

Original Article

Health insurance support on maternal health care: Evidence from survey data in India

HEALTH INSURANCE SUPPORT ON MATERNAL HEALTH CARE

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Conflict of interest

The author declares no conflict of interest.

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IA: Conceptualization, analysis and supervision.

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Availability of data

The study has used unit level data of social consumption on health from the 75th round of National Sample Survey Organization (NSSO) data under the Ministry of Statistics and Program Implementation (MOSPI), conducted in India (July 2017 to June 2018). This is publicly online available which can be accessible at <http://www.mospi.gov.in/unit-level-data-report-nss-75th-round-july-2017-june-2018-schedule-250social-consumption-health>.

ABSTRACT

Background: Maternal health care financing is key to the smooth functioning of health systems in a country. In India, maternal health care still persists as a major public health issue. Adequate health insurance could transform the utilization of maternal health care services. Therefore, we aim to examine the health insurance policies that cover maternal health and their performance in India.

Methods: The unit-level data of social consumption on health by the National Sample Survey Organizations conducted in India (2017–18), are used. Bivariate analysis, logistic regression and propensity scoring matching are applied.

Results

About 14.1% women are covered by health insurance support at the national level. Uninsured women are less likely to receive full antenatal care services (ANC) and institutional delivery. Socio-economic characteristics play a significant role in utilizing maternal health care benefits through health insurance support.

Conclusions: Our study concludes that the health insurance coverage is the most significant contributor to the better utilization of full ANC and institutional delivery at the national level. There is a need for proactive and inclusive policy development by the Government of India to incentivize public financing through health insurance which can shrink the challenges of public health burden and reduce the health risk.

Keywords:

ANC, health insurance, institutional delivery, maternal health, PNC

Introduction

Health is key to economic progress and social welfare. A country with good health indicators has a lower risk of falling into epidemic traps.¹ Public health challenges are thus key to address, and maternal health care is one such significant challenge, especially in low- and middle-income countries.^{2,3} But better public health measures require adequate health financing, which is very difficult to manage in developing countries. Good health spending can improve both mortality conditions and health outcomes.⁴ Similarly, a robust health care system, health policies and programs can be determinantal in addressing the health care needs of the populations.

Various studies have stressed the need for an efficient health care system and the comprehensiveness of health policies to reduce health risks.⁵⁻⁷ But it is difficult for low countries to manage due to limited available resources. Though, economic resources are essential for any country as they enable better usage of health care without having a significant influence on public spending. Health insurance is one such incentive through which better health care utilization is achieved without impacting much on the budget of governments.^{5,8} This approach can lower the risk of public health challenges and reduce the public expenditure to diversify economic resources.

Health care financing and maternal health

Health spending in public health is a significant challenge for developing countries due to a lack of financial resources and extensive health care needs.⁹ Although these countries do some health spending towards their health care system, the percentage of public health expenditure is insufficient to avert the health care risks they face.¹⁰ Health financing through health insurance can be beneficial in averting maternal health care risks and is key in the utilization of maternal health care services.^{11,12} Health financing through different means enables progress in health outcomes and results in adequate service coverage and financial protection.¹³ It is effectively done through various means ranging from revenue raising to pooling of funds and purchasing of services.¹⁴ Since the developing countries cannot afford complete health system financing, health insurance can be one key area, which can play a significant role in public-private partnerships to lower the health care risks.¹⁵ Studies in this context have found that health insurance is positively related to the use of maternal health services.^{16,17}

Similarly, several other studies have found that the health insurance coverage increased the probability of having the recommended number of prenatal visits.^{18–20} Studies in Ghana, Indonesia and Rwanda have found a significant positive impact of health insurance on maternal health outcomes.^{21,22} Health insurance coverage lowers the risk of maternal deaths due to adequate health care financing. It incentivizes pregnant women to access maternal health services throughout pregnancy, childbirth and post-delivery.^{23,24} Antenatal care (ANC) services received through health insurance reduce the risk of low birth weight babies and caesarean section deliveries.²⁵

Similarly, it enhances the incentive for institutional births.²⁶ A study in Egypt while differentiating between those who access health insurance and those who do not, found that health insurance increases maternal health care utilization. However, it has little effect in Tanzania, where the impact has been seen very low.²⁷

