Australian College of Midwives
Submission to the Senate Inquiry Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two other Bills

Introduction

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia. The introduction of legislation into the Parliament of the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009 heralds important changes to the maternity care system in Australia.

ACM wholeheartedly supports many aspects of this legislation in relation to a greater expansion of the role of midwives and the development of a private practice midwifery workforce. These developments aim to improve access for Australian women to safe, quality maternity care. The legislation being examined by this committee provides for Medicare Benefits Schedule access, government supported indemnity insurance (and run-off cover) and access to the Pharmaceutical Benefits Scheme for eligible midwives.

However the legislation before this Senate Inquiry does not enable safe quality maternity care to be provided for women who choose to have a baby at home. The decision to exclude homebirth care from the indemnity support scheme is the major area of concern for ACM and will be the focus of this paper.

Homebirth was specifically mentioned in the report of the National Maternity Service Review. The comments were that "moving prematurely to a mainstream private model of care incorporating homebirthing risks polarizing the professions" (Commonwealth of Australia 2009 p21) and "it is likely that insurers will be less inclined to provide indemnity care for private homebirths and if they did provide cover that the costs would be high" (Commonwealth of Australia 2009 p21). Funding for the recommendations of the National Maternity Service Review, under the 2009/2010 Budget, excluded homebirth.

ACM has had discussions with the Minister for Health, her office and the Department of Health and Aging officials regarding the Budget announcements. Three reasons for excluding homebirth have been discussed throughout these negotiations:

- implications that homebirth is unsafe;
- that homebirth may polarize the professions; and,
- that indemnity insurance for homebirth may be too costly for the government.

This paper will address these points. We present potential outcomes and solutions. ACM would welcome the opportunity to give evidence in person to the Senate committee.

Reasons for exclusion of homebirth from current legislation

Safety – the view that homebirth is unsafe

Homebirth is safe for low risk women in well integrated models of maternity care (Bastian et al 1998; de Jonge 2009; Symons et al 2009; Ackermann-Liebrich et al. 1996; Northern Region Perinatal Mortality Survey Coordinating Group 1996; Wiegers et al. 1996; Gulbransen et al. 1997; Murphy & Fullerton 1998; Young et al. 2000; Janssen et al. 2002; Johnson & Daviss 2005). The research above has also examined both employed and self-employed midwives. Appendix 1 provides a review of the literature with a synopsis of several pieces of key research detailing the evidence of the safety of planned homebirth for low risk women in the care of a midwife.

There does not appear to be a consensus on the specific criteria to be used for booking women to birth at home or in hospital (Campbell 1999) and there is no specific evidence to support different criteria (Nursing and Midwifery Council (UK) 2005).

Divergent views on homebirth – that homebirth may polarize the professions

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) do not endorse home births (http://www.ranzcog.edu.au/publications/statements/C-obs2.pdf). RANZCOG do not provide a rationale or basis for this position. Three references listed on the RANZCOG statement are studies that conclude that home birth for low risk women in well integrated models is safe. There are five other references - one is an opinion piece, three were written pre 1990 and therefore do not reflect current practice and one is a systematic review of a comparison of birth in 'home-like' environments with hospital environments, which does not consider homebirth. There is also no demonstrated process for stakeholder engagement in developing their Homebirth statement.

The position of obstetricians in Australia is in direct contrast with the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK which has a joint position statement with the Royal College of Midwives (RCM) in the UK (2007) which states:

> *(We) support home birth for women with uncomplicated pregnancies. There is no reason why home birth should not be offered to women at low risk of complications and it may confer considerable benefits for them and their*

> *families. There is ample evidence showing that labouring at home increases a woman's likelihood of a birth that is both satisfying and safe, with implications for her health and that of her baby*.

RCOG is a very large, well respected organisation. There is little difference between obstetric care in the UK and Australia other than the degree of privatization of the Australian model of care and resulting high levels of medical intervention in birth.

The views around homebirth are divergent; the impact of excluding homebirth from the regulatory framework is a compromise of public safety. It is difficult to rationalize that this is an appropriate decision to appease medical concerns- especially when the RANZCOG position is unable to be substantiated with evidence and is inconsistent with the RCOG position statement.

Cost – that extension of the government subsidised indemnity scheme for midwives would be too costly

The report of the Maternity Service Review and subsequent discussions has indicated that high cost may be a factor in the decision to exclude homebirth. However the Australian College of Midwives (ACM) has not received written advice from the government or from insurers as to the potential cost of policies which may include home birth or how this compares with indemnity insurance premiums for midwives for in hospital births.

The only comment from insurers on the cost of homebirth is a media article quoting a risk assessor from Avant, the largest medical insurer (Cresswell 2009). This media article does not provide any information that reflects the model of private practice midwifery, the number of women a private practice midwife would care for or the income that a private practice midwife would earn. It also alludes to the opinions of doctors being a factor in decisions relating to insuring midwives (Cresswell 2009).

Private practice midwives held indemnity insurance either in their own right, or as one component of union membership until 2001. At this time the policies were quoted as being below $1000 for $5million worth of cover. Obstetricians at this time also enjoyed lower insurance policies. The proportional value between obstetricians policies and midwifery policies at that time should be considered. There is no evidence to suggest that midwives have become proportionally riskier than obstetricians. Comparisons would probably find that obstetricians in 2009 do more surgery than in 2001 and that they possibly complete more antenatal screening with likely increases in litigious procedures. Midwives scope and practice over the last 8 years has not changed. They possibly provide less care at home, due to the lack of insurance, but have not changed in their scope of practice.

Further consultation with private practice midwives and the ACM needs to occur to discuss the care provided by private practice midwives in the home and to determine

the types of risk involved. There are significant differences between midwifery and obstetric care. Media reports indicate that insurers consider midwives and obstetricians as carrying the same risk (Cresswell 2009). Obstetric care involves major surgery, induction of labour and use of epidural anaesthesia. All these procedures involve substantial risk. Midwives providing care in the home do not perform any of these interventions. The actual risk of unpredictable, catastrophic events in the absence of other interventions would need to be examined in the context of healthy women with (generally) uncomplicated pregnancies, in well networked and collaborative systems of care.

