Why the C-Section Rate Is So High

theatlantic.com/ideas/archive/2019/10/c-section-rate-high/600172

Emily Oster Economist at Brown University, W. Spencer McClelland Physician at NY Midtown OB/GYN

October 17, 2019

Getty Images

Every day, roughly 10,000 babies are born in the United States, and about a third of them are born via Cesarean section. This share has gone up significantly over time, and many in the scientific community believe that it's higher than is necessary. Increases in C-section rates have not translated to healthier moms or babies. Although it's impossible to know the "necessary" rate with real precision, the World Health Organization says it is closer to 10 or 15 percent.

Why do doctors perform so many unnecessary (or "non-indicated," in the medical vernacular) C-sections?

This is a question both patients and doctors worry over, with an answer that is by no means straightforward. But here's a data point to consider: While most people agree that what matters most is that mother and baby come through the process safely, doctors are generally paid quite a bit more for a C-section than for a vaginal birth. This financial nudge might just have something to do with the rate of non-indicated C-sections in the U.S.

Emily Oster: New evidence on pot during pregnancy

Cesarean sections are lifesaving if you need them. In some situations, a C-section is not only preferable but mandatory—situations involving conditions like placenta previa, in which going into labor would precipitate life-threatening hemorrhaging, or cord prolapse, which can cause the death of a baby if a C-section is not performed in a manner of minutes. But in most instances, the surgery is not the preferred mode of delivery. Evidence and expert consensus are consistent on the message that C-sections, on average, come with greater risks than vaginal births: more blood loss, more chance of infection or blood clots, more complications in future pregnancies, a higher risk of death. Even if serious complications don't occur, C-section recovery tends to be longer and harder.

And the fact is that a lot of C-sections are performed in clinical gray areas, where the necessity is not clear—for reasons like "abnormal labor progress," or out of concern for the baby's safety based on the fetal heart tracing (an intervention notoriously poor at identifying babies who truly are at risk if they continue in labor). And some C-sections are performed electively, at maternal request.

This complexity regarding C-section decision making is not, in and of itself, a problem. If a doctor and a patient have a nuanced, fully informed discussion about the right mode of delivery, given the risks and benefits, they may reasonably arrive at the conclusion that a C-section is the right approach, even if it is not strictly required. The trouble is, that ideal of a doctor and a patient making an objective and informed decision together is hard to come by.

Doctors and patients are not the only people involved in the decision, and they certainly don't make it in a vacuum. Most births in the U.S. occur in hospitals. By their very nature, hospitals introduce pressures that may alter birth choices. Labor rooms are scarce, and patients (and their doctors) may be subject to implicit or explicit pressure to avoid "taking too long."

Hospitals also tend to be risk-averse; many have developed systems that are intended to improve patient safety, but may result in pressure to perform C-sections rather than letting labor continue. If there is any doubt that the culture of individual hospitals can have an effect on a patient's chance of a C-section, one need only observe that hospitals' C-section rates vary from 7 percent to 70 percent. Differences in patient complexity cannot account for that spread.

But even setting aside risk aversion, the decision to perform a C-section can be clouded by considerations other than medical necessity. For example, physician-patients are about 10 percent less likely to have a C-section than comparable nonphysician patients. Why this is the case is not clear, but it suggests that doctors may treat some patients differently from others. Studies have also found that C-sections—especially first-time C-sections—spike

around morning, lunchtime, and the end of the day, which could be (could be) interpreted as induced demand by doctors who are responding to scheduling pressures: getting to office hours, eating lunch, going home.

Yet another possible reason for the country's high C-section rate, as we mentioned, is that physicians are routinely paid more for a C-section than they are for a vaginal delivery—on average, about 15 percent more. Why is this the case? The prevailing logic is that a C-section is major surgery, so the physicians' payment should reflect the greater potential for complexity. But this logic rests on a crude generalization. Vaginal birth can be very straightforward, but it can also be very complicated and time-consuming. The same is true for a C-section. Despite this, payments are fixed—they reflect the mode of delivery, not the difficulty.

