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Independent midwifery-led home births in Australia: a step ahead or a step too soon?

Abstract

Objective: To discuss provision of home births in Australia and make recommendations how to proceed in developing a regulated, safe home birth service.

Review methods: A narrative review of comparative home birth studies from other health systems was performed in order to inform recommendations.

Results: Delivery in a home setting in low risk women reduces some maternal complications but there exists a problem of increased perinatal/neonatal mortality seen in many studies. The risk is low in absolute terms however can be further reduced or nullified in well integrated systems. The perinatal/neonatal risk profile is increased in nulliparous verses multiparous women.

Discussion: The perinatal/neonatal risk is not consistent across all studies and in well integrated systems there is no excess risk identified. Key proposals to enhance accountability and safety are suggested:

Mandatory integration of all home births into a healthcare system, risk stratification and review of cases by an Obstetrician with a private midwife, standardized clinical guidelines should be agreed, a communication protocol between the midwife and hospital maternity team during labor should be agreed and implemented, informed refusal and documentation of discussions for women who do not accept professional advice, ongoing training and regulatory oversight including centralized registration with an affiliated hospital.

Establishing these measures will facilitate safer home birth practices and allow for comprehensive statewide monitoring, ultimately supporting informed choice while prioritizing the health of both mother and baby.

Conclusion: The regulation and integration of a home birth system is a necessary step in providing safe care for women who would like to deliver at home. Secondly the provision of a home birth service is an important step in reducing the current trend to freebirths seen in Australia.

Keywords: midwifery, pregnant women, birth, maternity

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Introduction

For many years, clinical efforts have predominantly centered on hospital-based maternity care, often underestimating the role of community-based support for pregnant women. Recently, there has been a notable shift in public perception, driven by personal and social experiences. There are growing concerns about the appropriateness of hospital births for all women and increasing interest in alternative approaches, particularly private midwife-led home births.

Healthcare professionals, rather than criticising or underestimating this shift in maternal preferences, must acknowledge it and work proactively to ensure that births do not occur in systems where care is unregulated, unmonitored or outside legal and clinical safeguards. This evolving shift has the potential to bring a renewed balance to maternity care; where an appropriate blend of medical intervention and natural care is achieved. Such an approach could lead to greater overall patient satisfaction, reduced pressure on hospital-based services, and improved economic efficiency within the healthcare system.

The impetus for initiating this scientific inquiry into home births stems from a recent series of cases of inappropriate care associated with independent midwife led home birth practices. These cases exposed significant risks to both mothers and neonates, with several near-miss morbidities resulting from poor case selection, inadequate counselling, insufficient risk stratification and delays in escalating care when complications arose. Such critical lapses not only jeopardised patient safety but also placed undue strain on hospital-based healthcare providers who were left to manage the outcomes.

This article primarily focuses on a literature review addressing evolving birth practices and current global trends in home births. It examines the critical balance between maternal and neonatal safety when considering home birth options and outlines quality improvement measures aimed at enhancing the safety outcomes for both mother and newborn.

Evolving birth practices: the transition from home to hospital births

Global advancements in medical knowledge and clinical skills are driven by evidence-based practice, improved access to information, scientific progress and rapid developments in communication and technology. This has contributed to a marked shift from home births to hospital-based deliveries since the early 20th century. This transition occurred relatively seamlessly and was underpinned by compelling evidence that hospital births are associated with a substantial reduction in maternal and neonatal morbidity and mortality.

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These advancements have led to improvements in both maternal and neonatal outcomes. World Health Organization (WHO) data indicate that the global maternal mortality ratio (MMR) dropped to 339 deaths per 100,000 live births in the early 2000s and further decreased to approximately 223 deaths per 100,000 live births by 2020.[1] According to the Australian Institute of Health and Welfare report, Changing Patterns of Mortality in Australia Since 1900, the MMR in the early 20th century, during the initial phase of the shift from home to hospital births, was approximately 600 deaths per 100,000 live births.[2] The current Australian MMR is 4.8 deaths per 100,000 live births.[2]

This reduction is particularly evident in high-income countries, where access to timely medical care and adherence to standardised, evidence-based maternity protocols are consistently maintained. In contrast, middle and low-income countries continue to face challenges due to under-resourced health systems and uneven implementation of clinical standards.