Health finance in Indian setting

Health spending in India is a significant concern and a good reason for health distress. In India, public expenditure on health is much lower than the global average and even lower than many developing countries of Asia and Africa.²⁸ India's total spending on health is only 1.28%.²⁹ Given the population size, this share should have been very significant. There is an urgent need to increase health care spending given the rising demand for health care needs and for achieving the Sustainable Development Goal targets. Although, the National Health Policy (2017) proposed increasing public expenditure on health to 2.5% of GDP by 2025 and strengthening the access to maternal and child health care.^{30,31} In Karnataka, micro health insurance was shown to have a positive impact on health service access and utilization, with insured individuals being more likely to access and utilize inpatient treatments than uninsured ones.³² Similarly, another study has found the ineffectiveness of Rashtriya Swasthya Bima Yojana (RSBY) in reducing the burden of out-of-pocket spending on low households.³³ Inadequate inpatient care can be accessed by low-income families even after introducing of publicly financed insurance plans.³⁴

However, understanding the health insurance and its impact on maternal health care outcomes is central. Since any such study can be pivotal, this study has tried to understand the effect of health insurance on the access to and utilization of maternal health care services. Any significant finding can be essential in the context of reforms and policies that are required to

make health insurance coverage more accessible in order to lower maternal health risks and enhance India's health status. Therefore, the present study examines the health insurance policies that cover maternal health and their performance in India.

Data

The present study has used the 75th round of National Sample Survey Organization (NSSO) data under the Ministry of Statistics and Program Implementation which was conducted in India. The study has used unit-level data of social consumption on health, schedule 25.0 of the 75th round (2017–18) by the NSSO, Government of India (July 2017 to June 2018). It provides comprehensive information on the details of the pregnancy of every female household member aged 15–49 years who were reported to have been pregnant at any time during the last 365 days, covering prenatal care and of childbirth and postnatal care and including expenditure on childbirth. The study has used maternal–child health care services in a 365-day reference period as a unit of analysis. A total of 113823 households (555351 individuals of which 31914 pregnant women in the last 365 days, covering prenatal care and of childbirth and PNC) were successfully interviewed.

Methods

Outcome variable

Three indicators of maternal health care services, namely: (i) full antenatal care (at least four antenatal visits, at least one tetanus toxoid injection and iron-folic acid tablets or syrup was taken for ≥ 100 days), (ii) institutional delivery (delivery conducted in the health facility irrespective of the type of institution) and (iii) PNC (women received check-ups in the first 7 days after the delivery of the child) were the outcome variables of the study. All of these variables are made dichotomous (coded as 0 or 1).

Predictor variables

The main independent variable of interest has been health insurance coverage. The NSSO asked respondents whether they were covered by health insurance for health insurance support and what type of health insurance they had. We constructed a dichotomous variable of whether a woman was covered by any health insurance. Also, this has been taken as treatment variable in the propensity scoring matching (PSM) analysis. Additionally, age of the respondent (< 20

20–24 25–29 ≥30 years), place of residence (rural and urban), religion (Hindu, Muslim, Christianity and Others), social group (STs, SCs, OBC and Others), household size (less than or equal to five members and more than five members), wealth quintile (poorest, poor, middle, rich and richest), mother’s education (illiterate, primary, secondary and higher) and mother’s working status (working and not working) have been used as a predictor variable in the study.

Statistical analysis

The bivariate and multivariate statistical techniques were used to analyse the data. In the multivariate technique, logistic regression and PSM were used to evaluate the effect or consequences of the coverage of health insurance on maternal health care utilization.

Logistic regression was carried out to see the significant effect of predictor variables on the outcome variable. The general regression model used for the study has been defined in the following equation:

$$\text{Logit } p = \log \frac{p}{1-p} = \log \Omega = b_0 + b_1x_1 + b_2x_2 + \dots + b_kx_k$$

where, where p is the probability that the event Y occurs and coefficient ‘ b ’ is the factor by which the odds changes with unit increase in independent variable. If ‘ b ’ is positive, odds ratio (OR) will increase, as this factor will be >1 . Contrary to that if ‘ b ’ is negative, OR will decrease. When ‘ b ’ is 0, the factor exponential of ‘ b ’ = 1 and, therefore the odds remain unchanged.

Propensity score matching

Our study adopted PSM analysis to estimate the effect of the health insurance coverage on maternal health care utilization —i.e. full ANC, institutional delivery and PNC. PSM has been a useful tool that can evaluate the treatment effect for cross-sectional/observational/non-experimental data ³⁵.

