REFERRAL REFUSAL:
AN INVESTIGATION INTO THE REASONS FOR AUSTRALIAN GPS REFUSING REFERRAL TO PRIVATELY PRACTISING MIDWIVES

Homebirth Access Sydney

CONTENTS

INTRODUCTION

Upon realising they are pregnant, 90.1% of Australian women will first consult a General Practitioner (GP) with the remainder of women consulting an Obstetrician (OB), midwife (Adams et al., 2017) or seeking no consultation at all. This statistic suggests that Australian GPs are the gatekeepers to maternity care, being most commonly approached to connect women with their potential pregnancy care providers and inform them of their birthing options (Stevens et al., 2014). The most easily accessible and affordable maternity care available in Australia occurs via public hospital, where women are cared for by OBs and/or midwives (Adams et al., 2017). Australian women can also receive care from midwives through publicly funded birthing centres or homebirth programs, though these are restrictive and rare, or with Privately Practising Midwives (PPMs), though the Government funding and private health insurance rebates for this model are very low (Adams et al., 2017) and accordingly monetary cost to women is high.

Pregnancy and birth care options outside the hospital system are increasing in popularity (AIHW, 2018), in many instances due to less chance of birth interventions and therefore greater potential for bodily autonomy (Scarf et al., 2018). With 99.3% of all births in Australia taking place in a hospital or birthing centre, and 0.4% occurring prior to arrival at their chosen place of care, homebirths only account for approximately 0.3% of all births (AIHW, 2018). However, 74.3% of Australian women who choose homebirth for a subsequent pregnancy have previously given birth, many of these occurring in a hospital setting (AIHW, 2010). This high statistic raises the question, "Why are women seeking birth outside the hospital for subsequent pregnancies?" For many women, birth trauma received within a hospital setting is a factor (Holten et al., 2018), with 1/3 of Australian women reporting birth trauma (Boorman et al., 2014) and somewhere between 1/5 and 1/8 of women leaving birth with post traumatic stress disorder (Schwab, Marth and Bergant, 2012; Dekel, Stuebe and Dishy, 2017). Women report they birth outside the system in order to avoid hospital interventions, perceiving risk to be higher in the hospital than at home (Jackson et al., 2012; Jackson 2014). Furthermore, women who've chosen to birth at home after a previous hospital birth report that they experienced lack of autonomy during their hospital births leading to unwanted interventions, and were consequently seeking empowerment, self-education and awareness in their subsequent birth experience (Holten et al., 2018). So why do these women choose care with a PPM over other options?

Research supports that midwife-led continuity of care increases rates of spontaneous vaginal birth and reduces the use of regional analgesia, potential for preterm birth and foetal loss, improving maternal morbidity, neonatal mortality and women's satisfaction with their pregnancy and birth (Sandall et al., 2016). With the knowledge that only 8% of Australian women obtain continuity of care (Dawson et al., 2016), employing a PPM is one way to ensure this continuity. Beyond this, many women choose a PPM as they desire a care provider who shares the same childbirth philosophy, who understands the woman and her needs, and can offer a strong, trustworthy, genuine relationship at a time where she is particularly vulnerable (Davison et al., 2015). Despite the literature supporting midwife-led care as improving safety, patient satisfaction and maternal morbidity, the Australian Medical Association (AMA) state that, "Midwife-led care should not become the standard" (AMA, 2018). Furthermore, the Royal Australian College of General Practitioners (RACGP) note that their GPs recognise the importance of making informed choices and therefore can offer patients a tailored pregnancy experience, however only in adherence to the integrated pregnancy care model involving themselves and obstetricians alongside midwives (RACGP, 2018). Indeed, the medical community favour OBs and GPs over PPMs based on the perception that they provide 'adequate' pregnancy care that apparently PPMs cannot (Haertsch et al., 1998). Accordingly, the current Medicare Benefit Schedule (MBS) guidelines follow this recommendation, requiring that if women are to receive Medicare rebates for their antenatal and postnatal care with a PPM they must obtain a referral from their GP showing a collaborative agreement between the midwife and GP (DOH, 2013; RWH, 2018), though collaboration in the reverse (GP to midwife) is not mandated.