Some Australian States provide publicly funded home birth services and accept the sovereign risk for these models within the context of statewide planned home birth policies (e.g. South Australia, NSW, WA, NT).

Clearly further advice could be sought by this committee in determining whether homebirth care has been accurately costed in to any possible insurance support. Insurers could be asked to demonstrate the model of homebirth care and risks involved to determine if this appears based on current homebirth models.

.

Governments stated aims in maternity reform – reasons for legislation

Improve choice for Australian women

Some Australian women choose to give birth at home. Whilst the exact numbers are not known due to limitations in data collection, it is less than 0.5% of all births. Internationally homebirth models that are well accepted and are an integrated component of maternity services are more popular. In the Netherlands where home birth is a well accepted choice, around 30% of women plan to birth at home with national mortality rates for mothers and babies that are comparable to Australia. In Australia, there are small pockets where home birth is more easily accessed and a greater proportion of women make this choice.

Most home births occur with a private practice midwife. There are a small number of publicly funded models across Australia. These are generally in limited geographic areas and usually located in metropolitan areas (with a few births occurring in state based models outside metropolitan regions in specific programs such as that of Hunter New England Health). They also often cater for a defined group of women – not always confined to those of low risk (e.g. young women or Aboriginal and Torres Strait Islander women).

Women choosing homebirth often do so out of a desire to maintain control of their birth experience (Cohen and Dorsey 1998). This control includes the choice of practitioner to attend their birth. For most women, this choice is only available in the private sector.

Improve access for Australian women

Australian women predominantly access birth services in metropolitan, regional and larger rural health services. For many women their location prevents the ability to birth close to home. This is a particular issue for women in remote locations including many Aboriginal and Torres Strait Islander women. A component of birthing culture for Aboriginal women is the desire to birth on country (Myles 1992 QLD Health 1996, Kildea 1999 Kildea 2001, Kildea 2005). Remote area birthing generally occurs outside of a clinical setting. It is not reported as being common in Australia although there are many anecdotal reports of women remaining in remote locations to birth. There is evidence of the safety for women birthing in remote areas (Hancock 2005, Houd et al 2003, Van Wagner 2007). The exclusion of homebirth from the legislation being examined by this Senate hearing would preclude birth on country except if this birth was a component of a state based and funded program. It would preclude community controlled health services from utilising private midwives to provide care.

Maintaining quality and safety

Midwives currently providing home birth care are registered. This provides a quality assurance mechanism with the registered midwife being accountable to professional standards of competence, ethics and conduct.

Exclusion of home birth services from regulation will not improve aspects of quality and safety. Home birth will fall outside of regulatory mechanisms meaning that:

- outcomes will be unreported and invisible,
- there will be no professional requirements of those providing the services (as they will not be registered midwives) and
- there will be no compunction to have appropriate collaborative processes, back-up and transfer mechanisms.

ACN anticipates that some midwives will choose to continue to practice either underground or as unregistered caregivers. They will not be able to attend education for updating practice as they will fear being reported. They will also be less willing to transfer women in to hospital because of fear of being prosecuted. Such midwives will miss out on vital professional development.

ACM argues that, rather than driving homebirth underground and increasing risks to mothers and babies, there is a need to ensure standards of practice for homebirth services. We recognise that there has been an insufficient process to ensure the quality and safety of the midwives providing care in addition to registration. We also recognise that this is the case for all midwives providing care to women.

National regulation, with requirements for recency of practice and with a requirement of demonstration of continuing professional development, will provide an improved quality framework. There is also a preparedness to discuss further measures specific to

homebirth under quality and safety frameworks and under Medicare eligibility requirements.

A recent Coronial report in NSW took the unusual step of directing comment to the Federal (and NSW state) Health Minister stating that the draft national registration legislation would have the ""effect of driving home birthing 'underground' which would be a dangerous outcome"(Reimer 2009). The Coroner further recommends that the Federal Health Minister not take steps that would make homebirth unlawful but rather examine the minimum standards of qualification, credentialing process and compliance with the Australian College of Midwives consultation and referral guidelines for midwives (Reimer 2009).

The way forward

Option 1 - No change to either piece of legislation

The current advice at all political levels is that there will be no change made to either the Health Practitioner National Regulation law to exclude midwives providing home birth care from the requirement of professional indemnity insurance or to the legislation being discussed by this inquiry to include indemnity for midwives providing home birth care under the federal funding mechanism. If this is the result midwives who are privately practicing will from July 2010 be unable to care for women birthing in the home under the conditions of their registration. It is likely that:

- A proportion of private practice midwives currently providing home birth care will not continue their registration. They may continue to provide "midwifery" care using a different title ("birth worker" is currently used) but will not have to maintain competence or currency (as defined under regulation). This will impact on complaints mechanisms and safety as there will be no compulsion to attend ongoing professional development to provide outcome data.

- A proportion of private practice midwives may re-register, may continue to provide care in private practice and may fulfill government eligibility criteria for Medicare access. They may or may not provide home birth care. Those who do may look for ways to flaunt the system in this or to avoid detection of home birth care. This will decrease safety as there will be a disincentive to transfer in a timely fashion or to consult with anyone when there are difficulties in a home birth.

- Women will be less able to access a private practice midwife for home birth care. The inability of registered midwives to provide care for women for birth in the home will not stop women from making the choice to have their baby at home. It will merely force them to either birth with an unregistered care provider with or without educational experience of birth or will force them to birth at home

alone. The phenomenon of unattended homebirth ("freebirth") is increasing (Newman 2008). There is no data to support the safety of birthing without an educated, registered professional and there are highly publicised reports in the media of poor outcomes as a result of unattended births.

The lack of transitional processes in discontinuing access to homebirth is also problematic. With no change to either piece of legislation being considered, there is no discussion about transitional processes. From July 1 2010, private practice midwives will effectively be unable to provide care to women choosing to give birth at home, which is a significant component of their livelihood. For some midwives providing care for women at home is their only form of practice – meaning that they will have no livelihood from July 2010. For private practice midwives seeking Medicare eligibility there will be no access to MBS funding, until November 2010. This means that there will be several months where they are unlikely to be able to provide in hospital birth care. No private practice midwives currently have visiting rights to hospitals and it is not certain how the ability for midwives to provide birth care for women in hospital will be progressed. This is likely to also restrict the ability for private practice midwives to earn an income for some time.