We used a binary exposure variable (women covered by health insurance: yes, versus no), and all possible available confounding covariates (independent treatment variables) that are determinants of both exposure and response were adjusted.

With this approach, we have calculated the robust estimators to determine the effect of health insurance on maternal health care services (full ANC, institutional delivery and PNC). The

main assumption in this method is that conditionality of propensity score; the observable selected characteristics of the treatment (insured) and control groups (uninsured) have similar distributions.³⁶ The study has used STATA 14.0 package for the complete analysis.

Results

Figure 1 presents the percentage of women covered by a specific type of health insurance support in India. Women who have been covered health insurance support has found to be 14.1% at the national level during 2017–18. About 10.1% among women who opted for the government-sponsored support (such as RSBY, Arogyasari, etc.).

[Figure 1]

Figure 2 shows the percentage of women covered and uncovered by health insurance supports who received the all-selected utilization of maternal health services by place of residence in India. Insured women had a ~10% rural–urban gap in receiving full ANC, compared to 12.6 percent for uninsured women. High percentage of institutional delivery is observed in which ~95% insured women reside in rural areas and 99% reside in urban. While receiving utilization of PNC, the percentage of insured and uninsured women are found to be same in rural area (~88%) and lesser than the urban insured and uninsured women in India.

[Figure 2]

Table 1 shows the percentage of women who have received maternal health care services in India in 2017–18. Health insurance coverage is greater in urban areas (16.6%) than in rural areas (13.3%). The result shows the selected maternal health care services (full ANC, institutional delivery and PNC) and various socio-economic and demographic characteristics.

[Table 1]

Table 2 shows the percentage of women covered and uncovered by health insurance support, who received the selected maternal health care services (full ANC, institutional delivery and PNC) in India, 2017–18. The results showed that greater percentage of women in urban areas are covered by health insurance support. Similarly, it can be seen that household size plays a

key role in health insurance coverage, with women having less than five members have higher coverage of health insurance. Similarly factors like income, education and early age are key for utilizing the maternal health care services through health insurance.

[Table 2]

Table 3 shows the results of logistic regression showing the OR and 95% confidence interval (CI) of health insurance status on all selected maternal health care services in India in the period 2017–18 by selected socio-economic characteristics. About 11% of urban women are less likely to have health insurance supports in terms of full ANC services compared to rural women while on the other side, urban women are 38% more likely to have institutional delivery compared to rural women. The odds of receiving full ANC services and institutional delivery are less significant (OR=0.92, [0.86–0.99] and (OR=0.50, [0.41–0.56]) among Muslim women compared to Hindu women. The odds of Christian women are ~32% (full ANC), 65% (institutional delivery) and 45% (PNC) less likely and significant than the odds of Hindu women. When compared to insured women, uninsured women are less likely to receive full ANC services and institutional delivery. The results show that socio-economic characteristics play a significant role in utilizing health care benefits through health insurance support. The odds ratio for women with better socioeconomic conditions, like income, education, caste and religion were greater than those belonging to vulnerable groups.

[Table 3]

Table 4 shows the basic descriptive statistics of the estimated propensity score matching results all the cases. The results in the table shows the balancing property at 1% significance level. The score indicated that there were no systematic differences in covariates between women at individual level, who were covered and uncovered by health insurance support. This means that if both groups of women had similar socio-demographic characteristics except for health insurance support, then a difference in means in the utilization of maternal health care services between women of exposed and of non-exposed groups could be attributed to health insurance.

[Table 4]

Table 5 shows the average exposure effect (AEE) for ANC, institutional delivery and PNC with the nearest neighbour matching technique. Our study shows that insured women have a significant positive exposure effect on health insurance supports of 7.2% to receive full ANC, 9.1% to receive institutional delivery, and 2.8% to receive PNC at the national level. The result reflected the hypothesis that health insurance support plays a significant role in accessing and utilizing the better maternal health care services which can lower the risk for maternal and child health burden in India.

