Latest figures on Operative Delivery December 3, 2005	
Annual Economic cost of Cesareans in 2003 was 14.6 Billion Dollars	**Cesarean Section rate for 2004 29.1%**

In August (2005) Reuters reported that 1.2 million Cesareans were performed, making it the number one hospital procedure in 2003, at a cost of 14.6 BILLION dollars.

In the face of those statistics for Cesarean delivery -- 30% so far -- the decision by the University Hospital of Michigan Hospital at Ann Harbor to build C-section rooms instead of labor rooms seems like a smart business move. But here's the rub. Delivery via Cesarean surgery is associated with 33 unique 'route of delivery' complications, including doubling the maternal death rate – intra-operative, post-op, delayed or downstream -- as compared to 4 specific 'route of delivery' complications associated with vaginal birth.

Downstream complications of Cesarean surgery include reproductive difficulties such as infertility, miscarriage or tubal pregnancy and post-cesarean sequelae in subsequent pregnancies, such as abnormal placentation, abruption and fetal demise, uterine rupture, emergency hysterectomy, permanent neurological damage or death of mother and/or baby.

This is costly in personal suffering, as well as its staggering economic expense to society. To put that 14.6 billion dollars in perspective, the reader should note that the 2005 federal energy bill signed by President Bush this August was for only 14.3 billion. The total cost for the 1989 Loma Prieta earthquake in the Bay area was estimated at only 6 billion dollars – a mere 5 months worth of Cesarean surgery.

During the last 30 years, Cesarean intervention has gone from one out of twenty to one out of three pregnancies, with no reduction in the incidence of cerebral palsy or the rate of permanent, birth-related neurological damage. Also a problem is that the steep downward trend in maternal deaths gained over the course of 20th century stopped falling in 1982. After 14 years of no further improvement, there has been a slight rise in maternal mortality since 1996, primarily as a result of delayed and downstream complications of the sky-rocketing Cesarean rate. Any method that can reduce Cesarean surgeries will simultaneously prevent maternal mortality, which is two to four times greater with a C-section that normal birth.

It is already scientifically documented that physiological management, as the foremost standard of care used by all maternity care providers (physicians, obstetricians, nurse midwives and community midwives), is an evidenced-based model that is both preventive and protective of mothers and babies. Treating normal birth 'normally' prevents many iatrogenic complications from developing and reduces obstetrical and neonatal interventions of all sorts. Most especially, it dramatically reduces the rate of Cesarean delivery, thus protecting women and babies in future pregnancies from the life-threatening complications of major surgery. It is cost effective.

The current high C-Section rate under obstetrical management stands in stark contrast to a recently published study in the British Medical Journal on physiological management of normal birth by community midwives. The BMJ study amply documented that midwifery care (which is physiologically- based) and planned home birth (PHB) dramatically reduces the incidence of Cesarean surgery, and therefore is protective of the lives of childbearing women without increasing the risk to their unborn or newborn babies.

The June 2005 paper in the British Medical Journal (BMJ 2005;330:1416–9) is the first large prospective study ever published on planned home birth (PHB) as attended by professionally - certified, direct-entry midwives in North America. This is a category of practitioners that by

training, tradition and legal requirement uses only physiological methods and practices primarily in non-medical settings (private client homes, maternity homes or birth centers), where medical and surgical interventions are not permitted. If a complication requiring medical treatment arises during pregnancy or labor, the mother is transferred to hospital-based obstetrical services. All of those interventions, surgical procedures, etc and outcomes for mothers and babies transferred to the hospital are included in the outcomes statistics for the midwives in this study.

The conclusion of the study in the BMJ stated that:

> "Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital birth in the United States ."

It should be noted that the dramatically reduced Cesarean rate associated with midwifery care and PHB is occurring simultaneously with a dramatic increase in the Cesarean rate for planned hospital delivery. However, the crucial issue is not place of birth (home or hospital) or the status of the practitioner (doctor vs. midwife). Only a tiny a minority of women choose (or are appropriate for) midwifery care or out of hospital birth services.

For these families, PHB with a professional midwife is both a safe choice and an effective strategy for reducing their risk of a medically unnecessary Cesarean section and its cascades of negative after effects. The real questions is what the rest of us can do to reduce the one in three risks of major surgery faced by the remainder of the childbearing population.

The obvious take-home message is the wisdom of routinely using of physiological management for healthy women with normal pregnancies, regardless of the setting chosen by the parents or required by medical circumstances. That requires rehabilitation of our current high-tech, highly-interventive, extremely expensive and non-sustainable maternity care system.

Consumer action is need to identify effective and dependable Cesarean-reduction strategies. It entails working to bring about national and local policy changes, so these methods become the routine way that maternity care is provided to healthy women in the United States (i.e. physiologic process as the standard of care). This makes normal birth safer for all childbearing families. It also helps to keep jobs at home by keeping health care costs in line with the global economy, where physiological management by physicians and midwives is the cost-effective norm around the world. In a competitive global economy, boutique obstetrics (such as the current promotion by the obstetrical profession of medically unnecessary or 'maternal choice' Cesareans) is unsustainable on economic grounds. It can also deadly -- the most unsustainable state of all.

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