Option 2 - An exemption from the Health Practitioner National Regulation law for midwives providing care to women planning homebirth

The ACM is of the view that a requirement that all practitioners hold adequate indemnity insurance for all areas of practice protects the public and is a sound requirement. The exemption of private practice midwives providing homebirth care from this requirement is seen as a potential temporary measure until access for private midwives to professional indemnity insurance that covers care for women who plan homebirth has been resolved.

The ACM is aware that this is a separate legislative process to the legislation being examined by this Committee.

Option 3 - Extension of the current legislation to include home birth practice

The research indicates that well integrated models of home birth care are safe (Appendix 1). However it is important to recognise the issue faced in the current Australian model of home birth. Home birth, predominantly in the private sector, has been marginalized by the opinions of medical professional bodies and lobby groups (RANZCOG 2008, Joyce 2009). This marginalization has made it extremely difficult for individual private midwives to integrate their care into hospital based maternity services.

It is important that at this juncture of the reform process already underway that consideration is given to ways of better integrating private home birth care into the

maternity service rather than taking an approach that could potentially drive home birth underground (Reimer 2009).

Midwives providing care under all models must be able to demonstrate competency and currency in practice under new national regulation law (Australian Health Workforce Ministerial Council 2009).

The Australian College of Midwives therefore proposes a model of home birth which ensures quality practitioners, who are experienced, credentialed and completing continuing professional development who use collaborative processes for consultation and referral according to nationally agreed guidelines to provide care for low risk women.

Quality practitioners

Indemnity insurance would only be extended to midwives who are Medicare eligible midwives. These midwives will have already undertaken a credentialing process and will be linked in to models of professional development, and will work in collaboration with medical practitioners. A summary of the eligibility criteria for MBS access which has been developed by the ACM and has been presented in draft form to the Dept of Health is attached as Appendix 2. ACM is currently in the process of consulting a wide range of stakeholder groups including organisations representing GP and specialist obstetricians, on these proposed criteria.

Guidelines for care

ACM has developed, in consultation with a number of stakeholders (obstetricians, general practitioners, anaesthetists, neonatologists, consumers and others), evidence-based guidelines to be used by midwives in making decisions regarding consultation and referral of the care of women. These guidelines are accepted as being the most relevant for use by midwives and in identifying the need for consultation despite not being endorsed by RANZCOG (Boxell et al 2009). There is need for nationally endorsed guidelines to support midwifery care.

There is also a need for national evidence based guidelines for all areas of maternity care, including antenatal care, minimum standards of care in labour, caesarean section, Birth after caesarean, and care of women with twins and breech babies. Such guidelines exist in other developed countries and inform practice. The absence of any such guidelines in Australia result in women receiving advice from different maternity care providers that is often at odds with research evidence. The Maternity Review recommended development of Guidelines, and this should be progressed as a priority.

Policies and frameworks

Many home birth policies exist in Australia and internationally. The ACM is in the process of consulting on a national homebirth framework internally and with stakeholders. The adoption of a policy or framework for private practice midwives

providing homebirth care could be a way to progress the need for indemnity, whilst addressing insurance risk concerns. The ACM draft position statement on homebirth (Appendix 3) forms the basis for any further policies or frameworks the College will develop around homebirth.

The Nursing and Midwifery Council in the UK has reviewed the literature in an attempt to develop recommendations for guidance in homebirth (Magill-Guerdin 2005). This review states that there is no justification for making decisions about place of birth during the booking visit (Magill-Guerdin 2005 p5). The decision to have homebirth must be made after consideration of the woman's circumstances and there is a need to revisit this decision throughout pregnancy or as circumstances change. The report of the UK Confidential Enquiry into Maternal and Child Health 2000 – 2002 emphasised the need for midwives to plan care with clearly identified risk assessment criteria and develop care to meet individual needs (Confidential Enquiry into Maternal and Child Health 2004). Thus any decisions made, either to birth in hospital or at home, must be revisited throughout the pregnancy, labour and birth.

Women must be able to access a midwife of their choice under an accessible model of care that includes the option of birth at home. In this model women attend an antenatal visit where a history is taken and areas requiring consultation and referral (as per ACM guidelines) are identified. The woman will book in to her local hospital with her private practice midwife as her primary carer (assuming Medicare eligible midwives have visiting rights to hospitals). At some point during pregnancy the woman will discuss with her midwife her ideas around place of birth and makes decisions around the place of birth without "losing" the ability to have her private practice midwife as her primary carer[1].

Current private practice midwives may not desire or reach Medicare eligibility status. Under homebirth policies or frameworks midwives who did not meet Medicare eligibility status would not be able to provide home birth care. There will also be a need for endorsement of guidelines which would guide the consultation and referral processes around this framework. There is a requirement for ongoing negotiations and discussions with all stakeholders. This model requires concessions from current privately practicing midwives.

[1] Currently midwives in private practice do not have visiting rights to hospitals because of a lack of insurance. Thus, women choosing to home birth are unable to continue receiving care from their private practice midwife if they transfer to hospital. This may be a current disincentive to choose to birth in hospital.

Summary

The current situation facing women wanting to birth at home is dire. Women are faced with the prospect of being unable to access the services of a registered midwife for birth care at home after 1 July 2010, resulting in 3 possible options

1) birth in hospital,
2) to birth at home with an unregulated care provider who may or may not have the appropriate skills, knowledge and equipment to ensure safety for the mother and baby, or
3) to birth at home alone with no registered health professional present.

Many women, particularly those who have experienced trauma in an earlier birth in a hospital, will resort to the latter two options. ACM fears this will result in an increase in morbidity and mortality for mothers and babies.

The Australian College of Midwives recommends that the government subsidised indemnity scheme for midwives be extended to include labour and birth care at home under a quality and safety framework. The Australian College of Midwives is examining a number of existing frameworks for planned birth at home birth and intends to consult consume and medical organisations as this work is progressed.