[Table 5]

Discussion

Maternal health is an important public health issue given its importance in terms of child survival, women's health and gender empowerment. The subject has been of intense debate among public health researchers, while analysing multiple aspects ranging from access, utilization, inequality and benefits of health care services among women.³⁷ Earlier studies have already connoted the importance of health care financing and the benefits it imply through utilization of health care services. Despite this, very less has been explored to address the role of public financing in utilization of maternal health care services in Indian settings.^{38,39} Our results have found some substantial differences in health care utilization across the socio-economic groups with women living in rural areas facing the greater challenges of maternal health care services and their utilization. These results are coherent with earlier findings, where socio-economic disparity was found as a key barrier in the utilization of maternal health care services.^{17,40}

Health care financing is a pertinent challenge in India, given the minimal share of budget spending by the government.¹³ There is also a significant inequality across the socio-economic groups to utilize the health care services given the lack of public spending and health care financing as discussed in the earlier research.⁴⁰ Women with poor socio-economic and living conditions especially in rural areas, face barriers not only in accessing the health care services, but they also lack financial incentives to utilize these services on their own. This is clearly indicated through our results, and the resulting differences are mainly due to the lack of available health care financing incentives.

Health insurance plays a significant role in the utilization of health care services. Therefore, while examining the role of health insurance in utilizing maternal health care benefits, we found that women covered through insurance benefits are more likely to access these services as compared to uninsured women. Our findings were consistent with many earlier works in this aspect.^{16,17,21,22,41} Although socio-economic factors do play a significant role in the utilization of health care services and benefiting from them. But when we analysed using the PSM technique, we found that health insurance can also play a determinantal role in the utilization of health care services. There is a significant and positive association of health care financing with health insurance in terms of maternal health outcomes, which is one of the noteworthy results of this study.

Public financing is key to utilize the health care services, especially when there are large socio-economic and geographic disparities present in a country. This study, therefore highlights the role of public financing since increase in health financing through health insurance has positive consequences on health care benefits.^{21,39,41} There is a need for enhancing public health financing in India, given the role it can play in enhancing the health care services and their utilization, particularly in terms of maternal health outcomes. Earlier studies have already depicted the importance of public financing in funding of health care costs and supports during and proceeding the weeks after childbirth of women has a positive impact on maternal health outcomes.⁴² Moreover, in order to reduce the disparities in utilization of maternal health care services a target-oriented approach in the current policies is required to address these challenges.

Strength and limitation

The study has explained the importance of health insurance in utilizing the health care benefits and reducing the health disparities. However, the present study gave an ample account of maternal health care services and the likely impact that health insurance can play a role in minimizing the inequality in health care services. There is a further need for in-depth analysis to examine how health insurance can enhance the maternal health care services in India. Other studies are required to address this challenge of how public financing can be covered across these sub-populations, which are vulnerable to poor socio-economic and geographic settings. Moreover, studies can also examine the awareness about already available health care services, which could not be addressed in this study, given the data limitation.

Conclusions

The coverage of health insurance is the most significant component influencing the better utilization of full ANC and institutional delivery at the national level. As a result, government measures aimed at incentivizing public finance through health insurance can help to mitigate the burden of public health. By increasing and making financial incentives available to disadvantaged communities in India, we can reduce risks while avoiding high-risk pregnancy-related complications and consequences, as well as infant health losses. In addition, the Indian government has to establish proactive and inclusive policies to encourage more public and private health insurance systems.

