Incentives and disincentives: necessary, effective, just?

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7.12 The success of population education and family planning programmes in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long-term success of family planning programmes. Any form of coercion has no part to play... Over the past century, many governments have experimented with... schemes, including specific incentives and disincentives, in order to lower and raise fertility. Most such schemes have had only marginal impact on fertility and, in some cases, have been counter-productive. Government goals for family planning should be defined in terms of unmet needs for information and services.

– ICPD Programme of Action

THE Programme of Action of the International Conference on Population and Development (UN 1994) implied that policies and programmes should not focus only on population numbers and growth rates. It argued instead for an integrated approach linking population action to development, including human development, women’s empowerment, gender equality and the needs of young people. Furthermore, it introduced the concept not only of reproductive health but also of reproductive rights to the population field. In so doing, it shifted the basis of population thinking away from a primarily macro focus to one grounded in the rights of people.

The period after ICPD has seen significant changes in the population field in the country. Most important, the paradigm for thinking about population policies, including its language and concepts, has shifted away from numbers per se to issues related to reproductive health. At the policy level this includes the enunciation of a population policy statement – The National Population Policy (NPP) 2000 (GOI 2000).
There is now global recognition that the effectiveness of programmes promoting reproductive health and rights depends critically on broader health system issues which affect both the demand for and the supply of health services. These include, among others, questions of cost, access, and the quality of health services. Clearly, reproductive health cannot be handled independently of the functioning of the existing primary, secondary and tertiary health systems through which it is implemented.

In this regard, there are some worrying issues. According to the Planning Commission, the pace of improvement in key health status indicators such as infant mortality, appears to have slowed down and even stalled in some cases in the past decade. The recent second round of the National Family Health Survey (NFHS-2, 1998-99) showed that maternal mortality is still extremely high (IIPS and ORC Macro 2000).

A comparison of data from National Sample Surveys (NSS) in the late 1980s and mid 1990s points to significant increases in the cost of both in-patient and out-patient health care in rural and urban areas (Sen, Iyer and George, forthcoming). Increased drug costs and rising fees for different health services may well have played a major role in this. These cost increases affected both private and public health services. The rising cost of health care can have a range of possible impacts on the poor. These include cutbacks on other consumption like food which directly impacts on nutrition and health status; increased indebtedness; growing untreated illness; and growing gender biases in health seeking behaviour. Left unaddressed, this may well come to mean that, even if reproductive or other health services are made available, the poor may not be able to access them.

Detailed analysis of the NSS data shows that untreated illness among the poor has clearly increased. Inequity by household consumption expenditure group appears to have worsened, and the divide between rich and poor in terms of untreated illness and expenditures on health services, as well as in the use of both public and private health care institutions, has grown. The rich are now the major users of not only private but also public hospitals (ibid).

While the implementation of an integrated reproductive health and rights approach and effective functioning of the larger health system are key factors affecting people’s health status, the main conditioning factor for health is poverty itself. Unfortunately, following more than a decade of steady declines in both urban and rural poverty during the latter 1970s and 1980s, the country’s performance on the poverty alleviation front has been disappointing during the 1990s.

Despite a reasonable average rate of economic growth of GDP of
about 5% per year during the past decade, rural poverty stagnated. While urban poverty declined steadily, the rural poverty headcount ratio was at the same level at the beginning and the end of the decade after a sharp worsening in the middle. Economic inequality as measured by the Gini index also showed some worsening in the urban areas.

Indifferent performance on the poverty front, combined with growing doubts about the affordability and access of health services to the poor, and the slow pace of health system reforms pose major challenges to forward movement on reproductive health. This is especially so in the context of widespread gender bias in nutrition and health care in households in many parts of the country. In the face of rising costs and ongoing hidden costs of care, it is likely that women find it increasingly difficult to access formal care and experience recurring bouts of untreated illness.

Many people now acknowledge the importance of gender inequity and social/economic disparities as major barriers. Furthermore, all stakeholders agree that quality of services remains one of the biggest challenges to implementation and to utilisation of health facilities. There is also a wide consensus on the broad determinants of quality. Despite this, the experience of the last five years shows no significant change in service environment or availability or even infrastructure (GOI, Planning Commission 2000). There has been a great deal of resistance to moving away from a population control agenda to one that is people-centred.

One form that a continuing population control agenda has taken is support for incentives and disincentives. The core question we address here is whether such incentives and/or disincentives are necessary, effective or just. Given the context outlined above, can incentives and disincentives improve quality and address the problems of equity and access to health services? Can they enhance the accountability of service providers to the community, especially to women? How relevant/effective are incentives and disincentives? How do they impinge on rights?