Key factors in this progress include improved access to skilled care, enhanced medical/midwifery training, better nutrition together with the introduction of critical interventions such as antiseptic techniques and blood transfusion services.[3,4] More recently, the management of complex pregnancies through a multidisciplinary team approach, coupled with standardized clinical protocols and pathways, has further improved outcomes. It is imperative to acknowledge that modern medical care has saved, and continues to save, millions of maternal lives globally.

Nevertheless, a contemporary global discourse is emerging around the appropriateness and extent of medical interventions in childbirth. While medical advances have undoubtedly played a vital role in reducing maternal and neonatal risks, growing concerns have been raised regarding the potential overuse of interventions. This has led to important questions about whether all such measures are medically justified.

There is increasing concern among patient communities and healthcare professionals alike about whether the over medicalization of childbirth may, in some cases, cause more harm than benefit. This evolving discussion underscores the need for a critical evaluation of current obstetric practices with the aim of ensuring a careful and respectful balance between necessary medical intervention and the support of low-intervention home birth where appropriate.

Global trend in home births

A universal consensus on the safety and outcomes of home birth must be approached with caution, as evidence varies significantly across countries. Each country is unique in terms of its topography, demography, degree of urbanization, traditional cultural practices, social and cultural hierarchies, accessibility to emergency healthcare and the strength of its midwifery training programs. Moreover, governmental funding for maternal healthcare services including support for midwifery, emergency transport, and postpartum care—plays a critical role in shaping the safety and feasibility of home births. Public awareness of childbirth-related issues is also influenced by socioeconomic status, education levels, cultural norms and the population's ability to understand and balance risks and benefits. These contextual differences make it challenging to generalize findings from one country to another.

The highest rates of home births are still observed in low-income countries such as Chad, Ethiopia, and Niger where home birth rates range between 70% and 78%.[5] This pattern is largely driven by inadequate access to healthcare services, persistent socioeconomic barriers, and deeply rooted cultural practices. Notably, these same countries also rank among those with the highest maternal mortality ratios globally—exceeding 1,000 deaths per 100,000 live births.[6] This stark overlap underscores a strong correlation between unregulated home births and poor maternal health outcomes in the context of a poorly funded healthcare system.

The Netherlands has a relatively high rate of home births, with approximately 15% of all pregnancies resulting in planned home deliveries.[7] A significant increase was observed among low-risk pregnancies during the COVID-19 pandemic, with home birth rates rising from 27% pre-pandemic to 37% during the pandemic period.[8] The Netherlands remains unique for its high home birth rates, though these have declined from 35% in 2000 to 16% in 2019. It is essential to further explore the reasons behind this significant decrease.[9]

A cost-analysis based prospective non-randomised study conducted within the Dutch obstetric system compared two groups of nulliparous women based on their preferred place of birth—either at home or in a short-stay hospital setting. The study found that the total costs associated with pregnancy, delivery, and postpartum care were comparable between home births and short-stay hospital births. The most significant cost differences between the two groups were related to maternity care assistance, hospitalisation, and travel expenses.[10]

In England, home birth rates remain relatively low. In 2015, home births accounted for just 2.3% of all births, declining further to 1.9% by 2022.[11,12] Among these, only 0.3% were among nulliparous women, while 1.6% were among multiparous women. A national prospective cohort study conducted in 2011, "Birthplace in England", investigated perinatal and maternal outcomes by planned place of birth for healthy women with low-risk pregnancies.[13] The study reported the following key findings: The overall incidence of adverse perinatal outcomes was low across all birth settings (both obstetric and non-obstetric units).For healthy multiparous women with low-risk pregnancies, there were no significant differences in adverse perinatal outcomes between planned births at home, in a midwifery unit, or in an obstetric unit. For healthy nulliparous women, however, the risk of adverse perinatal outcomes appeared to be higher for planned home births (Table 1). An analysis of transfer rates revealed that nulliparous women attempting home births were significantly more likely to be transferred to a hospital setting during labour or delivery (Table 2).