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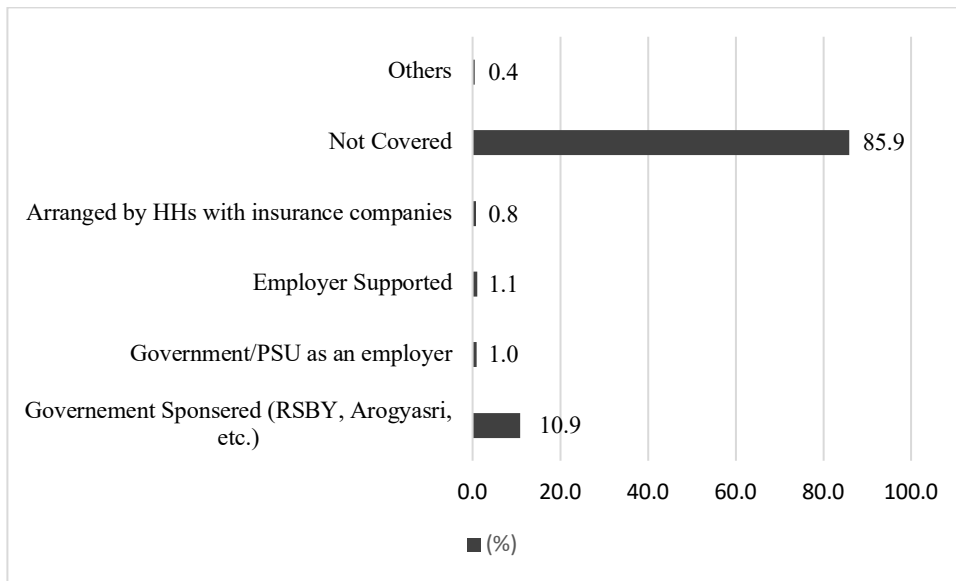
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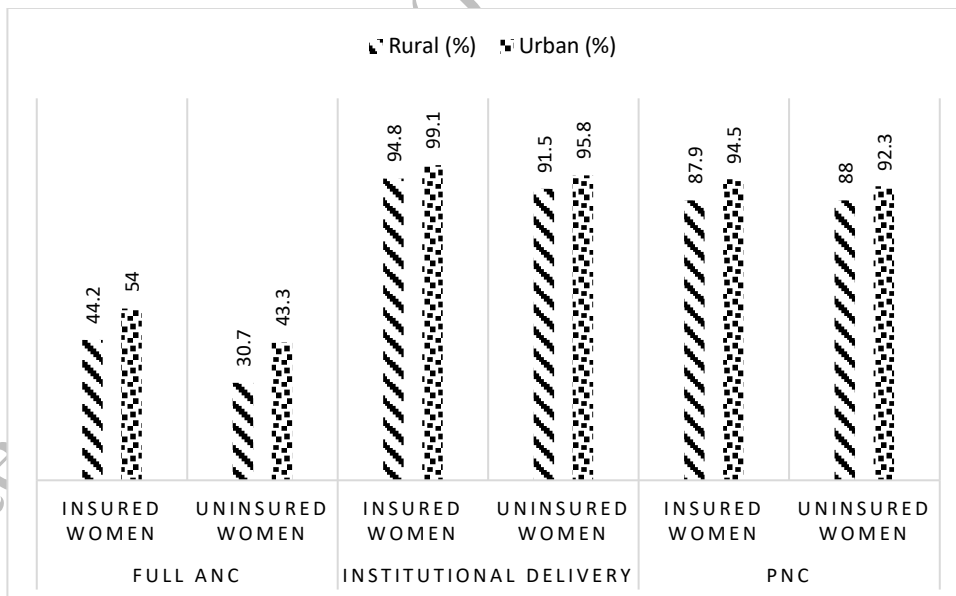
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Figure 1 Percentage of women covered by specific type of health insurance supports in India.



Source: 75th National Sample Survey 2017–18, unit level data.

Figure 2 Percentage of women covered and uncovered by health insurance supports who received the all selected utilization of maternal health services by place of residence in India, 2017–18.



Source: 75th National Sample Survey 2017–18, unit level data.

Table 1 Percentage of women received the selected utilization of maternal health services in India, 2017–18.

Background	Sample distribution		Insurance coverage	Utilization of maternal health services		
	%	n	%	Full ANC (%)	Institutional delivery (%)	PNC (%)
Place of residence						
Rural	75.9	19104	13.3	32.6	91.9	88.0
Urban	24.1	12810	16.6	45.0	96.3	92.7
Religion						
Hindu	79.0	23869	14.7	35.6	93.8	89.3
Muslim	16.8	4700	8.47	33.3	88.9	87.2
Christian	2.2	2113	37.5	49.4	90.5	90.9
Others	2.0	1232	8.6	41.5	94.9	94.9
Insurance status						
Covered	14.1	5547	14.1	47.0	96.1	89.9
Uncovered	85.9	26367	0.0	33.8	92.4	89.0
Social group						
ST	10.1	4693	23.4	35.3	89.3	88.9
SC	21.0	5657	10.9	33.7	92.7	89.3
OBC	46.1	12831	14.0	34.8	92.5	88.3
Others (or General)	22.9	8733	13.1	42.8	95.7	90.6
HouseholdsSize						
≤5 members	52.9	17479	15.6	36.5	92.8	89.5
> 5 members	47.1	14435	12.4	34.6	93.0	88.7
Wealth quintile						
Poorest	30.8	7212	8.4	24.8	89.7	86.5
Poor	24.4	6555	10.6	32.5	92.5	87.6
Middle	20.3	6491	18.3	41.4	93.4	89.9
Rich	14.8	6180	18.3	45.9	96.8	92.0
Richest	9.8	5476	25.4	50.4	98.1	95.6
Women's education						
Illiterate	19.7	4090	11.7	23.4	84.1	83.2
Primary	39.0	11640	12.5	35.5	94.0	89.0
Secondary	28.6	10350	15.1	39.2	96.0	91.9
Higher	12.8	5834	20.3	46.8	97.6	93.1
Women's working status						
Working	10.1	3218	23.5	34.9	91.6	84.4
Not Working	89.9	28696	13.0	35.7	93.1	89.6

