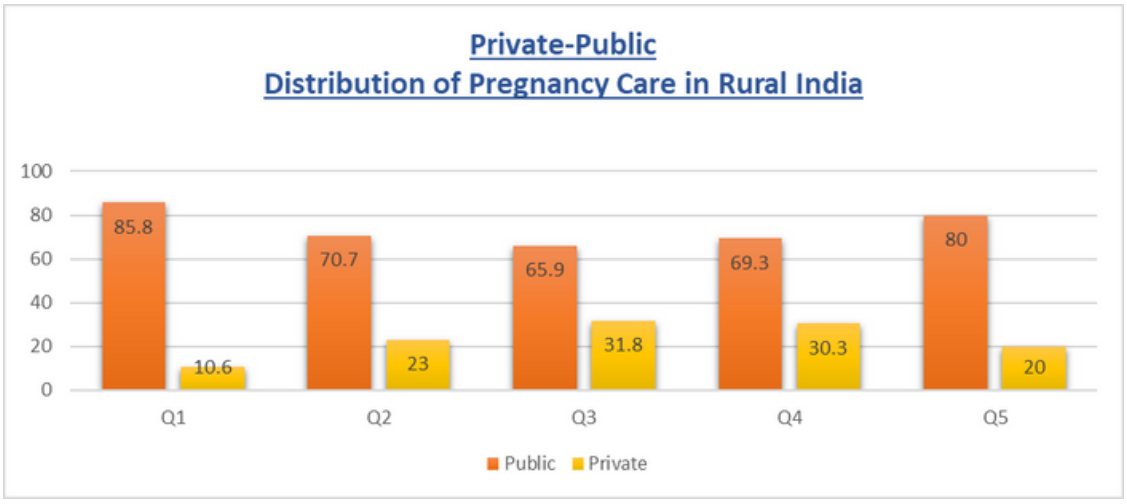
When we consider the total average expenditure on maternal healthcare, rural areas report an average of Rs 3,398.6, whereas urban areas nearly double this figure, with an average of Rs 6,281.0. Notably, in Quintile 4, the expenditure on maternal healthcare falls below the overall urban average, while Quintile 5 spends nearly twice that of Quintile 4. This observation raises pertinent questions about whether, in urban India, families' decisions regarding pregnancy are significantly influenced by their financial capabilities. In essence, the data strongly highlights the urban-rural disparity in maternal healthcare expenditure.

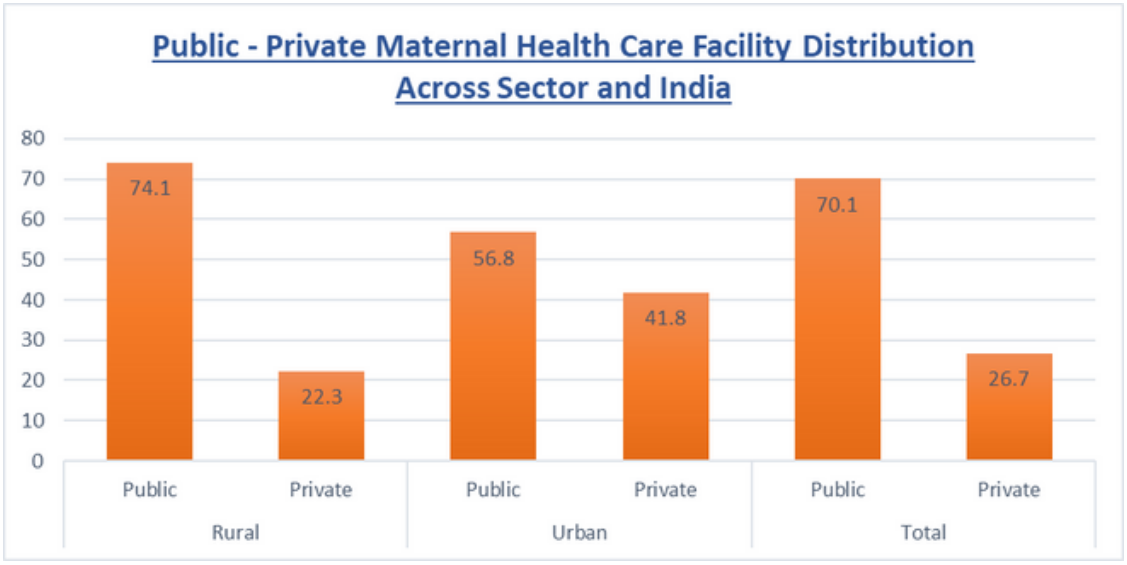
A clear indication of dependence on private health care provision is observed in the upper echelons of the consumption expenditure, especially in Urban India. The top two quintiles in the rural India shows that 30 per cent of fourth quintile and 20 per cent of top




Pregnancy Care in Private Healthcare Facilities (%)
60
50
40
30
20
10
0
10.6
16.2
23
24.3
31.8
46
30.3
37.3
20
55.9
Q1
Q2
Q3
Q4
Q5
Rural
Urban


Private-Public
Distribution of Pregnancy Care in Urban India
100
80
60
40
20
0
83.6
16.2
71.1
24.3
46.4
46
62.4
37.3
44
55.9
Q1
Q2
Q3
Q4
Q5
Public
Private





Source: Authors' Calculation from NSSO 75th Round.

quintile receive private health care during pregnancy. While in Urban areas, this is strikingly higher: Almost 56 per cent of top quintile and 37.3 per cent of the fourth quintile take private health care during an ongoing pregnancy (See Figure 2). This perhaps might be indicated further by the costs borne by the households.

In the context of rural regions, as indicated in Figure 2, it's noteworthy that approximately 74.1% of women opt for public healthcare facilities, while 22.3% choose private healthcare facilities. An interesting pattern emerges when we shift our focus to urban India, where the preference for private healthcare facilities sees a twofold increase, with 41.8% of women favouring them

Within the lower income quintiles, specifically Quintiles 1 and 2, there isn't a substantial difference in the choice between public and private healthcare facilities, both in urban and rural areas. However, as we move up the standard of living ladder to the higher income quintiles, particularly in quintiles 4 and 5, a discernible trend emerges. It becomes apparent that women in urban areas display a stronger inclination (55.9%) toward opting for private healthcare facilities, in contrast to their rural counterparts, where only 20.0% choose private healthcare. This shift underscores a significant socioeconomic dimension in healthcare decision-making.where greater financial capacity in urban areas appears to be a driving factor in the preference for private healthcare services.

Women's Agency or Economic Condition: Revisiting Claudia Goldin

Goldin (2006) emphasised the role that norms and institution going to play with regard to women's involvement in the economy. This note works as a reminder: involvement is shaped by 'n' number of things, often that 'n' changes qualitatively.

As an exemplar, we talk about pregnancy in India: where rural regions consistently exhibit higher pregnancy rates but significantly lower maternal healthcare spending and then urban counterparts, highlight that they are (richer ones) affording pregnancy with private care.
Now we ask: Is there a concern that should be reiterated when rural is seen in conjunction with the urban? For private facilities?

Is there an illusory effect expenditure that says: 'private is better'? Is pregnancy care being is pushed to that and the marginalised sections (in urban India) considering costly health care services as best ones? If pregnancy remains a question of agency of women, this note observes there is no homogeneous decision of pregnancy in India.

It's conditioned by regions, class, and social locations. These differences must make an entry into the policy and academic debates

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