References

Ackermann-Liebrich, U., Voegeli, T., Gunter-Witt, K.,Kunz, I., Zullig, M., Schindler, C., Maurer, M. & Zurich Study Team, 1996, 'Home versus hopsital deliveries: follow up study of matched pairs for procedure and outcome', BMJ: British Medical Journal, vol. 313, pp.1313–1318.

Australian Health Workforce Ministerial Council 2009 Exposure draft (Bill B) Health Practitioner National Regulation law.
http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Exposure%20draft%20of%20Health%20Practitioner%20Regulation%20National%20Law%202009%20(Bill%20B).pdf

Bastian H, Keirse MJNC, Lancaster PAL 1998, 'Perinatal death associated with planned home birth in Australia: population based study', BMJ:British Medical Journal, vol. 317, pp. 384-388.

Commonwealth of Australia. 2009. Improving Maternity Services in Australia – The report of the National Maternity Service Review.

de Jonge, A, van der Goes, BY, Ravelli, ACJ, Amelink-Verburg, MP, Mol, BW, Nijhuis, JG, Bennebroek Gravenhorst, J and Buitendijk, SE 2009, 'Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births', British Journal of Obstetrics and Gynaecology, DOI: 10.1111/j.1471-0528.2009.02175.x.

Northern Region Perinatal Mortality Survey Coordinating Group 1996, 'Collaborative survey of perinatal loss in planned and unplanned home births', BMJ: British Medical Journal, vol. 313, pp. 1306-1309.

Campbell, R & Macfarlane, A 1994, Where to be Born? The Debate and the Evidence, 2nd Ed. Oxford, Radcliffe Infirmary..

Campbell, R., Review and Assessment of Selection Criteria Used when Booking Pregnant Women at Different Places of birth. British Journal of Obstetrics and Gynaecology 1999 Vol. 106 pp550-556

Chamberlain M, Barclay K, Kariminia A, Moyer A, Aboriginal Birth Psychosocial or physiological safety. Birth Issues, 2001. 10:3/4. 81-85.

Confidential Enquiry Into Maternal and Child Health, Why Mothers Die 2002 – 2004 6th. Report London: Royal College of Obstetricians and Gynaecologists Press. 2004.

Gulbransen G, Hilton J, McKay L & Cox A 1997, 'Home birth in New Zealand 1973-93: incidence and mortality'. New Zealand Medical Journal, vol.110, pp.87-89.

Hancock H, 2005. Aboriginal women's perinatal needs, experiences and maternity services: A literature review to enable considerations to be made about quality indicators. Ngaanyatjarra Health Service, NT.

Houd S, Qinuajuak J, Epoo B, 2003. The outcome of perinatal care in Inukjuak, Nunavik, Canada 1998-2002. Circumpolar Health, Nuuk. 239-241.

Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D & Klein MC 2002, ' Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia', Canadian Medical Association Journal, vol. 166, pp. 315-23.

Johnson KC & Daviss BA 2005, 'Outcomes of planned home births with certified professional midwives: large prospective study in North America', BMJ: British Medical Journal, vol. 330, 18 June, pp. 1416-1422.

Joyce H 2009 Doctor in charge. Life Matters. ABC network. http://www.abc.net.au/rn/lifematters/stories/2009/2614150.htm

Kildea S. 1999. 'And the women said…Report on Birthing Services for Aboriginal Women from Remote Tope End Communities' Territory Health Services. Northern Territory Senate Community Affairs Reference Committee.

Kildea S, 2001. Birthing in the Bush – Maternity Services in Remote Areas of Australia. CRANA Conference "From Generalist to Specialist" 28-31//8/01.

Kildea S, Birthing Business in the Bush: It's Time to Listen. 2005. Unpublished thesis, Centre for Family Health and Midwifery, University of Technology Sydney.

Magill-Guerdin J 2005 Report of issues arising from a document review to support recommendations for guidance for home births http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=1981 accessed July 13 2009.

Murphy PA & Fullerton J 1998, 'Outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study', Obstetrics and Gynecology, vol. 92, pp.461-470.

Myles H, 1992 " Some Good Long Talks" About Birthing for Aboriginal Women in Remote Areas of Queensland. Consultation Report for Women in Aboriginal Communities in Queensland. Prepared on

behalf of The Aboriginal and Torres Strait Islander Health Policy Unit & The Women's Health Policy Unit Queensland Health.

New Zealand Ministry of Health 2001, Report on Maternity 1999, viewed 24 April 2007, http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c.

Newman L Newman L. 2008. Why planned attended homebirth should be more widely supportedin Australia. Australian and New Zealand Journal of Obstetrics and Gynaecology 2008; 48: 450–453

Northern Region Perinatal Mortality Survey Coordinating Group 1996, 'Collaborative survey of perinatal loss in planned and unplanned home births', BMJ: British Medical Journal, vol. 313, pp. 1306-1309.

Olsen O & Jewell MD 1998, 'Home versus a hospital birth', Cochrane Database of Systematic Reviews, Issue 3,viewed 24 April 2007, http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000352/frame.html

Parratt J & Johnston J 2002, 'Planned homebirths in Victoria, 1995-1998', Australian Journal of Midwifery, vol. 15, pp.16-25

Queensland Health 1996. Aboriginal Birthing on Homelands Report. Women's Health Unit, Queensland Health.

Royal Australian College of Obstetricians and Gynaecologists/ Royal College of Midwives 2007 Position statement No 2. Homebirth http://www.rcog.org.uk/files/rcog-corp/uploaded-files/JointStatmentHomeBirths2007.pdf accessed July 10 2009

Reimer N 2009 Report of the Coroner. 26 June 2009.

Symons A, Winter C, Inkster M and Donnan T. 2009. Outcomes for births booked under an independent midwife and births in NHS maternity units: maternity units: matched comparison study BMJ 2009;338;b2060; doi:10.1136/bmj.b2060.

Van Wagner V, Epoo B, Nasstapoka J, Harney E, 2007. Reclaiming birth, health, and community: Midwifery in the Inuit villages of Nunavik, Canada. Journal of Midwifery Womens Health, 52:4, 384-391.

Wiegers TA, Keirse MJNC, van der Zee J & Berghs GAH 1996, 'Outcome of planned home and planned hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands', BMJ: British Medical Journal, vol .313, pp.1309-1313.