In 2014, Stevens and others reported that of 93 GPs surveyed in South Australia, 43% were not being notified of the periodic changes within the available models for pregnancy, birth and postnatal care. Given the majority of pregnant women seek information firstly from their GP, this indicates that women's access to knowledge of all available options when engaging their GP is somewhat up to chance. If GPs are unaware of the pregnancy, birth and postnatal care options available to women, and yet somehow a woman decides she wants to receive care from one of the minority options, her likelihood of obtaining a referral to this model of care is low. This is even more likely given the disdain held for the midwifery profession and the statements released by the AMA (2018) and RACGP (2018). It is important to note here that a GP referral to any model of care does not constitute endorsement of that model, but rather support for the woman's choice, referring on both care and responsibility to the referred party. Despite this, there have been multiple reports of women being refused a referral from their GP to seek antenatal and postnatal care with a PPM. Consequently, this study aims to determine how widespread this issue is, understand the main reasons provided for referral refusal, explore how GPs are interpreting the collaborative guidelines and report on the main impacts caused to women by GP referral refusal to PPMs in Australia.

METHODOLOGY

ONLINE SURVEY

To determine the lived experiences of PPM referral refusal by Australian women, we released a survey on September 18th, 2018 via Homebirth Access Sydney's social media channels, namely Facebook. The survey was directed towards Australian women who had experienced PPM referral refusal and consisted of the following questions:

1. Were you denied a referral to a Privately Practising Midwife by your GP?
2. When?
3. Suburb of where the GP is located
4. How long were you a patient of this practice/GP at the time of the referral refusal?
5. What were the reasons you were given for why your GP refused to refer you to a Privately Practising Midwife?
6. What were some of the impacts of the refusal to refer you to a Privately Practising Midwife?
7. What is your GP's/practice name and/or contact details?
8. Do you have any more information you would like to add?

INTERVIEWS AND EFFORTS FOR COLLABORATION WITH GPS

Based on the quantitative and qualitative observations obtained from the survey responses, we planned to conduct interviews with the GPs of the women surveyed. The interviews consisted of questions related to the GPs history with referring to PPMs as follows:

- What is your history with referring to PPMs?
- Why do you choose to refer/not refer to PPMs for antenatal and postnatal care?
- If you choose not to refer due to insurance limitations, who is your insurer?
- If you choose not to refer due to potential litigation, please describe that situation.
- If you are not comfortable referring, why?

Furthermore, we spoke with our own GPs to obtain information about their views on the referral refusal issue, most of who were known to refer their patients to PPMs as required.

RESULTS

SURVERY FINDINGS

Our survey remained open for 66 days, and during this time we received 57 responses. The primary reason provided to women by their GPs for refusing to refer to a PPM was that they favoured OB or GP led care (27%; Figure 1). This was followed by the GP believing care with a PPM to be unsafe (23%), their insurance would not cover them to refer to a PPM (20%) or they were bound by practice policy dictating they couldn't refer (9%; Figure 1). Of the remaining 21% of respondents, 13% said there were no midwives available, 4% said their GP wouldn't refer as they weren't confident in homebirth and 5% said they were unsure why their GP refused to refer (Figure 1).

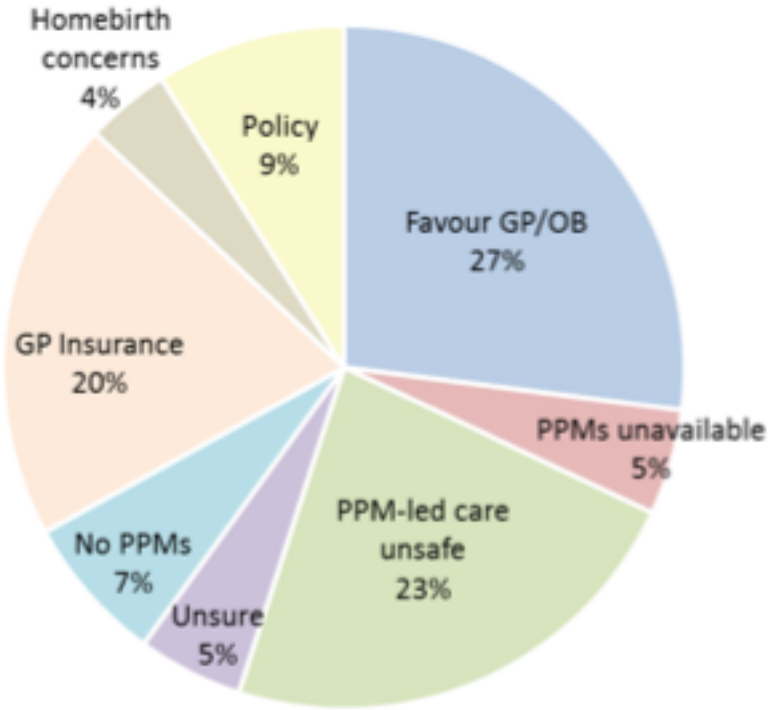

Figure 1: Reasons GPs refused to refer their patients to a Privately Practising Midwife.