Relevance and efficacy of incentives and disincentives: The population of the world increased from 1.6 billion in 1900 to 2.5 billion in 1950 and 6.1 billion in 2000. Much of the increase during the past century and virtually all of the projected increase to 10.4 billion in 2100 will be in countries of the South. While fertility is still above replacement level in much of the South, standard projections expect it to reach replacement level before 2025 in Asia and Latin America, and before 2050 in Africa. Despite this drop in birth rates, world population will continue to grow largely because of its own momentum, i.e., the effect of a young age structure caused by high population growth rates in recent decades. Bongaarts and Bulatao (1999) estimate that roughly half of the
projected increase in this century will be due to the momentum effect.

For India, Visaria and Visaria (2000, Table 8) estimated the momentum effect during 1991-2101 to be as high as 69.7% because of the relatively young population. The contribution of high fertility desires will only be 5.9% while unwanted fertility would account for 24.4%. The reason for this is that, already at the time of NFHS-1 (1992-93), the wanted fertility rate was at, or below, replacement in all the southern states as well as Maharashtra and Punjab. By the time of NFHS-2 (1998-99) this group of states had expanded to include Gujarat, Assam, West Bengal, Orissa and Haryana. Even in the BIMARU states, the contribution of momentum in this century will be around 50% while the contribution of high wanted fertility will be under 20%.

The information about wanted and unwanted fertility was obtained in the NFHS surveys by asking married women about the ideal number of children they would like to have and comparing it with the actual numbers. The data is a reflection of women’s fertility preferences which clearly point to very high rates of unwanted fertility.

What are the major factors that can have an impact on momentum, wanted, and unwanted fertility? The single most important factor that can reduce momentum is raising the age at marriage/cohabitation especially for girls. The strongest impact on this can come through increasing years of schooling for girls. While the role of girls’s education in reducing fertility desires, increasing awareness of birth-control, and strengthening their ability to make or negotiate reproductive decisions is known, the potential impact of education on momentum has been less well publicised than it deserves.

Where unwanted fertility is concerned, improving the quality of and access to reproductive health services is clearly the barrier to be overcome. However, increasing women’s voice in reproductive decisions can also be critical. As for wanted fertility (the factor on which family planning programmes have typically tended to focus, particularly before ICPD), increased knowledge of birth control, better child survival, and strengthened social security are known factors.

In sum, girls’ education, women’s empowerment in reproductive decisions, better quality reproductive health services, as well as child survival and social security are crucial. This points to policy directions that accord with those of ICPD in important ways. It call for an approach that is voluntaristic and based on women’s human rights; that focuses on meeting sexual and reproductive health needs; that emphasises the importance of transforming male
attitudes and behaviour towards gender, including sex and reproduction; and that privileges the health and rights of young people, especially adolescents.

What is also clear is that, given the crucial importance of momentum and unwanted fertility in the country, incentives and disincentives to pressure people to want fewer children may simply be barking up the wrong tree. They may be neither relevant nor particularly effective in bringing down the growth rate of population.

Rights, equity and social justice: In the years since ICPD, the Ministry of Health and Family Welfare at the Centre has largely adopted the spirit of the new paradigm and has made significant attempts to modify previous directions. The official removal of contraceptive method-specific targets and the shift to the RCH programme as the umbrella for a new direction have been important policy signals regardless of how well or fully they may have been implemented. In doing so, it has turned away from the use of coercion either directly or through disincentives.

There are no direct disincentives proposed in NPP 2000, and it affirms early on, ‘...the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target-free approach in administering family planning services’ (GOI 2000:2). The government’s approach attempts thereby to achieve a balance between its stated goal of stabilising population growth and the need to make reproductive health care accessible and affordable to all, increase access to education, extend basic amenities such as safe water and sanitation, as well as empower women and increase their employment opportunities.

Furthermore, the immediate objectives of NPP 2000 are stated to be addressing existing and unmet needs for contraception, health infrastructure and personnel, and integrating the service delivery for basic reproductive and child health care.

However, there has been some concern expressed that linking maternity benefits or health insurance for people below the poverty line to acceptance of sterilisation is questionable from a social justice perspective.

State level population policies present a very mixed picture in their espousal of incentives and disincentives. Not all state policies do this, but some clearly do. While the picture is an evolving one, a current analysis reveals the following:

The driving force in some of these state policies are demographic targets, population control objectives, and disincentives, despite the
fact that the ICPD POA to which India is a signatory strongly rejects such approaches. Their implications for equity and social justice are highly questionable.

