

Publicly-funded homebirth models in Australia

ABSTRACT

Background

Publicly-funded homebirth programs in Australia have been developed in the past decade mostly in isolation from each other and with limited published evaluations. There is also distinct lack of publicly available information about the development and characteristics of these programs. We instigated the National Publicly-funded Homebirth Consortium and conducted a preliminary survey of publicly-funded homebirth providers.

Aim

To outline the development of publicly-funded homebirth models in Australia.

Methods

Providers of publicly-funded homebirth programs in Australia were surveyed using an on-line survey in December 2010. Questions were about their development, use of policy and general operational issues. A descriptive analysis of the quantitative data and content analysis of the qualitative data was undertaken.

Findings

In total, 12 programs were identified and 10 contributed data to this paper. The service providers reported extensive multidisciplinary consultation and careful planning during development. There was a lack of consistency in data collection throughout the publicly-funded homebirth programs due to different databases, definitions and the use of different guidelines.

Discussion

Publicly-funded homebirth services followed different routes during their development, but essentially had safety and collaboration with stakeholders, including women and obstetricians, as central to their process.

Conclusion

The National Publicly-funded Homebirth Consortium has facilitated a sharing of resources, processes of development and a linkage of homebirth services around the country. This analysis has provided

information to assist future planning and developments in models of midwifery care. It is important that births of women booked to these programs are clearly identified when their data is incorporated into existing perinatal datasets.

Keywords: publicly-funded homebirth, maternity services, models of care, midwifery

INTRODUCTION

Homebirth is a contentious issue in Australia with a polarity of views from the public, as well as those working in the health system [1]. Currently only 0.3% of women in Australia give birth at home [2], with 0.6% in the United States (US) , and 2.7% in the United Kingdom (UK) [3]. The homebirth rate in New Zealand varies from region to region but recent figures received from the New Zealand College of Midwives indicate that the rate of homebirths is approximately 7% [4]. In contrast, the Netherlands, which has a strong history of homebirth has a rate of around 30% [5].

Until recently, in most parts of Australia, homebirth was only possible for women who employed privately practising midwives or doctors and personally paid for care at home [6]. Since 2001, independent midwives providing a homebirth service have been unable to obtain professional indemnity insurance which has created significant challenges for women who want to give birth at home[7, 8]. There are anecdotal reports that the lack of professional indemnity insurance cover has reduced the numbers of midwives who work in private practice[9]. These factors and the lack of government funding have meant that there has been extremely limited access to homebirth for Australian women. In the *National Review of Maternity Services* undertaken in 2008 [10], more than 60% of the submissions were about homebirth, with the vast majority from women who wanted access to homebirth [11]. As a response to consumer demand both before and after the *National Review of Maternity Services*, publicly-funded homebirth models have been implemented in different ways across the country.

Publicly-funded homebirth programs in Australia commenced some 15 years ago in Western Australia (WA), with services in other states and territories developing in more recent times. The publicly-funded homebirth option of care is usually available to women who are at low risk of medical or obstetric complications. The programs are based within the public hospital system with professional indemnity insurance cover for the midwives provided by the hospital as part of their employment. These programs are often linked with, or arise from, existing birth centres or midwifery group practices.

Currently there are at least 12 publicly-funded homebirth programs in Australia with a number in planning phases. Few of these have been formally evaluated. To date, evaluations include the St

George Hospital Homebirth Program in New South Wales (NSW)[12], the Community Midwifery Program in Western Australia (WA)[13, 14] and Northern Women's Community Midwifery Program in South Australia (SA) [15].

There is little literature on the development of publicly-funded homebirth programs. Only one publicly-funded homebirth provider has published information on its planning stages and development processes [12]. Homer and Caplice [12] and McMurtrie et al. [16] described the initial planning and development stages which included the creation of a multidisciplinary steering committee, contact with the area Ambulance Liaison Officer, and the assurance of professional indemnity insurance coverage from NSW Health. Specific documentation and practices (including a home visit at 36 weeks gestation) were required by NSW Health to have access to professional indemnity insurance. It is likely that other programs around Australia have undergone similar establishment processes although this is largely unknown. In addition, Newman and Hood (17) document the importance of consumer involvement in the development of publicly-funded homebirth programs.

