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Essay

Inequity in healthcare—The outlook for obstetric analgesia☆

Gustavo Duarte Ortiz[a,*], *José Ricardo Navarro-Vargas*[b], *Javier Eslava-Schmalbach*[c]

[a] *Resident, Third Year of Specialization in Anesthesiology and Resuscitation, Universidad Nacional de Colombia, Bogotá, Colombia*
[b] *Associate Professor of Anesthesiology and Resuscitation, Universidad Nacional de Colombia, Bogotá, Colombia*
[c] *Professor, Clinical Research Institute, School of Medicine, Universidad Nacional de Colombia*

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ABSTRACT

Healthcare inequity is a social phenomenon that has been subject of multiple studies and debates. Obstetric patients are not spared from its effects. The general belief is that obstetric analgesia in particular is substandard, usually because of healthcare inequities. This article intends to discuss the issue based on the authors' analysis of the literature and the current clinical practice, in addition to making proposals to cope with inequity and reduce the considerable social gap in this area.

Inequidad en el sistema de salud: el panorama de la analgesia obstétrica

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RESUMEN

La inequidad en salud es un fenómeno social que ha sido motivo de múltiples estudios y debates. La población obstétrica no es ajena a esta problemática. En especial se considera que la analgesia obstétrica no recibe el estándar de cuidado que debiera, derivada en muchas ocasiones por inequidad en el sistema de salud. En este artículo se pretende exponer el tema después de un análisis de la literatura y de la práctica diaria realizado por los autores, así como propuestas para afrontar el fenómeno y disminuir las grandes diferencias sociales que hay en este campo.

Colombia's Social Security System was regulated by Law 100 of 1993. The law establishes that the purpose of the social Security System is to guarantee the inalienable rights of the individual and the community to a quality of life consistent with human dignity, protected from any contingencies. Social security is as public service that should be provided under the principles of efficiency, universality, solidarity, wholeness, unity and participation.[1]

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* *Corresponding author at*: Universidad Nacional de Colombia, Anesthesiology, Street 60, No 19-47, Bogotá, Colombia.
E-mail address: gduarteo@unal.edu.co (G. Duarte Ortiz).

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Pregnancy and labor are physiological processes that usually become a painful experience for most pregnant women, particularly labor. Some of the key factors in the perception of pain by the mother are age, parity and socioeconomic level. There are currently several options for achieving adequate pain control during labor. Of the numerous techniques available, epidural analgesia is considered the gold standard for pain control during labor.[2–4] The advantages of epidural analgesia include better pain control, reduced central sensitization and lower risk of developing chronic or post-traumatic pain, reduced neuroendocrine response, and a lower requirement of systemic opiates and their adverse reactions.[5] This has proven to be beneficial both for the mother and for the baby.

The percentage of patients that are offered, and in whom an epidural catheter is placed for labor pain management, varies from country to country and even from one institution to another. For instance, in developed countries such as France, the percentage of patients in labor who receive epidural analgesia is around 75%[6]; in Sweden it is 45% for primiparous women and 16% for multiparous[7] for a total of 71% of native mothers. This percentage is lower when considering only immigrant female patients. In other less developed countries such as South Africa, only 21% of the pregnant women were aware of epidural analgesia and asked for it; over 50% believe that women should experience moderate pain during labor as part of the process and up to 66% of patients were not aware of the fact that pain could be controlled during labor through an intervention.[8]

Figures in Colombia are equally discouraging. A case review in a public institution indicates that in terms of labor pain, Colombia ranks within the group of least favored countries.

2786 labors were managed in that institution in 2011; 54% (1447) were vaginal deliveries and of this group, only 456 patients (31.5%) received epidural analgesia.[5]

There are no studies in Colombia to indicate the preferences of obstetric patients in terms of choosing a particular method of analgesia during labor, and neither to determine whether they are aware of the most frequent complications derived from labor management, of the safety of epidural analgesia administered by a specialist, of the right time to sign the informed consent, etc. According to the figures of the Colombian Department of Statistics–DANE,[9] out of 621.901 deliveries recorded in 2011, 43% were through cesarean section; however, there is no information about the frequency of administration of obstetric analgesia and the results thereof. In studies done in countries like Ireland, most maternal patients (79%) believe that labor pain really affects a conscientious decision to sign the informed consent.[10]

The reasons why there are this type of differences between countries such as Colombia and France are no different from the reasons in other areas.[10] On the one hand, there are a certain percentage of pregnant women who see labor pain as something natural; others just do not ask for analgesia during labor because they are not aware of that. These may be up to 50% of all pregnant women.[11] Doing a pre-labor evaluation by the anesthesiologist may have a strong impact on the awareness of the pregnant mother and the acceptance of pain management.[8] The socioeconomic level of the mother has been found to be related to the demand for epidural analgesia; this demand is higher among the higher socioeconomic strata.[12] There are other factors related to the institution where the patient is cared for. Epidural analgesia is more frequently used at University centers that take care of a larger number of patients as compared to small clinics. However, what is really concerning is the fact that the medical team that takes care of the patient does not ask for analgesia or, in some cases, the request is placed too late.