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Table 1 Neonatal outcomes (selected) based on planned place of births for nulliparous and multiparous low risk women in UK 2011 (Ref 13)

Neonatal outcome	Parity	Home n=16,553	Free standing Midwifery unit n=11,199	Midwifery unit alongside an Obstetric unit n=16,524	Obstetric Unit n=19,551
Primary outcome (n/1000)	Nulliparous	9.5*	4.5	4.4	3.5*
	Multiparous	2	2.2	2.5	2.6
Stillbirth (n/1000)	Nulliparous	0.9	0.3	0.1	0.1
	Multiparous	0.1	0.5	-	0.2
Early Neonatal death (n/1000)	Nulliparous	0.4	0.5	0.1	0.4
	Multiparous	0.3	0.3	0.1	0.1
Neonatal encephalopathy clinical (n/1000)	Nulliparous	3.8	2.3	2.5	2.2
	Multiparous	1.1	0.9	0.3	1.7
Meconium aspiration syndrome (n/1000)	Nulliparous	3.3	1.1	1.1	1.6
	Multiparous	0.6	0.7	1.5	1.4
Brachial plexus Injury (n/1000)	Nulliparous	0.6	0.2	0.5	0.8
	Multiparous	0.2	0.1	0.3	-
Neonatal unit admission (n/1000)	Nulliparous	28.5	21.6**	26	36.1**
	Multiparous	13.1***	12.2	13.6	19.2***

*adjusted odds ratio 2.8 (1.59-4.92)

** adjusted odds ratio 0.59 (0.37-0.94)

***adjusted odds ratio 0.67(0.46-0.98)

Table 2 Transfer rates (% of total) of women who attempted a home birth in UK 2011 (Ref 13)

Parity	Overall transfer	Pre delivery transfer	Post delivery transfer	Timing of transfer missing
Nulliparous (n=4568)	45%	35.10%	8.90%	1.00%
Multiparous (n= 12256)	12.00%	6.40%	5.20%	0.40%
All women	21.00%	14.20%	6.20%	0.60%

Although the home birth rate in the Netherlands is approximately 16.3% other high-income countries report home birth rates substantially below this level.[9] The pronounced difference, particularly between the Netherlands and other European Union countries with comparable demographics, topography, and cultural characteristics, can be attributed to the concerted efforts of the Dutch government and medical community in engaging with their maternal population. These efforts have enabled the development of well-structured, distinct and safe tiered maternity care pathways that support informed decision-making and promote safe home birth practices.

The percentage of home births in the United States increased from 0.93% in 2016 to 1.61% in 2024. In 2024 alone, there were 52,183 home births, of these 47,045 were intended home births.[14] This rise is largely attributed to concerns arising from the COVID-19 pandemic, particularly regarding the perceived safety of hospital environments. Many women in the US began to view hospitals as less satisfactory settings for childbirth due to the increased likelihood of procedural interventions and concerns about potential threats to their psychological well-being.[15,16]

The most recent Committee Opinion from the American College of Obstetricians and Gynecologists (ACOG) states that "hospitals and accredited birth centers are the safest settings for birth".[17] However, this stance, based primarily on birth certificate data, has been challenged by a community-based study using two large birth registry datasets. The study provided contrasting evidence, concluding that planned home births in the United States have outcomes comparable to planned birth center births for low-risk birthing individuals.[18]

The primary outcome was a composite of perinatal mortality and specific neonatal morbidities: stillbirth after the start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus, and fractured clavicle.

