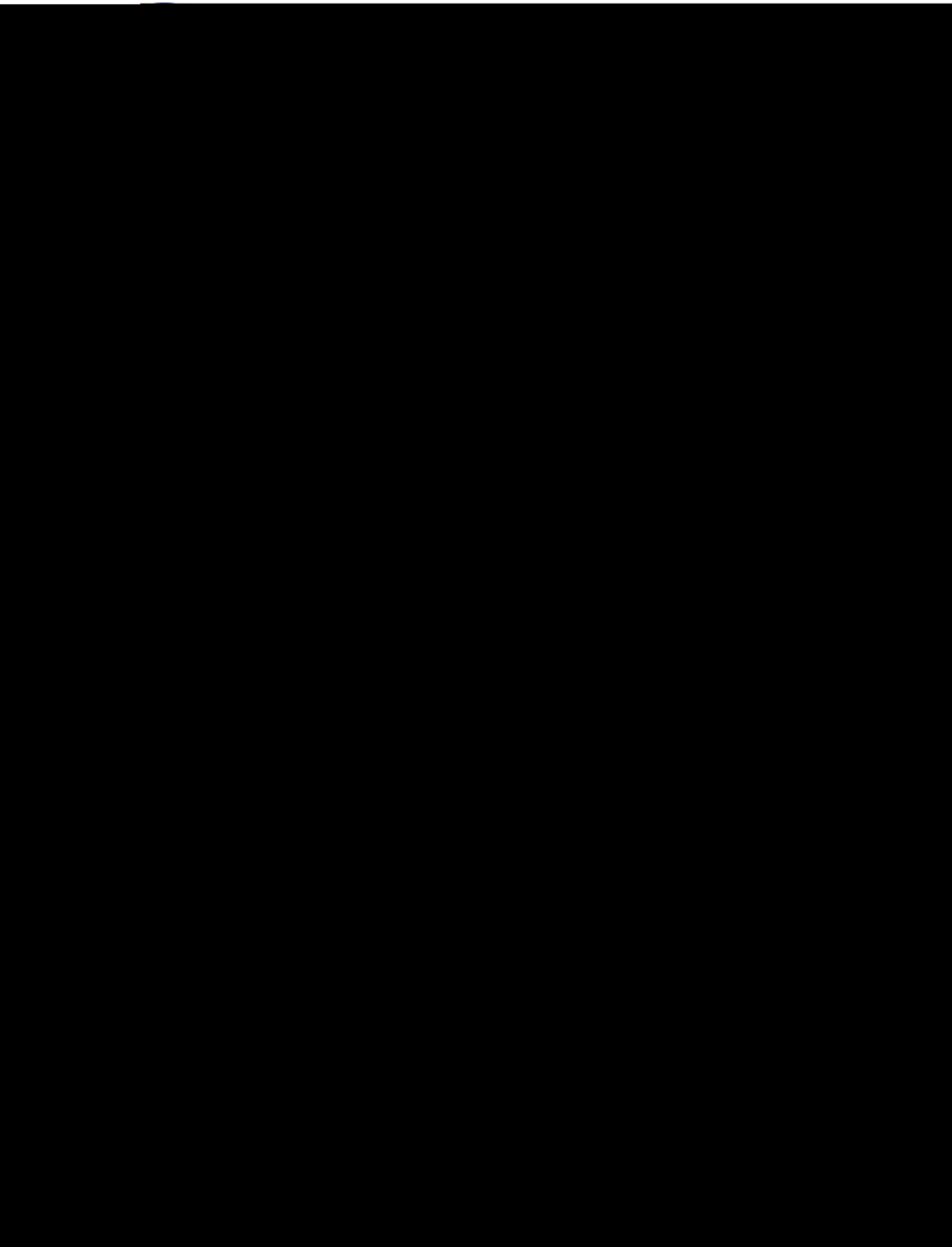

Limited hospital visiting rights to private midwives
Professional indemnity insurance has not been available to independent midwives since 2001.
Scope of practice limits midwife's ability to order tests, prescribe medicines, and to practice in partnership with another midwife.
Every private midwife must practice in collaboration with a named obstetrician.

Many of these problems are structural problems and are resolvable. Others such as fear of birth will require community wide strategies. Submissions to the Federal inquiry point the ways. In making midwife led continuity of carer models available to

(Donnolley et al. 2017 [11]) identified 129 models of care in a single NSW hospital in a single year, arguably showing its usefulness as a reporting tool. However, that so many recognisably different types of care can be identified in such a narrow sample shows that this concept of "model" is far removed from that which is used by most other authors. Significantly, it also alerts us to the possibility that the fine detail of how a program is structured or implemented may influence its results.

There is an almost complete lack of information about how midwife-led, out-of-hospital maternity care has been organised in Australia, and what its outcomes have been. Contra Bryant but perhaps pro Donnolley there has never been one standard model, and anecdotal evidence indicates strong heterogeneity in eligibility criteria, in the care regime, and in clinical and social outcomes.

Research into homebirth in Australia including an early paper by Bastian et al. (1998) [12] has widely been cited as providing evidence that homebirth in Australia is inherently unsafe. Bastian et al. reported an excess of perinatal deaths associated with intrapartum asphyxia and with overdue births (>42 weeks gestation); a pattern that is not matched in homebirths elsewhere. Subsequent critiques (Kierse 2013 [13], Homer date [14]) suggest that their sample included a very mixed set of practices such that their conclusions were not scientifically valid.

Very recently, Davis-Tuck et al. (2018) [15] found homebirths in Victoria 2000-2015 to have been as safe as hospital births for low-obstetric-risk mothers, with no excess asphyxia and better outcomes for both the mother and the baby. However, they reported a higher rate of perinatal mortality for high risk mothers at home than for high-risk mothers in hospital. On examination, this pattern occurred because the chief risk in the high-risk homebirth cohort was gestation >42 weeks while the chief risk in the high-risk hospital cohort was BMI>30. While Davis-Tuck et al. concluded that only a low-risk mother should contemplate birth at home, our analysis of their data suggests instead that gestation >42 weeks should trigger a switch from home to hospital delivery.

Recent studies also show that many of the common interventions of childbirth, as are now practiced in the vast majority of Australian births, can have adverse medical consequences, both short and long term, for the mother and baby (Peters et al. 2018 [16]; Mueller et al. 2017 [17]; Dahlen 2016 [18]; Yang et al. 2016 [19]). In addition, unnecessary caesarean cannot be explained by population characteristics or demand side factors, and current high rates have not been accompanied by significant maternal or perinatal benefits and are associated with short and long term risks that can extend many years beyond the delivery and affect the health of the woman, child and future pregnancies (WHO 2018 [20]). But data in written submissions to the recent Federal enquiry suggest as few as 5% of Australian births are completed without medical intervention. This is a shocking indictment of the current state of Australian maternity care.

The social and mental health consequences of unwarranted interventions, including the effects of birth trauma on both the mother and the service providers, are of increasing concern in Australia, as was recently discussed in the Report of the Victorian Inquiry into Perinatal Services (2018) [21] and in submissions to the

12. Bastian, H., Keirse, M.J.N.C., and Lancaster, P.A.L. 1998. Perinatal death associated with planned home birth in Australia: population based study. *BMJ*