World Health Organisation 1999, 'Care in Normal Birth: A practical guide', Geneva, W.H.O.

Young G, Hey E, MacFarlane A, McCandlish R, Campbell R & Chamberlain G 2000, 'Choosing between home and a hospital delivery', BMJ: British Medical Journal, vol.320 pp 798-800

Appendix 1 Safety of Homebirth – Annotated Biblography

de Jonge, A, van der Goes, BY, Ravelli, ACJ, Amelink-Verburg, MP, Mol, BW, Nijhuis, JG, Bennebroek Gravenhorst, J and Buitendijk, SE 2009, 'Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births', British Journal of Obstetrics and Gynaecology, DOI: 10.1111/j.1471-0528.2009.02175.x.

Study subject: 529,688 low risk women. All low risk women giving birth in the Netherlands between January 2000 and December 2006.

This study shows that planning a home birth does not increase the risks of perinatal mortality and severe perinatal morbidity among low-risk women, provided the maternity care system facilitates this choice through the availability of well trained midwives and through a good transportation and referral system.

Symons A, Winter C, Inkster M and Donnan T. 2009. Outcomes for births booked under an independent midwife and births in NHS maternity units: maternity units: matched comparison study BMJ 2009;338;b2060; doi:10.1136/bmj.b2060.

Study included 8676 women – 1462 receiving care from an independent midwife and 7214 receiving care from the NHS (Scotland). NB the place of birth is not a focus of this study.

Clinical outcomes across a range of variables were significantly better for women accessing an independent midwife, there were significantly higher perinatal mortality rates for high risk cases in this group. When high risk cases were removed from both groups – perinatal mortality for low risk women was the same in both groups.

Johnson, K & Daviss, BA 2005, 'Outcomes of planned home births with certified professional midwives: large prospective study in North America', British Medical Journal, DOI: 10.1136/bmj.330.7505.1416, viewed 8 July 2009, <www.bmj.com>.

Study all 5419 women who planned to give birth at home with a midwife in the US in the year 2000.

The study concluded 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 births in the United States.

Bastian H, Keirse MJNC, Lancaster PA 'Perinatal death associated with planned home birth in Australia: population based study' in BMJ 1998:317-384-388

7002 homebirth (all Australian homebirths between 1985 and 1990) were studied.

Authors found that home birth for low risk women compares favourably with hospital birth, high risk homebirth is inadvisable and experimental.

Northern Region Perinatal Mortality Survey Coordinating Group. Collaborative survey of perinatal loss in planned and unplanned home births. BMJ 1996;313: 1306-9.

Review of 558,981 births.

Perinatal hazard associated with planned homebirth was very low. The perinatal mortality of women who had no plan for professional care in labour was high.

Olsen O. Meta-analysis of the safety of home birth. Birth 24,1 (1997) 4-13.

Meta-analysis of sic controlled observational studies of 24,092 low risk women.

Conclusion home birth is an acceptable alternative to hospital confinement for selected pregnant women and leads to reduced medical interventions.

Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D & Klein MC 2002, 'Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia', Canadian Medical Association Journal, vol. 166, pp. 315-23.

Study of 862 planned home births compared with 571 hospital attended midwife births and 743 hospital attended physician births.

Conclusion no increased maternal or neonatal risk associated with planned homebirth under the care of a regulated midwife.

Policy for Planned Birth at Home in South Australia. Government of South Australia. Department of Health. July 2007.

Copy of the findings of the literature review published in this document.
RATIONALE
There is no well-grounded evidence on the relative merits of home versus health unit birth for women and babies at low risk of perinatal complications. No randomised controlled trials have been reported, apart from one attempt which included only four home and six health unit births (Dowswel let al. 1996; Olsen & Jewell 1998), and this is likely to remain the case. Moreover, such trials probably would not be able to address the issues that matter to women or be large enough to address crucial safety issues (Macfarlane 1996; Wiegers et al. 1996; Kotaska 2004).
Information largely depends, therefore, on carefully conducted cohort studies from which a number of conclusions can be drawn.

2.1 The natural process of labour is facilitated and vaginal birth rates are higher when healthy women with a normal pregnancy give birth in the familiarity of their home environment and are attended by a skilled midwife (Campbell & Macfarlane 1987; Tyson 1991; Ackermann-Liebrich et al. 1996; De Vries 1996; Northern Region Perinatal Mortality Survey Coordinating Group 1996; World Health Organisation 1999; New Zealand Ministry of Health 2001).

2.2 There is a lower rate of birth interventions, such as augmentation of labour, episiotomy, instrumental birth and caesarean section, when women give birth at home (Ackermann-Liebrich et al. 1996; Homer 2001; van der Hulst et al. 2004; Johnson & Daviss 2005). These interventions significantly increase costs and morbidities associated with maternity care in Australia (Roberts et al. 2000; Tracey & Tracey 2003).

2.3 Giving birth at home gives women a greater sense of achievement and satisfaction (Cunningham 1993; Ackermann-Liebrich et al. 1996) and those having a home birth have been found to be more confident of making the same choice again than women having a planned health unit birth (Cunningham 1993; Wiegers et al. 1998a). Women who have

experienced both health unit and home births usually express greater satisfaction with the latter (Davies et al. 1996), feeling more relaxed and peaceful in their natural surroundings. Psychological well-being three weeks after birth has been reported as higher among women with planned home, rather than planned health unit, births (Wiegers et al. 1998a).

2.4 Home births can be achieved safely when conducted within appropriate guidelines, (Ackermann-Liebrich et al. 1996; Northern Region Perinatal Mortality Survey Coordinating Group 1996; Wiegers et al. 1996; Gulbransen et al. 1997; Murphy & Fullerton 1998; Young et al. 2000; Janssen et al. 2002; Johnson & Daviss 2005).

2.5 The lack of selection of appropriate women for home birth and the failure of those present to respond adequately to situations of risk arising during pregnancy or labour is associated with an unacceptably high rate of adverse outcomes including perinatal death (Mehl-Madrona & Mehl-Madrona 1997; Bastian et al. 1998)[2].