Home birth trends in Australia

According to the first Australian population based retrospective study, the home birth rate in Australia was 0.7% over a 12-year period from 2000 to 2012.[19] The study concluded that for healthy women experiencing uncomplicated pregnancies, planned births either at home or in birth centres were associated with positive maternal outcomes. However, due to the relatively low number of home births during the study period, definitive conclusions about perinatal mortality could not be drawn. The rate of home births across Australia range from 0.1% of births in New South Wales to 0.6% in the Northern Territory.[20]

As of the latest available data, home births remain a relatively uncommon choice among expectant mothers in Victoria, Australia. In 2020, a total of 421 home births were recorded in the state, representing approximately 0.4% of all births. This included 108 births under public maternity services and 313 attended by privately practicing midwives.[21]

A retrospective analysis of clinical outcome data from a large metropolitan health service in Victoria found a home birth incidence of 0.3%. The study concluded that a publicly funded home birth

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program, when governed by appropriate clinical guidelines, appears to be a safe option for women with low-risk pregnancies.[22]

However, women's choices to give birth at home are not fully supported in Australia due to several systemic barriers, including limited funding for home birth services, a lack of professional indemnity insurance for private midwives and an insufficient number of qualified midwives to meet rising demand. As a result, there has been a concerning increase in "freebirths", births attended by unregulated birth workers or without any trained healthcare professional present. Motivating factors for choosing unassisted or unregulated births include previous negative experiences with maternity care providers, rigid healthcare systems and limited access to publicly funded home birth options or affordable private midwifery care.[23]

Home births: empowering women or endangering newborns? a critical review

The studies reviewed are outlined in Table 3. A systematic literature review was not undertaken and representative studies (mainly systematic reviews) were summarised in a narrative style with the emphasis on studies from high income countries. Articles that were termed to be reviews and systematic reviews under the search terms "home births perinatal outcome" and "planned place of birth perinatal outcomes"were retrieved from the pubmed database. Of the 91 and 28 respectively articles retrieved there were 5 used for this review after exclusion of articles that focused on low and middle income countries, duplicate and updated literature analyses and articles not focused on home births. Additional articles from defined regions and opinion pieces were also included.

Table 3 Summary of key studies on planned home birth vs. hospital birth

Study/Year	Country/Setting	Population	Maternal outcomes	Neonatal outcomes	Notes/Limitations
Literature Review /2016[24]	7 studies with cohorts more than 5000	General home birth literature	Improved obstetric outcomes at home (less intervention)	Higher neonatal risk, especially for first births	Authors recommend hybrid models (home-like environment + hospital safety)
Systematic review/2026[30]	International. High income countries published since 2004	Planned home or FMU births vs Obstetric unit births	Home births and FMU births had fewer maternal ICU admissions (AOR 0.41, 95%CI 0.19–0.89), fewer severe perineal tears (AOR 0.64, 95% CI 0.45–0.93), lower intrapartum CS rates (AOR 0.29, 95% CI 0.26–0.33).	Increased peri/neonatal mortality (OR 1.70, 95% CI 1.05–2.74) noted for home and FMU births	Transfers occurred in 9%–33% of births.
Systematic Review & Meta-analysis /2018[25]	High-income countries	Low-risk pregnancies	Planned hospital births had lower chance of vaginal birth	No significant difference in infant mortality, but insufficient power for rare outcomes	High heterogeneity, inconclusive for guidelines
Systematic Review & Meta-analysis / 2019[26]	International studies	Planned home vs. hospital, low-risk	No excess maternal risk	Perinatal or neonatal mortality. Nulliparous integrated system: OR 1.07 (95% CI, 0.70–1.65); Non-integrated system: OR 3.17 (95% CI, 0.73–13.76). Multiparous, integrated system: OR 1.08 (95% CI, 0.84–1.38); Non-integrated system: OR 1.58 (95% CI, 0.50–5.03)	Integration of midwifery into healthcare system crucial for safety
Observational Study /2016–2018[27]	Catalonia, Spain	Low-risk women, home vs hospital delivery	More favorable maternal outcomes at home (less lithotomy, epidurals, episiotomies)	Limited data: No differences in neonatal outcomes	Selection bias possible (differences between women choosing home vs. hospital)
Meta-analysis /2010[28]	International - developed Western nations	Planned home vs. hospital	Fewer interventions at home	Neonatal mortality unplanned home births 0.15% v 0,04% in planned hospital births OR 2.87 (1.32-6.25)	Early influential meta-analysis, widely cited
Birthplace in England Study /2011[13]	England	Low-risk women	Maternal adverse outcomes low in all settings	Home birth ↑ risk of adverse perinatal outcomes (OR 1.59; 95% CI, 1.01–2.52) for women without complications at onset labor	High-quality prospective data
CDC Dataset Study /2006–2009[29]	United States	Planned home vs. hospital	Not main focus	Home birth associated with higher neonatal mortality: total (1.26‰ vs 0.32‰), early neonatal (0.93‰ vs 0.14‰); especially higher in nulliparous (2.19‰ vs 0.33‰)	Strong U.S. dataset, shows marked risk for first-time mothers