Women's age						
<20 years	4.5	956	16.6	33.5	92.7	90.7
20–24 years	39.7	10634	13.9	35.1	94.0	89.1
25–29 years	35.5	12137	14.6	38.2	93.2	88.9
≥ 30 years	20.3	8187	13.1	32.8	90.7	89.2
Total	100	31914	14.1	35.6	93.0	89.1

Abbreviations: ST–Schedule Tribe; SC–Schedule Caste; OBC–Other Backward Caste; ANC–Antenatal care, PNC–Postnatal care

Source: 75th Round National Sample Survey 2017-18, unit-level data.

Table 2 Percentage of women covered and uncovered by health insurance supports who received the all selected utilization of maternal health services in India, 2017–18.

Background	Full ANC		Inst. Delivery		PNC	
	Covered by health insurance support	Uncovered by health insurance support	Covered by health insurance support	Uncovered by health insurance support	Covered by health insurance support	Uncovered by health insurance support
Place of residence						
Rural	44.2	30.7	94.8	91.5	87.9	88.0
Urban	54.0	43.3	99.1	95.8	94.5	92.3
Religion						
Hindu	47.4	33.5	95.8	93.5	90.2	89.2
Muslim	38.8	32.9	98.4	88.1	85.4	87.3
Christian	54.6	46.2	96.6	86.8	93.0	89.8
Others	51.5	40.6	96.2	94.7	93.0	95.0
Caste						
ST	40.2	32.5	91.2	88.6	85.6	89.6
SC	51.0	30.8	96.4	92.2	90.4	89.1
OBC	46.1	32.1	97.8	91.7	90.0	88.1
Others (or General)	51.3	40.3	96.7	95.5	92.9	90.3
Household size						
≤ 5 members	47.8	34.4	96.0	92.3	94.0	88.9
> 5 members	45.8	33.0	96.4	92.6	84.6	89.2
Wealth quintile						
Poorest	29.2	24.4	94.4	89.3	85.2	86.6

Poor	44.2	31.1	96.5	92.0	83.5	88.1
Middle	46.9	40.2	95.1	93.1	90.4	89.8
Rich	56.1	43.6	96.2	97.0	94.3	91.5
Richest	58.5	46.7	99.0	97.8	96.4	95.3
Women's education						
Illiterate	25.8	23.1	93.6	82.9	84.1	83.0
Primary	46.8	33.9	94.5	93.9	88.9	89.1
Secondary	52.9	36.8	97.8	95.7	91.6	91.9
Higher	56.4	44.3	98.8	97.3	95.0	92.6
Women's working						
Status						
Working	45.2	31.7	91.8	91.5	85.1	84.1
Not working	47.4	34.0	97.1	92.6	90.9	89.4
Women's age						
<20 years	47.0	30.8	96.1	92.1	91.2	90.8
20–24 years	44.9	33.5	96.6	93.6	88.9	89.1
25–29 years	49.2	36.3	95.7	92.9	90.7	88.6
≥ 30 years	47.1	30.6	96.1	90.0	90.2	89.1
Total	47.0	33.8	96.1	92.5	89.9	89.0

Abbreviations: ST–Schedule Tribe; SC–Schedule Caste; OBC–Other Backward Caste; ANC–Antenatal care, PNC–Postnatal care.

Source: 75th Round National Sample Survey 2017–18, unit-level data.

Table 3 Result of logistic regression showing the odds of the selected utilization of maternal health services in India, 2017–18.