Take the case of electoral disincentives. Although it may seem reasonable to expect those who wish to stand for elected office to abide by the small family norm, requiring this may be unconstitutional. It may also set the country back on the slippery slope of coercion that has been the reason for the family welfare programme’s past unpopularity. Once on this path, there is little to stop over-enthusiastic politicians and public officials from proposing (as is already being done) that one or two children should be the requirement for access to PDS rations, mid-day meals, micro-credit for women, schooling, or government jobs for adolescents.

In a country where gender bias is so strong, electoral disincentives are more likely to work against women standing for public office than men, since men are well-known to cast off wives and children with greater ease. In the current climate where an elected seat is viewed by many as the route to wealth and power, a would-be elected official hungry for a seat is likely to be tempted to cast off the current wife who has borne him more than the allowed number of children, and this will be difficult to enforce against. The people most likely to be affected by electoral restrictions will in this case be the cast-off wife or the woman who cannot stand for office because it would mean abandoning her children.

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<th>Categories of incentives/disincentives</th>
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<td><strong>Participation in government</strong></td>
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<td>Employment benefits (or eligibility for government employment)</td>
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<td><strong>Access to development schemes</strong></td>
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<td>Anti-poverty &amp; employment schemes</td>
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<td>Health insurance or other health benefits</td>
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<td>Money awards to select BPL groups</td>
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<td><strong>Performance awards and service provider incentives</strong></td>
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Linking access to development schemes to acceptance of sterilisation is particularly problematic in view of the poor performance on poverty and inequality, especially in the last decade. Reduced access to anti-poverty schemes on grounds of family planning has potential *perverse* effects on exactly those factors such as girls’ education, women’s access to income/jobs, health status, child survival and access to health services that are most likely to reduce momentum, unwanted and wanted fertility. Furthermore, those most in need among and within households may end up with even less access than before.

The Indian family planning programme has experimented with service provider incentives over many years. A large body of opinion within and outside government holds that such incentives have the unfortunate effect of distorting service delivery, both in scope and quality. For instance, it is well-known that before the removal of targets and incentives from family planning programmes, service providers would focus on meeting family planning targets to the detriment of other basic health services.

Two questions often come up in this debate. The first is whether incentives are less coercive than disincentives. The line between incentives and disincentives is often difficult to draw. For instance, providing health insurance to a BPL family conditional on sterilisation may appear on the surface to be an incentive. However, given sharply rising health costs and the acute problem of access to health services by such groups, denial of health insurance can also be viewed as a disincentive. For this reason, both incentives and disincentives need to be questioned.

The second question is whether group incentives or disincentives are less problematic than individual ones. What, for instance, would be wrong about reducing development funds to a village (or state?) that does not meet set demographic goals? The problem here is one of intra-group equity and voice in decisions. Setting group norms may well result in the dominant group members (men in households, village leaders or dominant castes or communal majorities) coercing the rest.

Given the economic and social, including gender inequalities that mark Indian society, it is important to have a framework of reproductive rights within which specific policies, actions and approaches can be identified. Such a framework has to start from the recognition that support for these rights is reflected not only in what programmes and projects are put in place but also in how this
is done.

Indian population policy stands at present at a crossroads. Having chosen to sign and to begin to implement the ICPD Programme of Action, the government needs to move forward strongly. State governments need to be discouraged from their flirtation with incentives and disincentives that can once again generate political controversy and backlash, and state policies need to be brought into consonance with national and international norms.

Policy needs to move forward to address women’s and girls’ own clear desires and needs for better health and a safeguarding of their rights. The lessons from other developing countries are clear in this regard. When programme directions build on and strengthen the directions that behaviour change is already beginning to take, the needs and behaviour of people and macro development goals can be synergised.

Footnotes

1. Fees for service are being increasingly used as part of decentralisation and in order to increase financial viability. However, globally, support for user fees has declined for three main reasons: (i) the net revenue earned is insignificant; (ii) effective targeting is difficult and its absence reduces demand for health services by the poor and women; (iii) separation of users into two categories of those who pay and those who don’t leads to significant quality differentials, and also reduces the political support for free or subsidised services.

2. How population momentum works can be seen through a simple illustration. Consider two populations which at a given time point are the same size, and have the same death and birth rates. However, if one of them has more young people of potential reproductive age, it will have a higher growth rate. Thus, age structure has an important independent effect on population growth rates.

3. According to the National Family Health Survey (NFHS), a birth was considered unwanted if the number of living children at the time of conception was greater than the ideal number of children reported by the (married female) respondent.

References


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