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Table 3 Continued...

Nationwide cohort study/2014[32]	Netherlands	Planned home v planned hospital births Perinatal mortality and morbidity up to 28d.	Intrapartum or neonatal death - nulliparous women, 1.02‰ for planned home births versus 1.09‰ for planned hospital births, (aOR) 0.99, (95% CI) 0.79-1.24; and for parous women, 0.59‰ versus 0.58‰, aOR 1.16, 95% CI 0.87-1.55. NICU nulliparous admissions up to 28 days, 3.41‰ versus 3.61‰, aOR 1.05, 95% CI 0.92-1.18). Among parous women NICU admissions up to 28 days, 1.36 versus 1.95‰, aOR 0.79, 95% CI 0.66-0.93).	Results may only apply to regions where home births are well integrated into the maternity care system.

NICU, neonatal intensive care unit; ICU, intensive care unit; CS, caesarean section; 95%CI, 95% confidence interval; OR, odds ratio; AOR, adjusted odds ratio; CDC, centres for disease control; FMU, freestanding midwifery unit

Due to the paucity of data regarding home births, it is challenging to determine the maternal, fetal, economic, cultural, and social factors that are important to the success or failure of home births. A literature review on home births conducted in Belgium concluded that giving birth at home is associated with improved obstetric outcomes but presents a higher risk to the baby, particularly for first-time births. To mitigate the increased neonatal risks while preserving the obstetric benefits, the authors recommended creating a system that blends the reassuring, home-like environment with the safety and medical support of a hospital setting.[24]

A systematic review and meta-analysis published in 2018 assessed maternal and perinatal outcomes based on planned place of birth among low-risk pregnancies in high-income countries. The analysis found no statistically significant differences in infant mortality between planned home and planned hospital births. However, the authors emphasized that most included studies lacked adequate statistical power to detect rare but critical outcomes, such as perinatal death. Furthermore, heterogeneity in study settings, healthcare systems, methodological quality, and outcome definitions introduced substantial variability.[25] As a result, the review did not yield conclusive evidence to inform clinical guidelines or support definitive recommendations regarding the safety of home versus hospital birth for low-risk women.