Of the 57 responses received in the survey, 47 said they were refused a referral (82% of respondents) while only 10 said they gained a referral from their GP (18%; Figure 2). The majority of referral refusals occurred in NSW (18), Victoria (13) and Western Australia (8), with less occurring in Queensland (3), Tasmania (2), Australian Capital

Territory (1) and South Australia (1; Figure 3).

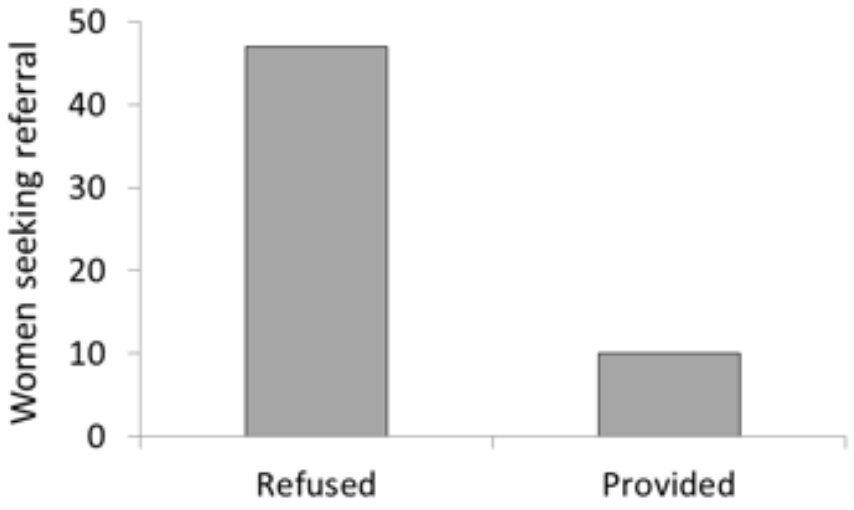

Figure 2: Number of women who were refused vs. provided referrals to a PPM after asking their GP.

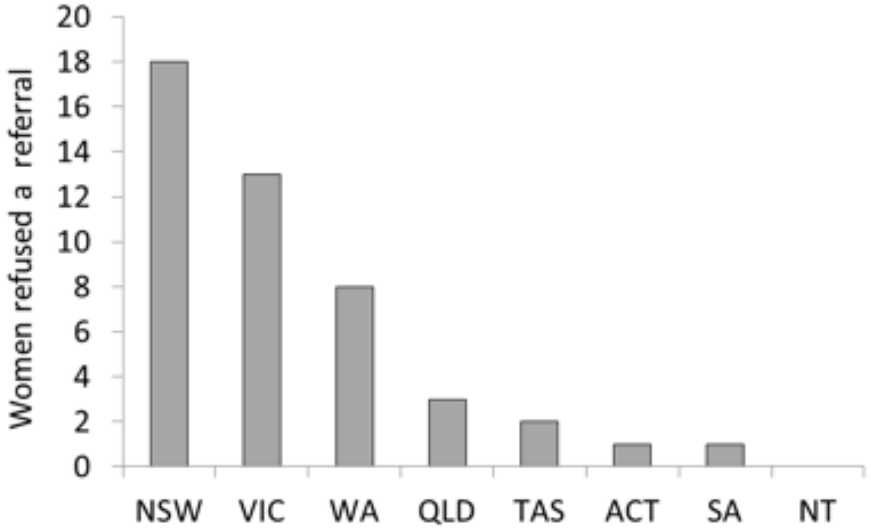

Figure 3: Number of women who were refused a referral to a PPM in each state.

Finally, 50% of the women who responded said they had been a client of their GP for 1-5 years, 21% for more than 5 years, 19% for less than one year and 10% said they were a new patient (Figure 4). Accordingly, the women being refused referrals, and having to seek referrals from other GPs, were overwhelmingly (71%) a patient of that GP for at least 1 year prior to asking and being refused a referral to a PPM (Figure 4). Of the 41 respondents who answered to the personal impact of the referral refusal, 44% said they "Felt emotional distress", 36% had to find a different GP to make the referral, 6.5% said they were unable to access a private midwife, 5% said they hired a midwife but couldn't claim any costs through Medicare, 4% said they were unable to have a homebirth and a final 4% said they decided to birth at home without a midwife in attendance.