2.6 Australian data have shown unacceptably high risks for the baby from planned home birth for twin pregnancies, pregnancies outside term (37 to 41 weeks) and breech presentations (Bastian et al. 1998), all of which contraindicate home birth. Planned home births, when meconium is present, also have a higher rate of meconium aspiration than do health unit births (Dargaville et al. 2006).

2.7 It is inevitable that some women planning to have a home birth will need transfer to a health unit after labour has started, even with a careful selection process during pregnancy (Davies et al. 1996; Wiegers et al. 1976; Parratt & Johnston 1998). This transfer is more likely to happen for women giving birth for the first time than for women who have given birth before. Where such transfer occurs in a timely fashion and in a spirit of cooperation, it typically has no negative effect on the woman's birth experience (Davies et al. 1996; Wiegers et al. 1998a).

References for this literature review.

Ackermann-Liebrich, U., Voegeli, T., Gunter-Witt, K.,Kunz, I., Zullig, M., Schindler, C., Maurer, M. & Zurich Study Team, 1996, 'Home versus hopsital deliveries: follow up study of matched pairs for procedure and outcome', BMJ: British Medical Journal, vol. 313, pp.1313–1318.
Bastian H, Keirse MJNC, Lancaster PAL 1998, 'Perinatal death associated with planned home birth in Australia: population based study', BMJ:British Medical Journal, vol. 317, pp. 384-388.
Campbell, R & Macfarlane, A 1994, Where to be Born? The Debate and the Evidence, 2nd Ed. Oxford, Radcliffe Infirmary..
Cunningham JD 1993, 'Experiences of Australian mothers who gave birth either at home, at a birth centre, or in hospital labour wards', Social Science & Medicine, vol. 36 pp. 475-483.
Dargaville PA & Copnell B 2006, 'Australian and New Zealand Neonatal Network. The epidemiology of meconium aspiration syndrome: incidence, risk factors, therapies, and outcome', Pediatrics, vol.117, pp 1712-1721.
De Vries R 1996, 'The social and cultural context of birth: lessons for health care reform Dutch maternity care', Journal of Perinatal Education, vol 5, pp. 25-30.
Dowswell T, Thornton JG., Hewison J, Lilford 1996, 'Should there be a trial of home versus hospital delivery in the United Kingdom?', BMJ: British Medical Journal, vol 312, 23 March, pp.753-757.
Gulbransen G, Hilton J, McKay L & Cox A 1997, 'Home birth in New Zealand 1973-93: incidence

[2] A further recent study Symon A et al 2009 Outcomes for births booked under an independent midwife and births in NHS maternity units" matched comparison study found an increase in perinatal mortality for women booked under the care of a independent midwife most of whom had a homebirth. When the level of risk was adjusted (i.e. high risk women were removed) there was no increase in perinatal mortality between the two groups.

and mortality'. New Zealand Medical Journal, vol.110, pp.87-89.
Homer CS, Matha DV, Jordan LG, Wills J & Davis GK 2001, 'Community-based continuity of midwifery care versus standard hospital care: a cost analysis', Australian Health Review, vol 24, pp. 85-93.
Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D & Klein MC 2002, ' Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia', Canadian Medical Association Journal, vol. 166, pp. 315-23.
Johnson KC & Daviss BA 2005, 'Outcomes of planned home births with certified professional midwives: large prospective study in North America', BMJ: British Medical Journal, vol. 330, 18 June, pp. 1416-1422.
Kotaska, A 2004. 'Inappropriate use of randomised trials to evaluate complex phenomena: case study of vaginal breech delivery', BMJ:British Medical Journal, vol. 329, pp. 1039-1042.
Longworth L, Ratcliffe J & Boulton M 2001, 'Investigating women's preferences for intrapartum care: home versus hospital births', Health and Social Care in the Community, vol. 9, pp. 404-413.
Macfarlane A 1996, 'Trial would not answer key question, but data monitoring should be improved',BMJ: British Medical Journal, vol. 312, pp.754-755.
Mehl-Madrona L & Mehl-Madrona M 1997, 'Physician- and midwife-attended home births. Effects of breech, twin, and post-dates outcome data on mortality rates', Journal of Nurse-Midwifery; vol.42 (2), pp.91-98.
Murphy PA & Fullerton J 1998, 'Outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study', Obstetrics and Gynecology, vol. 92, pp.461-470.
New Zealand Ministry of Health 2001, Report on Maternity 1999, viewed 24 April 2007, http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c.
Northern Region Perinatal Mortality Survey Coordinating Group 1996, 'Collaborative survey of perinatal loss in planned and unplanned home births', BMJ: British Medical Journal, vol. 313, pp. 1306-1309.
Olsen O & Jewell MD 1998, 'Home versus a hospital birth', Cochrane Database of Systematic Reviews, Issue 3,viewed 24 April 2007, http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000352/frame.html
Parratt J & Johnston J 2002, 'Planned homebirths in Victoria, 1995-1998', Australian Journal of Midwifery, vol. 15, pp.16-25.
Roberts C, Tracey S & Peat B 2000, 'Rates for obstetric intervention among private and public patients in Australia; population based descriptive study'. BMJ:British Medical Journal vol.321, pp.137-141.
Tracey S & Tracey M 2003, 'Costing the Cascade: estimating the cost of increased obstetric intervention in childbirth using population data', BJOG, vol. 110:717-724.
Tyson H 1991, 'Outcomes of 1001 midwife – attended home births in Toronto, 1983-1988', Birth, vol.18 pp.14-19.
Van der Hulst LA, van Teijlingen ER, Bonsel GJ, Eskes M & Bleker OP 2004, 'Does a pregnant women's intended place of birth influence her attitudes toward and occurrence of obstetric interventions?', Birth, vol.31, pp. 28-33.
Wiegers TA, Keirse MJNC, van der Zee J & Berghs GAH 1996, 'Outcome of planned home and planned hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands', BMJ: British Medical Journal, vol .313, pp.1309-1313.
Wiegers TA, van der Zee J, Keirse MJNC 1998a, 'Transfer from home to a hospital: what is its effect on the experience of childbirth'? Birth, vol. 25, pp 19-24.
Wiegers TA, van der Zee J, Kerssens JJ, & Keirse MJNC 1998, Home birth or short-stay a hospital birth in a low risk population in the Netherlands', Social Science & Medicine, vol. 46, pp.1505-1511.
World Health Organisation 1999, 'Care in Normal Birth: A practical guide', Geneva, W.H.O.
Young G, Hey E, MacFarlane A, McCandlish R, Campbell R & Chamberlain G 2000, 'Choosing between home and a hospital delivery', BMJ: British Medical Journal, vol.320, pp. 798-799

Appendix 2 – Summary Document of ACM Proposed Eligibility criteria*

The ACM recommends that the eligibility criteria for Medicare access for midwives be separated into two components, initial access to the MBS and ongoing MBS access. The basis of the eligibility criteria will be the ACM Midwifery Practice Review program.

