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Globally and Locally, A Rich-Poor Gap Persists

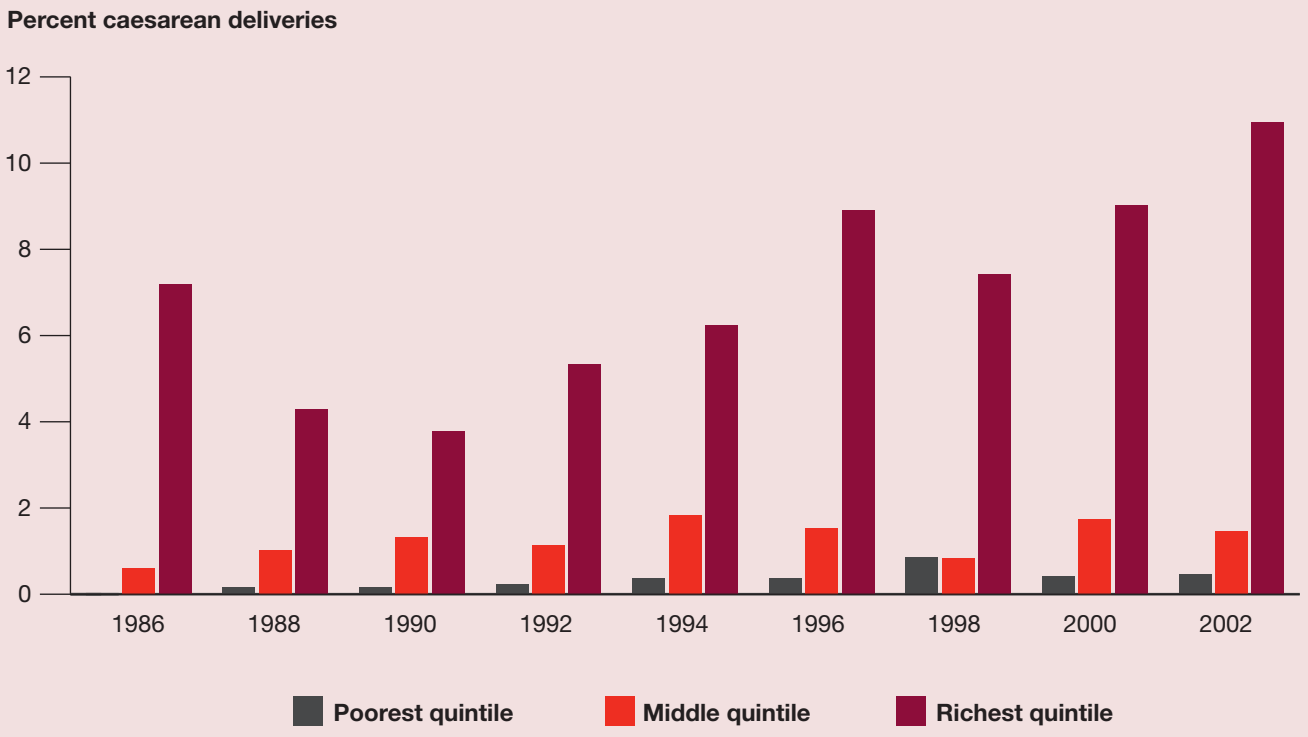
The gap in the levels of maternal death between developed and developing countries continues to be one of the greatest global health inequities. Research conducted by Immpact, a global research initiative, also found huge inequities in the countries where it worked. Although strategies such as delivery-fee-exemption policies and village midwives have resulted in increased utilisation of services, large differences in access to and use of skilled care between rich and poor remains.

Findings

Analysis of caesarean births shows large rich-poor gap.

Indicators measure the performance of the programme rather than its impact on health or behaviour and are useful for understanding inequities in access to services. Caesarean delivery rates are one example of an indicator that reveals the rich-poor gap in access to obstetric services, with the poorest women in many countries

Rich-Poor Gap: Trends in Caesarean Deliveries in Indonesia, 1986–2002



Source: Immpact.

getting no or extremely limited access to this potentially lifesaving surgery. Immpact research revealed that where caesarean rates were very low, a high proportion was carried out to save the mother's life. For example, caesarean rates were below 1 percent for the poorest 20 percent of the population in twenty developing countries. Rates were higher in urban areas or among the rich, with a greater proportion of caesarean deliveries conducted for foetal or other reasons.

In Indonesia, almost 40 percent of caesarean deliveries were done in private hospitals, where wealthier Indonesians tend to get their health care. Moreover, the rich-poor gap in rates of lifesaving emergency obstetric care actually widened between 1986 and 2001 in that country, as evidenced by the concentration of caesarean deliveries almost exclusively among the rich—in 2001 less than 1 percent of the poor delivered by caesarean, compared to 9 percent of the rich (see figure).

Poor families spend more of their own money for obstetric care than rich families.

Findings from Ghana show another rich-poor gap—wealthier households benefited more from the delivery-fee-exemption policy through decreased costs of delivery. While the out-of-pocket payments declined for all groups after the introduction of the policy, payments by the poorest household declined by 14 percent, compared to a decline of almost 22 percent for the richest households.

In Indonesia, Immpact research found that village midwifery services reached mostly the rich, who can afford to pay, but left the poor still unable to access skilled care. Although Indonesia recently established an insurance programme to pay midwives for services to the poor, only 22 percent of the poorest mothers were covered by the insurance scheme, because many women in remote areas were not aware that free skilled care was available to them or found it hard to navigate the process to qualify for the programme. As a result most poor mothers (80 percent) still bought cheaper delivery care from unskilled providers and made out-of-pocket payments for that care.

Community members value maternal health.

An Immpact study into community perceptions about maternal deaths found that most people would prefer societies where the gap in the number of maternal deaths between different areas of the country was narrowed, and were willing to make trade-offs for improved health of mothers. When asked to think about future generations, community members valued policies that benefit large numbers of mothers—even when the trade-off was smaller gains in life expectancy for society overall. Such information enables policymakers to understand the degree to which communities are averse to maternal health and survival inequalities.

For more information on Immpact, please visit www.immpact-international.org.

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