Background	Full ANC	Institutional Delivery	PNC
Place of Residence			
Rural ^a	1.00	1.00	1.00
Urban	0.89* [0.84–0.93]	1.38* [1.16–1.58]	0.98 [0.89–1.07]
Religion			
Hindu ^a	1.00	1.00	1.00
Muslim	0.92** [0.86–0.99]	0.50* [0.41–0.56]	1.08 [0.95–1.22]
Christian	0.68* [0.62–0.77]	0.36* [0.35–0.53]	0.55* [0.47–0.65]
Others	0.77* [0.69–0.88]	0.37* [0.29–0.47]	0.67* [0.55–0.81]
Insurance status			
Covered ^a	1.00	1.00	1.00
Uncovered	0.67* [0.63–0.71]	0.44* [0.37–0.55]	0.93 [0.83–1.04]

Social group			
ST ^a	1.00	1.00	1.00
SC	1.37* [1.26–1.50]	1.88* [1.62–2.38]	1.14 [0.98–1.31]
OBC	1.25* [1.15–1.36]	1.93* [1.81–2.55]	1.05 [0.92–1.20]
Others (or General)	1.30* [1.20–1.43]	2.18* [1.91–2.85]	1.00 [0.86–1.15]
Household Size			
≤5 members ^a	1.00	1.00	1.00
> 5 members	1.04 [0.99–1.09]	1.23** [1.09–1.39]	0.86* [0.80–0.94]
Wealth Quintile			
Poorest ^a	1.00	1.00	1.00
Poor	1.37* [1.28–1.48]	1.44* [1.15–1.54]	1.02 [0.92–1.15]
Middle	1.83* [1.70–1.97]	1.64* [1.34–1.88]	0.99 [0.88–1.11]
Rich	2.28* [2.12–2.47]	2.52* [1.93–2.96]	1.37* [1.20–1.57]
Richest	2.38* [2.18–2.61]	3.03* [2.15–3.83]	1.87* [1.57–2.23]
Woman's Education			
Illiterate ^a	1.00	1.00	1.00
Primary	1.58* [1.46–1.72]	2.15* [1.93–2.54]	1.49* [1.33–1.67]
Secondary	1.81* [1.67–1.97]	3.34* [3.00–4.25]	2.04* [1.80–2.31]
Higher	2.19* [2.00–2.41]	5.09* [4.18–7.42]	2.41* [2.05–2.83]
Woman's Working Status			
Working ^a	1.00	1.00	1.00
Not Working	1.05 [0.97–1.14]	1.61* [1.39–1.91]	1.10 [0.97–1.25]
Woman's Age			
<20 years ^a	1.00	1.00	1.00
20–24 years	0.96 [0.84–1.1]	0.94 [0.66–1.33]	0.82 [0.64–1.06]
25–29 years	0.91 [0.79–1.04]	0.85 [0.6–1.21]	0.88 [0.68–1.13]
≥ 30 years	0.85** [0.74–0.98]	0.81 [0.57–1.16]	1.03 [0.80–1.34]

^aReference category

Source: 75th Round National Sample Survey 2017–18, unit-level data.

Significance level-***P<0.01, **P<0.05, *P<0.1

Abbreviations: ST–Schedule Tribe; SC–Schedule Caste; OBC–Other Backward Caste; ANC–Antenatal care, PNC–Postnatal care

Table 4 Description of propensity score.

Description	Values
Range of common support	[0.19–0.48]
Mean of propensity score	0.4
Standard deviation	0.1
Significance of balancing property	0.01

Source: 75th Round National Sample Survey 2017–18, unit-level data.

Table 5 AEE for MCH services of women covered with and without health insurance supports in India by place of residence, 2017–18.

Indicators		AEE	Standard Error	P> z	CI [95%]	
					Lower	Upper
Full ANC	Overall	0.072*	0.004	0.000	0.0638	0.0810
	Rural	0.073*	0.006	0.000	0.0623	0.0846
	Urban	0.067*	0.007	0.000	0.0531	0.0801
Institutional Delivery	Overall	0.091*	0.009	0.000	0.0732	0.1092
	Rural	0.080*	0.010	0.000	0.0599	0.0991
	Urban	0.100*	0.021	0.000	0.0587	0.1419
PNC	Overall	0.028*	0.007	0.000	0.0137	0.0420
	Rural	0.001	0.009	0.915	-0.0167	0.0186
	Urban	0.066*	0.012	0.000	0.0416	0.0902

Notes: Significance level-***P<0.01, **P<0.05, *P<0.1

Source: 75th Round National Sample Survey 2017–18, unit-level data.

Abbreviations: AEE–Average exposure effect; ANC–Antenatal care, PNC–Postnatal care; CI–Confidence interval