A comprehensive systematic review and meta-analysis conducted in Ontario in 2018 examined the risk of perinatal and neonatal mortality among women who planned to give birth at home at the onset of labor, compared with low-risk women who intended to deliver in a hospital setting. The analysis focused on deaths occurring after the onset of labor. For first-time mothers (nulliparous women) in regions where midwifery-led home birth services were well-integrated into the broader healthcare system, the odds of perinatal or neonatal death were nearly equivalent to those planning hospital births, with an odds ratio (OR) of 1.07 (95% Confidence Interval [CI], 0.70–1.65). However, in regions with less integrated midwifery systems, the risk appeared elevated, with an OR of 3.17 (95% CI, 0.73–13.76), though the wide confidence interval reflects uncertainty(non-significance) in the estimate. Among women who had previously given birth (multiparous women), the odds of mortality in well-integrated settings were similarly low (OR 1.08; 95% CI, 0.84–1.38), while in less integrated environments, the odds increased to 1.58 (95% CI, 0.50–5.03) but not significantly elevated.[26] These findings suggest that the safety of planned home birth may be influenced by the degree to which home birth services are embedded within a robust, responsive healthcare system.

A population-based observational study conducted in Spain between 2016 and 2018 explored the outcomes of planned home births overseen by midwives versus hospital deliveries among women classified as low risk. The analysis indicated that women giving birth at home experienced more favorable maternal and perinatal outcomes than their counterparts in hospital settings. The superior results associated with home births were attributed, in part, to the avoidance of routine interventions commonly used in hospitals, such as delivering in the lithotomy position, frequent administration of epidural analgesia (which necessitates continuous fetal monitoring) increased episiotomy rates and limited access to non-pharmacological pain relief techniques.[27]

Despite these findings for maternal outcomes, the study offered limited insight into neonatal safety. The neonatal metrics assessed; namely neonatal intensive care unit (NICU) admissions and 5-minute Apgar scores below 7 were infrequent, which may reflect a moderate effect size and restrict the statistical power to draw firm conclusions. Furthermore, the substantial demographic and clinical differences between women opting for home births and those choosing hospital deliveries complicate direct comparisons and may introduce selection bias.

A meta-analysis published in 2010 evaluating maternal and neonatal safety in planned home versus planned hospital births concluded that the reduced use of medical interventions in planned home births was associated with a threefold increase in neonatal mortality rates.[28]

The Birthplace in England national prospective cohort study which is published in 2011, emphasized that the incidence of adverse perinatal events such as stillbirth after start of care in labour, hypoxic ischemic encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus or clavicle in women with low-risk pregnancies was low in every childbirth setting. However, the composite risk was comparatively higher in home births compared to hospital births odds ratio (OR), 1.59; 95% confidence interval (CI), 1.01–2.52).[13]

A study using data from the CDC-linked birth and infant death dataset in the United States (2006–2009) found that home births were associated with a significantly higher rate of total neonatal mortality (1.26 per 1,000 births vs. 0.32 per 1,000; $P < .001$) and a sevenfold increase in early neonatal mortality (0.93‰ vs. 0.14‰; $P < .001$) compared to hospital births. These risks were even more pronounced among first-time mothers, with total neonatal mortality rising to 2.19‰ versus 0.33‰ ($P < .001$), and early neonatal mortality reaching

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1.82‰ compared to 0.13‰ ($P < .001$). Furthermore, home births were associated with higher rates of serious neonatal complications, including a 5-minute Apgar score of 0, convulsive seizures, and hypoxic-ischemic encephalopathy (HIE). The study concluded that home birth carries a significantly increased risk of total and early neonatal mortality, especially among first-time mothers and those delivering at or beyond 41 weeks' gestation. It recommended that these findings be clearly communicated to women in the United States considering home birth, to support fully informed decision-making.[29]

A recently published systematic review only studied publications since 2004 from high income countries and found reduced maternal ICU admissions, intrapartum Caesarean sections and severe perineal tears but increase perinatal/neonatal mortality (OR 1.7 (1.05-2.74).[30]

The increase in perinatal mortality is complicated by risk selection, system integration, professional qualifications, and emergency transfer arrangements that are not consistent through all studies.