Given the national interest in publicly-funded homebirth, and the lack of clearly established processes for the development of such programs, we saw a need to bring together the midwives across the country who developed, or are in the process of developing, publicly-funded homebirth programs. To this end, we established the National Publicly-funded Homebirth Consortium in 2010 to collate information about publicly-funded homebirth programs in Australia; especially their initial development, and current working capacity. The Consortium provides those working in publicly-funded homebirth programs with a network to obtain support and advice for one another and aims to assist others who are planning similar programs. The initial aim of the Consortium was to collate data on the establishment of the programs, with a view to collecting data on maternal and neonatal outcomes at a later stage. This paper describes the publicly-funded homebirth models currently functioning in Australia and outlines the processes used in their development.

METHODS

The midwifery managers of the known publicly-funded homebirth programs in Australia were contacted in late 2010 and invited to join the National Publicly-funded Homebirth Consortium and complete a short survey using an online database [18]. The survey asked a series of questions including the number of years since the program was established, the process of development, the guidelines and systems used and data items collected, and processes for collecting and collating

data. There were categorical responses (yes or no) as well as open-ended questions that included reasons for establishment and information on the relevant guiding government policy documents. A content analysis of the qualitative data, and simple description of the quantitative data were undertaken.

We did not seek human research ethics approval for the survey as it was considered to be a descriptive audit and of negligible risk [19, 20]. The midwifery managers (who were the respondents to the survey) agreed to publish their data.

FINDINGS

Twelve publicly-funded homebirth programs were identified by the Consortium members and invited to complete the on-line survey. Eleven providers responded, although only ten responses were used in this paper, as one service was still in its development stage and had not commenced. The programs, together with their year of establishment are described in Table 1. Almost every state and territory in Australia has a publicly-funded homebirth program except Queensland, Tasmania and the Australian Capital Territory. Most programs were established after 2004, with the exception of the Community Midwifery Program in WA, which began in 1996.

Many respondents' stated their programs were established as a result of consumer demand. In two states (South Australia and New South Wales) respondents stated that published government documents [21, 22] had assisted the development of their programs.

Planning and establishing the services

A considerable amount of work went into developing the homebirth programs and there were marked similarities in the processes used through the planning and development phases. Most took a multi-disciplinary approach to the development of their program and established a steering or an advisory committee structure to provide leadership, trouble-shoot and address issues as they arose. For example, one program established an advisory committee involving stakeholder representation including midwives, obstetricians, Department of Health staff and administrators. Consumer consultation and involvement in the steering or advisory committees was a common thread. All but one homebirth service included consumer consultation in the process of setting up their service. Other services or support networks were often consulted during the planning and establishment phases. Nine programs consulted the ambulance service during the consultation process as part of a formal quality and safety/risk assessment.

Developing policies and guidelines

Eight services developed their own local policies and guidelines during the development phase. Policies and guidelines included the criteria used for women who were eligible for a homebirth and criteria for transfer to hospital. All programs stated that they used the Australian College of Midwives Consultation and Referral Guidelines [23, 24], six also used the *South Australian Government policy for planned birth at home* [21], and eight also used their own hospital-generated policies. Other policies noted were those from local state or territory governments or area health services.