You could imagine an alternative system that just paid for time, per hour of labor—which would acknowledge the fact that labor management tends to take longer than C-sections; after all, a C-section performed during labor by definition cuts short that labor. Such a system would also account for the costs physicians accrue by spending more time in the hospital: less sleep, less time with family, less time to see patients in the office. But such a system might then wrongly incentivize slow labors, or avoiding C-sections when they're needed, so a whole different set of problems would emerge.

At any rate, the fact is that the existing system creates a financial incentive to perform a C-section—or a disincentive to manage labor—that may make the difference in the clinical gray areas. When it's late at night and a labor is long, or progress seems uncertain, or a fetal heart tracing is anything but perfect, and a physician is contemplating the time costs of continuing labor, the present system makes choosing a C-section easy.

Indeed, studies have shown that the more physicians are paid for C-sections relative to vaginal births, the higher the C-section rates become. And when these differentials are reduced, C-section rates decrease.

Now, just in case any reader is jumping to the conclusion that the only reason she will have a C-section is because her doctor wants more money—or because her doctor wants to leave the hospital, or because she herself is not a physician—that is not what we are arguing at all. If this were true, C-section rates would be even higher than they are now. What we are arguing is that medical care is complex and labor management is subject to myriad pressures. While we may not be able to alleviate all the pressures at play, we may be able to reform one of them.

So let's change the monetary incentives. Let's not subtly encourage physicians to perform major surgery on their patients.

One simple approach is to lower the C-section payment, raise the vaginal-birth payment, and meet in the middle. But it's possible that if rates for C-sections go down, doctors will avoid surgery even in situations where they should perform one.

So we propose an alternative: Raise the payment rate for vaginal births to the C-section rate, and leave the C-section rate where it is.

Policy makers will object that this method is expensive. Medical costs in the U.S. are already high and rising. Simply paying more for something risks making that problem worse.

What this argument misses, though, is that the public will get much of its money back—possibly quite a lot of it.

Using Health Analytics data, which covers both Medicaid births and commercial-insurance births, we found that if insurers raised the vaginal-birth reimbursement rate to the level of the C-section rate and changed nothing else, costs would rise by about 1.7 percent. Based on an estimated per-birth cost of about $14,000, aggregated over 4 million births, that comes to roughly $965 million a year.

Read: How one hospital reduced unnecessary C-sections

But something else would change: Namely, the C-section rate would go down. Using data from one study on blended-payment approaches and one on differences across patients, we expect that the rate would go down by about three percentage points in the short run. And that would lead to a reduction in costs beyond doctors' fees, such as those related to long hospital stays, operating-room use, and more. The overall cost increase to the system would, then, actually hover around 0.8 percent, or $480 million a year.

And even this is probably an overestimate. In the long run, C-section rate could go down more than three percentage points. One reason is the adage "Once a C-section, always a C-section." Women who have C-sections are most likely to have a C-section with a subsequent pregnancy, although some of them may choose to try for a vaginal birth, or VBAC. (Further complicating the matter, some insurers reimburse physicians even less for a VBAC compared with either a C-section or a routine vaginal delivery, which further encourages physicians to advise their patients to have a C-section.) If this process gets interrupted—if fewer women have C-sections to begin with—then we may see the share of vaginal births go up dramatically over time, and healthcare costs go down.

Depending on how you do the numbers, it's possible this reform could save money in the long term. Regardless, if vaginal birth is a better outcome for moms in most situations—and we think it is—then we should be willing to accept some increase in costs for safer maternity care.

We want to hear what you think about this article. Submit a letter to the editor or write to letters@theatlantic.com.

Emily Oster*Cribsheet: A Data-Driven Guide to Better, More Relaxed Parenting, from Birth to PreschoolExpecting Better: Why the Conventional Pregnancy Wisdom Is Wrong—and What You Really Need to Know.*
ConnectTwitter

W. Spencer McClelland