The current literature indicates that planned home births attended by qualified midwives are associated with fewer maternal interventions and complications in low-risk women, evidence supporting comparable neonatal outcomes remains lacking. Childbirth must be viewed through the dual lens of maternal and neonatal well-being, as many obstetric interventions are prompted by concerns for fetal health. If maternal safety alone were the primary concern, low-risk deliveries could reasonably occur outside hospital settings. However, the unpredictability of fetal compromise underscores the need for immediate access to advanced neonatal care. To definitively establish the safety of home birth, high-quality studies free from bias and confounding issues, with adequate statistical power, are urgently needed. A summary of literature quoted is outlined in Table 3.

Recommended quality improvement measures to ensure home birth safety

A 2023 Cochrane review updating a 1998 publication on planned hospital versus planned home birth for low-risk pregnant women concluded that current evidence from randomized trials does not clearly show that planned hospital births reduce maternal or perinatal mortality or other critical outcomes. There were only 11 women included in the analysis therefore conclusions are difficult and this paucity of data emphasizes the lack of randomized controlled trials.[31]

A retrospective analysis conducted in Victoria, Australia, titled "Ten years of a publicly funded homebirth service in Victoria: Maternal and neonatal outcomes," concluded that outcomes for women enrolled in the publicly funded home birth program reflected effective triaging and appropriate case selection. The study found that, when supported by structured governance and clear clinical guidelines, publicly funded home birth programs represent a safe option for women with low-risk pregnancies.[22] While integrated, regulated systems such as these appear to ensure maternal and neonatal safety, concerns persist regarding home births attended by privately practicing midwives operating outside the formal healthcare system. The absence of standardized oversight, auditing, and integration into emergency services in such settings raises significant safety concerns.

A nationwide cohort study conducted in Netherlands in 2014, found that there was no increased risk of adverse perinatal outcomes for planned home births among low-risk women in the countries or regions where home births are well integrated into the maternity care system.[32]

In the state of Victoria, midwifery-led home births integrated into the public health system generally do not raise safety concerns. However, home births attended by privately practicing midwives present challenges. These births are often not registered with hospitals, and it remains unclear whether they are accurately reported to government authorities or correctly classified as home or hospital births. This lack of standardized reporting limits the ability to collect comprehensive data, assess adherence to clinical guidelines, and evaluate maternal and neonatal outcomes effectively.

Key proposals to enhance accountability and safety are suggested:

a. **Mandatory integration:** All home births, including those attended by privately practicing midwives, should be formally integrated into a healthcare system, whether affiliated with a public or private hospital, to ensure continuity of care and emergency support.

b. **Risk stratification and review:** Women intending to give birth at home should undergo formal risk assessment by a consultant obstetrician in collaboration with the attending private midwife at booking, with a follow-up review at 36 weeks. This ensures dynamic risk factors that emerge later in pregnancy are appropriately addressed.

c. **Standardized clinical guidelines:** A clear set of statewide clinical guidelines should be implemented, outlining strict inclusion and exclusion criteria for home birth eligibility. Compliance with these guidelines should be monitored through quarterly audits covering both process and outcome measures.

d. **Communication protocol during labor:** When labor begins in a home birth setting, the affiliated hospital must be notified. The private midwife should maintain ongoing communication with the hospital's maternity team, ensuring preparedness in case of escalation and fostering collaborative care.

e. **Informed refusal and documentation:** If a woman chooses to proceed with a home birth against clinical recommendations, comprehensive counselling with evidence must be provided by both the obstetrician and midwife. The woman should sign a formal document acknowledging the risks, which should be co-signed by both clinicians, ensuring medicolegal clarity and informed consent.