Entry criteria varied across the programs (Table 1). Six used criteria consistent with the level A codes in the Australian College of Midwives (ACM) Guidelines for Consultation and Referral [23]. The criteria of two programs stated that women should have an uncomplicated singleton pregnancy, cephalic presentation, with labour occurring within a specified gestation – in one case this was 37-42 weeks, and in the other 37-40 weeks. One provider had specific exclusion criteria including women with a previous caesarean section, multiple pregnancy and prior complicated obstetric (diabetes, hypertension, haemorrhage) or neonatal history. Their criteria also excluded women with a body mass index (BMI) over 40, and women under 18 years of age. The same provider required women to sign a 'terms of care document' at booking and at 28 and 36 weeks gestation to 'ensure criteria had not changed and there were no developing concerns'. One provider followed entry criteria guidelines from the *South Australian Government policy for planned birth at home* [25]. Three programs had distance from the hospital (no more than a 30 minute drive) as a criteria; one stated women were to live 'within the geographical boundaries' which they did not define. One program had a flexible approach which enabled women who lived outside the nominal boundaries to be included. This involved a home visit with informed consent and responsibility shared between women and their families and the midwives. One provider stated their eligibility criteria included the need for women to hold ambulance insurance cover. Most providers covered women for ambulance costs and incorporated it into their hospital budget.

The criteria used for transferring women from home to hospital care if required also varied considerably across programs (Table 1). Three used the ACM Guidelines for Consultation and Referral, and one specifically stated the codes B/C were their indication for consultation and/or transfer. Transfer upon recommendation by the midwife and/or the mother was specified in five programs. Three stated that recommendation by medical staff for transfer was part of their criteria for transfer. In three policies, transfer was said to be warranted if neonatal assistance was required postnatally. Two had that 'changes' from the booking criteria would indicate grounds for transfer

and one program added 'unsuitable home conditions' (taking into account occupational health and safety issues and the safety of their midwives). One program listed specific labour situations such as labour dystocia, antepartum haemorrhage, fetal distress, maternal fever, postpartum haemorrhage, third-fourth degree tear and 'anything that steps outside normal'. Another was more flexible stating 'no strict criteria but work within hospital policies and guidelines'. The respondent from this program stated that transfer to hospital occurred after consultation with medical staff.

Selecting the midwives

All programs carefully selected the midwives to provide a homebirth service. Nine of the ten services recruited the midwives for the program by calling for an expression of interest from existing employed midwives. Four provided extra education and up-skilling for the midwives who were planning to work in the program. The other six program employed midwives who already had experience in working in caseload midwifery models, or were previously working in private homebirth practice. Some programs required midwives to have met standard requirements. For example, in South Australia, midwives had to be accredited to the program before they were allowed to work on the homebirth program.

Two of programs were developed through specific government funded schemes. The Community Midwifery Program in WA was provided with initial funding from WA Health to have a pilot program for 80 homebirths in 1996 and the service in Orange NSW was started in 2010 with funding under the Federal Government's 'New Directions Mothers and Babies Program' [26]. Only two services stated that they undertook feasibility studies during the development of their homebirth service.

Number of women cared for by the programs

In total, 519 women were booked to the 10 responding homebirth programs during the 12-month period from December 2009 to December 2010. Only a few programs keep information on the demand for their service. For example, over the 12 month period, the Community Midwifery Program in WA had 575 applications from women for care by the program, 30% (n=177) of which had to be declined for medical, geographical and workforce factors.

Number of midwives working in the programs

Overall, there were 90 midwives working in publicly-funded programs in Australia. The largest employer of midwives in a homebirth program was the Women's and Children's Hospital Midwifery Group Practice (SA) which had 27 (full time equivalent [FTE]) midwives, ten of whom can be the primary midwife at a homebirth. A primary midwife was generally described as a midwife who had

the required experience and could take primary responsibility. Other larger programs included the Community Midwifery Program (WA) which employ 14 midwives, all of whom can be primary midwives, and the Belmont Midwifery Group Practice (NSW), which employ 16 midwives, 11 of whom can be primary midwives. Most Area Health Services employ between 3-7 midwives who can be primary midwives in their homebirth service. One midwife who works in rural NSW provides homebirth as part of a caseload service to women in more rural areas. She works as the primary midwife at homebirths with support from another midwife in the local health network.

Documentation systems

All 10 programs used standard public hospital documentation including partograms, medication charts and clinical notes. Two programs also routinely used fluid balance charts. One provider stated that they use the standard hospital documentation at home, but only used medication charts and fluid balance charts if women were transferred to hospital. Two programs provided women with hand-held records.