In addition to these considerations, within the organizational framework of the healthcare system (based on inequality), epidural analgesia in not an option available to a group of pregnant women, particularly when these women do not enjoy the so called complementary plans or insurance. In certain cases, under the current healthcare system, the cost of labor analgesia is charged as an additional item to be paid by the patient separately because it is not included in the "labor package". This is by all means embarrassing and unfair. Poor patients sometimes get ineffective or below the gold standard treatment and even dangerous or contraindicated therapies in some cases.[13]

The purpose of this article is to reflect on the need to disseminate these ideas so that the patient or the institution that provides medical care, requests the analgesia for labor subject to no restrictions, not only at the time of delivery, but also from the very moment that the patients arrives at the "waiting" room.[14,15]

If the Colombian government policy is to provide equitable healthcare, equal opportunities should be offered to all patient populations. However, the current system results have shown a persistent barrier to prompt access to quality healthcare by low-income patients; in contrast, the service is poor and total costs are increasing. Healthcare systems should be designed to meet the healthcare needs of the high-risk, low-income population, based on the premise that health is an inalienable right. Moreover, such policy should be based on equity at all levels, with competency and accountability.[16,17]

Conclusion

If a gold standard for a diagnostic or therapeutic intervention is available, such standard should be offered to every Colombian citizen with no restrictions. The legislators in the country should consider epidural analgesia as a humanitarian right, supported by scientific and rigorous research. This approach should be a priority, considering that mother–child morbidity and mortality are indicators of development of a country.

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Conflict of interest

The authors declare not having any conflicts of interest.

REFERENCES

1. Law 100 dated 1993 Available from: http://www.secretariasenado.gov.co [accessed April 2012].
2. Douma MR, Verwey R, Kam-Endtz CE, van der Linden P, Stienstra R. Obstetric analgesia: a comparison of patient-controlled meperidine, remifentanil, and fentanyl in labour. Br J Anaesth. 2010;104:209–15.
3. Simmons SW, Cyna AM, Denis AT, Hughes D. Combined spinal-epidural versus epidural analgesia in labour. Cochrane Database Syst Rev. 2007:CD003401.
4. Hawkins JL. Epidural analgesia for labor and delivery. N Engl J Med. 2010;362:1503–10.
5. Navarro R, Herrera P, Duarte G, Valero JF. Recomendaciones para el manejo del dolor en obstetricia. In: Fernández CF, Gómez MP, editors. Dolor agudo y postoperatorio. 1st ed. Bogotá, Colombia: ACED; 2011. p. 83–97.
6. Le Ray C, Goffinet F, Palot M, Garel M, Blondel B. Factors associated with the choice of delivery without epidural analgesia in women at low risk in France. Birth. 2008;35:171–8.
7. Ekeus C, Cnattingius S, Hjern A. Epidural analgesia during labor among immigrant women in Sweden. Acta Obstet Gynecol Scand. 2010;89:243–9.
8. Mugambe JM, Nel M, Hiemstra LA, Steinberg WJ. Knowledge of and attitude towards pain relief during labour of women attending the antenatal clinic of Cecilia Makiwane Hospital, South Africa. SA Fam Pract. 2007;49:16a.
9. DANE Colombia. Nacimientos por tipo de parto según Departamento de residencia de la madre. información estadística a 31 de diciembre de 2011. disponible en: http://www.dane.gov.co/index.php?option=com_content&view=article&id=1295&Itemid=119 [consultado 3.6.12].
10. Fröhlich S, Tan T, Walsh A, Carey M. Epidural analgesia for labour: maternal knowledge, preferences and informed consent. Ir Med J. 2011;104:300–2.
11. Palot M, Leymarie F, Jolly DH, Visseaux H, Botmans-Daigrement C, Mariscal-Causse A. Request of epidural analgesia by women and obstetrical teams in four French areas. Part I. Request for analgesia. Ann Fr Anesth Reanim. 2006;25:559–68.
12. Makara P. Can we promote equity when we promote health? Health Promot Int. 1997;12.
13. Nakamura G, Ganem EM, de Souza LM, Machado YM. Effects on mother and fetus of epidural and combined spinal–epidural techniques for labour analgesia. Rev Assoc Med Bras. 2009;55:405–9.
14. Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Background document to WHO—strategy paper for Europe. Institutet för Framtidsstudier. 2007;14:1–67.
15. Liu N, Wen SW, Manual DG, Katherine W, Bottomley J, Walker MC. Social disparity and the use of intrapartum epidural analgesia in a publicly funded health care system. Am J Obstet Gynecol. 2010;202:273.e1–8.
16. Mung'ayi V, Nekyon D, Karuga R. Knowledge. Attitude and use of labour pain relief methods among women attending antenatal clinic in Nairobi. East Afr Med J. 2008;85:438–41.
17. Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: can low-income countries escape the medical poverty trap? Lancet. 2001;358:833–6.