f. **Ongoing training and regulatory oversight:** Private midwives involved in home birth care should participate in regular, comprehensive training programs overseen by an appropriate regulatory body. These programs should focus on eligibility assessment, evidence-based intrapartum care, preparation for home births, timely recognition of complications, and efficient transfer to hospital when necessary. In addition, training must include structured communication strategies to ensure effective, timely, and respectful dialogue with hospital-based teams during antenatal planning, labor, and emergency transfers. Conflict resolution skills should also be incorporated, particularly for managing situations where disagreements arise between the midwife and the pregnant woman regarding clinical decisions, particularly in situations where clinical concerns arise that may compromise safety.

g. **Centralized Registration:** All home births must be formally registered with an affiliated hospital to ensure proper documentation, data collection, and the ability to evaluate maternal and neonatal outcomes across care settings.

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Establishing these measures will facilitate safer home birth practices and allow for comprehensive statewide monitoring, ultimately supporting informed choice while prioritizing the health of both mother and baby.

Discussion

Current advances in science and technology are aimed at increasing neonatal survival and reducing maternal morbidity and mortality. Slogans such as "Every mother and every baby counts" and "Every minute counts" are becoming increasingly prominent with each passing decade, underscoring the urgency of timely, quality maternal and neonatal care. While organizations like WHO and United Nations International Children's Emergency Fund strive to improve medical infrastructure in developing countries to ensure prompt access to health care and reduce perinatal morbidity and mortality, a contrasting trend is emerging in many high-income, developed nations.

Despite having well-established healthcare systems and standardized care, there is a growing movement toward home births. This shift is driven by a rightful desire to achieve a more natural childbirth experience and to uphold the mother's right to autonomy. However, this movement has, in some instances, been associated with increased maternal and neonatal morbidities, a reminder that every minute truly counts when complications arise and that access to immediate medical intervention can be critical to safeguarding lives and long-term well-being.

There are small-scale studies that suggest potential benefits of home births, such as lower Caesarean section rates and higher maternal satisfaction. However, these studies are not randomized controlled trials and therefore do not provide robust evidence to conclusively support the advantages of home births—particularly in a geographically vast and diverse country like Australia, where numerous barriers exist to establishing standardized and equitable maternity care.

When midwives, obstetricians, and neonatologists dedicate the majority of their professional lives to safeguarding the health and lives of mothers and their babies, it is disheartening to witness preventable maternal and neonatal suffering. Such outcomes sometimes stem from insufficient guidance and counselling provided to women requesting home births, inadequate risk stratification to assess their suitability for home birth, poor communication between home birth teams and healthcare institutions, lack of systematic auditing of home birth outcomes and limited involvement from governmental bodies in ensuring safety and accountability. These gaps highlight the urgent need for coordinated, evidence-based policies to support safe birthing practices for all women.

Moreover, it is imperative that women are well-informed that although a pregnancy may begin as low-risk, risk status is complex, dynamic, and can change rapidly. Timely medical intervention is often crucial to ensuring a safe birth for both mother and baby. While childbirth is indeed a physiological process, the assertion that it is inherently safe overlooks historical and contemporary evidence of maternal and neonatal deaths and severe morbidities. If birth were solely a natural, risk-free event, such outcomes would not continue to occur in both past and present contexts.

There is an urgent need to expand home birth options in Australia and to make mainstream maternity care more acceptable. Failure to take meaningful action may contribute to a potential rise in freebirths, an outcome associated with significant safety concerns.[33] Recent cases of adverse maternal and neonatal outcomes, with long-term implications observed within our geographical region, underscore the necessity for an immediate and comprehensive review of all home birth cases across the state of Victoria. This review should lead to the development of standardized guidelines accompanied by strict regulations to ensure adherence and safeguard maternal and neonatal health.

Conclusion

Finally, a critical question arises: Is Australia—characterized by low home birth rates (0.4%), vast geographical diversity, challenging rural terrains, and ongoing healthcare workforce shortages—prepared to support independent private midwifery-led home births with integration into a hospital system. This is the step ahead and should not be considered a step too far.

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Conflicts of interest

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