Seven programs had a consent form for the women to sign prior to the homebirth and two also had a consent form for the support people. These were usually signed at the 36 weeks visit.

Data collection systems

Data collection for monitoring and evaluation was reported to be important in all programs although there were often challenges associated with collecting and collating the data efficiently. Clear definitions were seen as essential in order to differentiate between planned and unplanned homebirth or women who gave birth before arrival to hospital or arrival of a midwife to the woman's home. Equal numbers of programs used Access and Excel databases [27, 28]. Seven services used an electronic perinatal data collection system as well as their Access or Excel database. Other systems used included various online programs and databases.

Lessons learned for other programs

The survey asked respondents to provide advice for others who were considering setting up a publicly-funded homebirth program. Common themes in the data showed the need for programs to be woman centred, community-based or focussed with an emphasis on primary care principles. A multidisciplinary steering committee involving consumers was seen as an essential ingredient for success. Funding was also stated as a priority. This was to cover staff for risk management tasks, technology (access to computers/printers/email), equipment (homebirth kits including resuscitative equipment and medication) and workload (enough staff to cover leave commitments). Initial funding

was required to purchase equipment and enable midwives to be released for professional development.

Another aspect was the need for effective and available mentoring for new midwives. A mentor or manager who could help develop the program, support the midwives and assist with ongoing audit and evaluation was seen as essential. It was also thought to be particularly helpful to have an existing caseload or midwifery group practice midwifery program from which to begin the homebirth program.

Respondents were unanimous in stating that women were central to the service, that midwives understood that women need to feel completely comfortable with their choice of birth place, and that 'babies deserve to be born safely in a caring environment'. This included the need to ensure the practice of the midwives was safe and effective and consultation and referral pathways, especially consultation with obstetricians, were well developed and articulated. It was also felt that midwives needed to be able to practice within the scope of a midwife without being constrained by hospital derived policies that were overly restrictive. Another comment was that midwives needed to 'be confident to be midwives, and trust that each woman has the innate [ability] to birth her baby'.

DISCUSSION

There is considerable debate in Australia about maternity care and the safety of different models of care provision. This debate has increased in the past two years, following the release of the Report of the *Maternity Services Review* [10], the granting of Medicare funding to midwives [29], and the *National Maternity Services Plan* [30]. The government is committed to supporting women's choice of maternity care based on the best evidence [30]. However, there are currently no data on the safety of different places of birth in this country particularly homebirth. The most commonly quoted Australian homebirth data describes an audit conducted on homebirths between 1985-1990 [31], which included high risk women in its analysis. This study, published in 1998, showed that homebirth for healthy women who did not have known medical or obstetric risk factors compared favourably with those having a hospital birth. It is timely therefore, to analyse the current situation in Australia in relation to publicly-funded homebirth.

The *National Maternity Services Plan* [30] states that "the evaluation of individual publicly-funded homebirth programs will provide an evidence base for further planning decisions." Unfortunately, evaluating individual publicly-funded homebirth models will provide only low-level information, which will be insufficient to allow informed decisions to be made about the types of services that should continue to receive support. Individual evaluations will not provide a large enough sample

size to make judgements about safety and quality. Therefore, a national study of all the publicly-funded homebirth programs is required. The aim of the National Publicly-Funded Homebirth Consortium is to bring all the programs in Australia together to provide the largest possible dataset in order to evaluate the outcomes of women who choose this model of care. An understanding of the systems and processes for these programs is the first step towards achieving this aim and hence the focus of this paper.

We surveyed the providers of publicly-funded homebirth programs in Australia to collate data on their processes of development, use of policy, and general operational issues. This is the first time that the publicly-funded homebirth programs in Australia have been described. The programs, despite similarities, all undertook different processes in their development. They used different documentation, and followed state-based policies regarding homebirth criteria and transfer to hospital, in addition to local hospital policies to guide the development of the program. Most followed the ACM Consultation and Referral Guidelines regarding booking and hospital transfer criteria. The formation of local guidelines in this respect is important, especially to contextualise criteria in relation to rural areas, yet there is a need for consistency in this regard.