The Midwifery Practice Review (MPR) program

MPR was developed by the Australian College of Midwives (ACM) in 2007 with funding from the Australian Commission on Safety and Quality in Healthcare (ACSQHC).

The program, operating since September 2007, obliges each midwife to provide a range of information about their practice ahead of their review including a CV, philosophy of practice, MidPLUS record, practice statistics, consumer, manager and self reflection of practice. The midwife then must participate in a face to face review meeting with 2 accredited MPR reviewers. The midwife must demonstrate that she/he:

- Practices according to the full role and scope of practice of a midwife as identified by the WHO.
- Practices consistently with the provisions of the *Australian Nursing and Midwifery Council (ANMC) National Competencies for the Midwife, Code of Ethics for Midwives, and Code of Professional Conduct for Midwives*
- Identifies and provides a critical analysis of statistical data regarding her/his individual practice and may also include data for the institution in which she/he works.
- Reflects upon her/his individual practice and incorporates evidence-based research, continuous quality improvement and best practice principles into practice.
- Has a professional development plan and evidence of participating in relevant continuing professional development activities
- Engages in feedback from women about the care they have received

Initial access to the MBS

When first applying for access to the MBS and PBS the midwife must provide evidence of:

a. Current registration with the Nursing and Midwifery Board of Australia

b. A minimum of 1 year of full time professional practice experience following initial registration (or endorsement) as a midwife

c. Enrolment and ongoing participation in 'MidPLUS' - the national continuing professional development program specifically for midwives

d. Successful credentialing via the ACM's Midwifery Practice Review (MPR) program with a follow-up review after the first year of MBS access, and thereafter every 3 years.

* Please note that a full version of this document is available from the ACM National office 1300360480

Initial MPR to determine MBS eligibility

The ACM recommends Midwifery Practice Review (MPR) be used as a credentialing program to determine midwives eligibility. This process is in line with similar processes for other health professionals accessing the MBS. Further information on MPR is available at LINK

ACM proposes that all midwives applying to become a Medicare provider for the first time must successfully complete a review in the MPR program. This will provide an assurance that the midwife:

Criteria 1 - is committed to providing woman-centred continuity of care[3]

Criteria 2 - has demonstrated competence in:

a. providing antenatal, intrapartum and postnatal care (i.e. working across the full scope of practice of the midwife) including responding to maternity emergencies and undertaking newborn examination

b. ordering and interpreting tests within the regulated scope of practice of a midwife

c. prescribing and administering pharmacological substances within the regulated scope of practice of a midwife and consistent with relevant state/territory laws

Criteria 3 - is practicing in accordance with national professional standards,

(including the national Competency Standards, Code of Ethics, Code of Professional Conduct for the Midwife[4], and the ACM National Midwifery Guidelines for Consultation and Referral 2008)

Criteria 4 - is actively engaged in relevant continuing professional development,

As determined by the Nursing and Midwifery Board of Australia and the ACM MidPLUS program

Criteria 5 - engages in evidence based consultation and referral

(using the Australian College of Midwives National Midwifery Guidelines for Consultation and Referral 2008).

Criteria 6- is a collaborative and reflective practitioner.

(including evidence of accessing and applying evidence to practice)

Midwives would also be required in this initial MPR to provide evidence of:

[3] Except where the midwife is unable to do so, e.g. because the woman resides in a remote community and is evacuated for labour and birth, the woman's pregnancy ends prematurely, the midwife is unable to attend the labour due to illness, etc.

[4] These are the existing national standards. If the new National Nursing and Midwifery Board develops different standards, then the NMBA standards will be applied.

Criteria 7 - having visiting rights and access to at least one maternity hospital in their local area

Criteria 8 - having a named mentor to assist them in the first 12 months of providing Medicare funded care

ACM will issue a certificate to midwives who meet criteria 1-8 above. The midwife will then supply a copy of her practice license, her Midwifery Practice Review certificate, and any other information required by Medicare Australia in support of their application.

Ongoing MBS eligibility at 1 year

The ACM proposes that all midwives granted MBS provider status be required to complete a follow up Midwifery Practice Review after their first year of practice as an MBS provider. This Review would focus on:

Criteria 1 - the midwife's de-identified outcomes data (statistics) for the women and babies cared for in the past year including their MBS claims history, to confirm that continuity of care is being provided as far as possible[5]

Criteria 4 - evidence of a professional development plan (MidPLUS)

Criteria 8 - evidence and documentary support of the mentoring/ supervision process that has occurred

Midwives who meet these requirements would receive a certificate confirming their ongoing eligibility for MBS provider status. ACM would notify Medicare Australia of the outcome of this review on behalf of the midwife.

Ongoing MBS eligibility after the first year

ACM proposes that every midwife providing Medicare funded care be required to successfully complete a Midwifery Practice Review every 3 years following the 12 month review.

Each subsequent review will consider evidence of criteria 2 to 7 above.

The difference between the initial review and subsequent triennial reviews will be:

- for Criteria 1, the midwife will need to provide evidence not just of a commitment to but actual provision of continuity of care, including de-identified data on outcomes for women and babies cared for by the midwife in the preceding 3 years[6]
- Criteria 8 - evidence of having a professional mentor - will be optional and not compulsory.

ACM could advise Medicare Australia on behalf of the midwife of the outcome of each 3 yearly review.

