Is The Caesarean Section Rate in Ireland Too High?

Abstract:

A caesarean section (CS) is a major obstetric intervention that may be life-saving or life-enhancing for either the mother or her offspring. Occasionally, it may be life-threatening, or may lead to minor or major short-term or long-term complications. In 1985, the World Health Organization (WHO) recommended that the caesarean section rate should not exceed 10-15% in all geographic regions. The WHO has refined its position on CS rates. It now acknowledges that there is little scientific evidence to underpin the recommendation of 15% and that the optimum percentage or range of percentages is unknown. Concerns within the Department of Health and Children (DOHC) about the high CS rate led to a Report on Caesarean Section Deliveries from 2000-2008. Health economists have tried to explain trends in Irish caesarean sections between 1999 and 2007. The most recent health indicators from the OECD show that Ireland's CS rate is the same as the OECD average and less than the United Kingdom. The rate ranged from 40% in Italy and Mexico down to 14% in the Netherlands, where up to a third of women are delivered at home. In 2009, the CS rate in the Netherlands also exceeded the WHO recommendation. The 2010 Key Trends in Health in Ireland from the DOHC shows that the CS rate in Ireland is almost identical to the rate in all the EU-27 countries. An international report showed that in the majority of United Nations (UN) countries the recommended WHO 15% CS rate is exceeded. In respect of CS rates at least, Ireland's performance is in line with other developed countries.

The WHO has refined its position on CS rates. It now acknowledges that there is little scientific evidence to underpin the recommendation of 15% and that the optimum percentage or range of percentages is unknown. The key global issue is that in 24.1% of UN countries the lives of women and their babies are at risk because CS rates are too low at < 5%. Emerged is that the important issue is not the CS rate, but rather the variations in CS rates locally, nationally, regionally and globally. In a comparison of rates of primary CS in 124 hospitals in the United States in 2004 the rate was 19% – 15% with a range of 9-37%. In a study of all deliveries in British Columbia between 2004-7, primary CS rate varied two-fold from 14.7 to 27.8% across Health Service Delivery Areas. In England, in a study of 620,640 births across 146 different NHS trusts, the CS rate varied from 14.9% to 32.1% after adjusting for different patient populations. There was a wider variation in emergency CS than elective CS. In Ireland, the mean CS rate in 2009 reached 26.1%, but the rate per hospital ranged from 18.7 to 35.6%. Both elective and emergency CS rates varied widely between hospitals.

The CS rate has attracted the attention of healthcare commentators and providers for a number of reasons. Unlike other health indicators, a CS is clearly defined and easily measured. In developed countries the rate has increased dramatically over a generation. There is evidence that delivery by CS may be more costly financially than vaginal delivery, mainly because the average length of postoperative bed stay is longer. Economic arguments about the increased cost of CS, however, are not clear cut. Emergency CS may be more expensive than a successful vaginal delivery, but elective CS with early discharge home may not be. True costs should also include neonatal costs. An analysis confined to the present pregnancy does not allow for the financial implications of the mode of delivery on a woman's future reproductive career, for example, repeat CS or the complications of vaginal birth after CS (VBAC). Furthermore, there may be a financial as well as a human cost to not doing a CS, whether an adverse outcome leads to a medical negligence claim or not.

A focus on the average CS rates locally or nationally may be attractive from a management perspective but it is not a good performance indicator. It should not be used in isolation from fetal outcomes and other maternal outcomes. For Irish women who are pregnant, a good fetal outcome is their priority. An average national rate also may potentially obscure the fact that the CS rate may be too high, or indeed too low, in individual hospitals or practices. Moving the focus to the wide variations in CS rates and analysing the indications for CS in different groups of patients can help identify whether the variations reflect case mix differences, patient preferences, resource issues or differences in clinical practices. The emphasis, however, needs to be on quality, not cost. By the standards of developed countries, Ireland's CS rate is not too high, particularly given our low maternal mortality ratio and good perinatal outcomes. However, narrowing the wide variations in CS rates between and within hospitals by improving clinical practices has the potential to lower the CS rate without compromising other clinical outcomes.

References


V O'Deyre, MJ Turner
UCD Centre for Human Reproduction, Coombe Women and Infants University Hospital, Dublin
Email: michael.turner@ucd.ie

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CS rates are not just of interest to those involved in front-line clinical practice. Advocacy groups interested in women's choices publish CS rates and other information for individual maternity units. The 2010 Key Trends in Health in Ireland from the DOHC shows that the CS rate in Ireland is almost identical to the rate in all the EU-27 countries. An international report showed that in the majority of United Nations (UN) countries the recommended WHO 15% CS rate is exceeded. In respect of CS rates at least, Ireland's performance is in line with other developed countries.