Most of the programs initiated a multidisciplinary steering committee in the development of their homebirth programs. Collaboration with medical staff and other stakeholders including consumers, ambulance personnel, General Practitioners and emergency department staff was highlighted in the last section of the survey that asked for other useful information on setting up a service. This was seen as a vital part of the process to ensure transparency of operation and to ensure a smooth operation of the model that covers all eventualities.

A number of respondents to the survey stated the desirability of having a mentor to guide the development of a publicly-funded homebirth service. In addition, enabling homebirth within an existing caseload model facilitated a smooth transition into a service that offered a full range of birthplace choices. Most programs had midwifery mentors who had previously worked in private homebirth practices to help support the midwives who were new to homebirth. Despite midwifery training curricula incorporating more community-based midwifery care, there remain few newly graduated, or even relatively experienced midwives in Australia who have been present at a homebirth [32]. Mentoring provided to midwives employed in the publicly-funded homebirth programs, and the review processes involved in becoming a primary midwife is likely to ensure the optimal functioning of homebirth programs and that midwifery skills in supporting homebirths are preserved.

Most of the recent programs were publicly-funded from the outset, usually set up through large Area Health Services or metropolitan hospitals. Some of the earlier programs however had their origins in a business model run by privately practising midwives. Some of these earlier programs have been able to accommodate women who often have more difficult circumstances and may not have been able to access care in some of the newer programs. It is likely that the process of negotiation, especially for women who higher social and emotional needs, takes time and requires stable staffing over many years. Many newer services without this history and experience, and with a likely higher turnover of midwives, may not be able to negotiate such flexibility.

It is possible that the establishment of publicly-funded programs has, at times, been to the detriment of privately practising midwives, many of whom worked hard for many years to regain indemnity insurance and be able to provide a homebirth service. While this is not the focus of this paper, it is important to recognise the important role that private midwives have played for many years in the provision of homebirth services. We recognise that the emergence of some publicly-funded programs may have left some privately practising midwives in a difficult position. We also understand that publicly-funded programs may not be able to provide the same type of service or cover the same geography that privately practising homebirth midwives can. Therefore there will always be a need for both homebirth options to exist. It is hoped that in the near future, policy decisions in relation to the provision of indemnity insurance for homebirth midwives will occur to enable women to access homebirth in the private setting.

While this study provides the first description of publicly-funded homebirth in Australia, it also has limitations. These include the method of data collection, that is, an online survey. We asked for the numbers of midwives working in the program and as many midwives work part-time, the full-time equivalent status of programs was not demonstrated by this survey (apart from the Women's and Children's Hospital, SA). One of the larger publicly-funded homebirth programs did not respond to the survey, hence the figures given are lower than the actual number. Lastly, the numbers of women cared for was for a 12-month period between December 2009 –2010, but the specific date in December was not specified. However, this is unlikely to alter the numbers significantly.

There were considerable variations across the publicly-funded homebirth programs in Australia. This includes different entry and exclusion criteria, the use of different guidelines and evidence to guide practice and a lack of consistency in data collection and reporting mechanisms. However, all programs had developed a tight framework based on safety, focussed on caring for low-risk women and had structures in place to deal with unexpected events. There is a need for a nation-wide prospective database of the outcomes of women booked to publically-funded homebirth programs

(and their infants). This would provide valuable homogenous data on maternal and neonatal outcomes related to this model of care and enable comparisons with other models of care. Such data would benefit not only maternity service providers, but women and their families when making choices about place of birth.

CONCLUSION

Publicly-funded homebirth programs have been established in Australia over the past 15 years. This study has highlighted a number of similarities and differences between programs. This is the first time such an evaluation has been undertaken and as such provides valuable information to assist future planning and developments in models of midwifery care. It is important that births of women booked to these programs are clearly identified when their data is incorporated into the existing national perinatal dataset which is published in Australia's Mothers and Babies Reports [2].

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