---

[5] except in remote areas where continuity of care during labour is often not possible

[6] Except where it has not been possible to provide continuity of care due to factors beyond the midwife's control (remoteness, early end to a pregnancy, illness on the part of the midwife, etc)

Summary

ACM believes it is essential that the ability to provide continuity of care to women is built in to the eligibility criteria for midwives. The Midwifery Practice Review program is an existing, cost effective and nationally accessible mechanism for credentialing midwives who wish to provide MBS funded care. Successful completion of MPR every 3 years will ensure participating midwives continue to provide safe and quality care to women and their families when working in private practice funded by Medicare.

Appendix 3 – Australian College of Midwives Position Statement

Australian College of Midwives
Draft Position Statement on Planned Home Births with a Midwife

The Australian College of Midwives believes that the opportunity to give birth at home should be offered to women who have uncomplicated pregnancies and labours. The College supports a woman's right to self-determination and control over her body and her pregnancy, including the right to give birth in the place of her choice. Some women prefer to give birth in the familiar, comfortable surroundings of their own home because they feel this is the safest place for them and their baby. Birth for women is a rite of passage and a family event; it is an intense physical and psychological journey that can leave women vulnerable to physical and emotional trauma but also potentially open to enormous personal self-growth. The physical and psychological care of childbearing women are therefore inextricably linked.

Evidence supports both the safety of homebirth for women with uncomplicated pregnancies (1-4) and the requirement for timely transfer from home with access to the full health care team in a hospital facility for women who experience complications during their pregnancy or in labour, to prevent increased morbidity and mortality for mother and baby (5; 6).

The rate of home births in Australia remains low at approximately 0.30% (7), in large part due to the unavailability of insurance and the lack of public funding for private midwives. It has been estimated that where safe homebirth is supported and offered to women with low risk pregnancies, the rate of home births may well be around 8–10% (8).

Just as the Australian College of Midwives supports women's right to choose high quality midwifery services in both the public and private systems, so too the College supports a midwife's right to choose to be self employed or employed.

Aim of this position statement
To provide women, midwives and other health practitioners with a clear understanding of where the peak professional body for Australian midwives stands in relation to women giving birth at home.

Guiding requirements for women
That a woman planning to give birth at home has:
- an uncomplicated singleton pregnancy at term
- access, including a booking, into a nearby hospital with secondary or tertiary facilities
- been informed as to the specific reasons for possible transfer out of the home environment and requirements to ensure timely transfer
- agreed to listen to her midwife's advice when transfer may be needed
- the right to refuse all or any aspects of care

- the right to a home visit by her primary midwife and the midwife's associate to discuss available evidence of risk and document the woman's informed refusal

Guiding requirements for midwives

That a midwife planning to provide midwifery care to a woman at home

- is a Registered Midwife.
- is a Medicare Eligible Midwife (see Eligibility criteria)
- is experienced in attending homebirths or is attending the labour and birth with a midwife experienced in attending homebirths.
- informs women about the range of antenatal, labour and birth and postnatal care options and their advantages and disadvantages
- utilises the ACM National Midwifery Guidelines for Consultation and Referral
- demonstrates effective communication and collaboration processes with other health professionals
- communicates and documents a plan of care for home birth that is centred around the woman's wishes
- has planned referral pathways for pregnancy and during the woman's labour and birth,
- has visiting access to local hospital/s
- plans for two midwives to attend the birth where possible (a second midwife will arrive at the discretion of the primary midwife and/or the woman's wishes)
- retains the right to organise alternative provision of care for a woman antenatally if there are concerns about the safety of the woman and her baby
- has a responsibility to remain with a woman in labour if the woman declines the midwife's advice to transfer to hospital, to record the events and to contact a colleague for support and ongoing advice
- has a right to expect that on transfer to a secondary or tertiary health facility, she as the midwife, will be treated with respect and that the woman's health care needs and those of her baby will be the central focus of the health care

Guiding requirements for maternity services

That maternity providers

- provide professional information for every woman on a range of birth environment options
- discuss the potential advantages or disadvantages of home birth and hospital birth with every woman
- inform women about the full range of antenatal care and facilitate the choice for their particular place of birth
- facilitate visiting access for eligible midwives
- support and include midwives in peer review and ongoing professional development (MidPlus and MPR).
- facilitate a safe and woman-centred process for women who request vaginal breech birth, vaginal birth after caesarean, vaginal twin birth etc in hospital or refer on to another practitioner/centre
- plan referral pathways with women choosing homebirth that are agreed during her pregnancy and continue during her labour, birth and postpartum period
- agree to work with planned referral pathways to ensure effective communication and appropriate mutual collaboration between the woman's midwife and other maternity service providers

- agree to respect the primary relationship developed between the woman and midwife over many months of the woman's pregnancy
- include the woman's midwife during the process of consultation or referral as an integral part of the health professional team.

References

1. Johnson K, C., Daviss B. Outcomes of planned home births with certified professional midwives: large prospective study in North America. British Medical Journal 2005;330:1416-1423.
2. de Jonge A, van der Goes B, Ravelli A et al. Perinatal mortality and morbidity in a nationwide cohort of 529,688 low risk planned home and hospital births. British Journal of Obstetrics & Gynaecology 2009;DOI: 10.1111/j.1471-0528.2009.02175.x.
3. Wiegers T, Keirse MJNC, van der Zee J. Outcome of planned home and hospital births in low risk pregnancies: prospective study in midwifery practice in the Netherlands. BMJ 1996;313(7068):1309-1313.
4. Olsen O. Meta-analysis of the safety of homebirth. Birth 1997;24(1):4-13.
5. Bastian H, Keirse MJ, Lancaster P. Perinatal death associated with planned home birth in Australia: population based study. BMJ 1998;317(7155):384-388.
6. Symon A, Winter C, Inkster M, Donnan P. Outcomes for births booked under an independent midwife and births in NHS maternity units: matched comparison study. British Medical Journal 2009;BMJ 2009;338:b2060.
7. Laws P, Hilder L. Australian mothers and babies 2006. In. Sydney: AIHW National Perinatal Statistics Unit, 2008.
8. RCOG, RCM. Royal College of Obstetricians and Gynaecologists/Royal College of Midwives Joint statement: Home births In: http://www.rcmnormalbirth.net/webfiles/Statement/Home%20Births_Joint%20Statement.pdf, ed. Vol. No.2, April 2007, 2007.