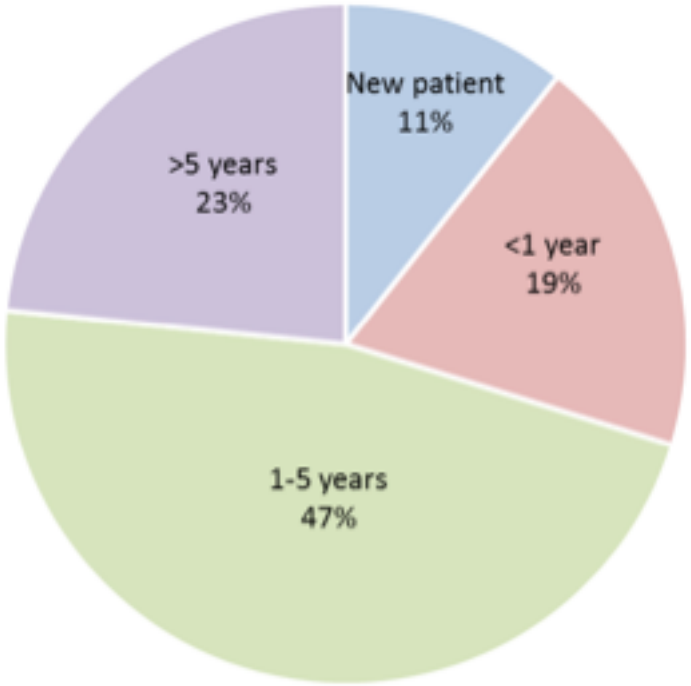

Figure 4: Length of time women had been patients of the GP who refused their referral to a PPM.

Respondents also had the opportunity to provide further details of the impact the referral refusal had on them in the 'other' text box. Some of the responses were as follows:

> **"I told this GP that unless there is a legitimate medical reason to intervene I will not feel safe going into hospital as my first experience was traumatic and resulted in PTSD that I am still accessing treatment for 3.5yrs later. I gave her many statistics and facts about the safety of HBAC/VBAC but felt unheard and dismissed."**
> -ID: 14334770

> **"Feel unable to go back to that clinic now even though I've gone there for years. Felt dismissed and judged."**
> -ID: 14335512

> **"I had to lie about my reason for referral."**
> -ID: 14335489

At the end of the survey respondents also had the opportunity to provide additional information. Some of these responses were as follows:

> "I stopped going to this GP immediately. She later sent me a letter to say our 'trust had been broken' and she did not want to see me as a patient anymore." -ID: 14337581

> "She spoke to me as if I'd asked her to do something illegal. It wasn't a positive way to begin my birth journey." -ID: 14341166

> "Every time I went in for other matters then pregnancy or before I found a midwife he constantly pushed me to see an OB to get checked even though I was having my 3rd baby and was having a very healthy pregnancy. Every apt was a fight that midwives know what they are doing and that I had zero intention of seeing an OB." -ID: 14349884

> "I asked if there was another GP within the clinic who would do the referral for me and I was told that there was not." -ID: 14335489

> "I know how important it is that women get these referrals. I had my baby unassisted at home… It was a half an hour labour. Very fast. It was really important that I had midwifery care - Continuity of care, with a midwife who knew my history. I was on the phone to her during my labour. She knew my concerns. She worked with me throughout the pregnancy. It was extremely frustrating - I felt strangled. I felt like I was suffocating. It was the care I needed, and not to be able to access it was frustrating." -Women X

GP INTERVIEW FINDINGS

Unfortunately, despite contacting many of the GP's that women had listed as not supporting their choice to obtain a referral to a PPM, these GPs either avoided our calls, did not return our calls or noted that they were unavailable for comment. Through discussing this situation with our own personal GP's who were known to refer, we obtained varied responses. Mostly, these responses included some combination of:

1. The Medicare Benefit Schedule guidelines are unclear, and so open to interpretation.
2. It is unclear whether these GP's insurers will cover them to refer to PPMs
3. It is a personal choice who a GP refers to, and if they don't feel comfortable referring to a PPM, they are not bound to do so, and
4. Fear of litigation if something were to go wrong during the care provided by a PPM. Despite a referral noting that antenatal and postnatal care would be provided by the PPM, in instances of investigation the GPs felt that they could be held accountable, as they are still considered the most qualified person to provide 'adequate' care (as noted earlier in the RACGP guidelines).

BULLYING TACTICS

Now let's get this straight: Aimee Sing, a 'consumer advocate,' is mobilising dozens of others to bully two highly competent female Mountains GPs to write referrals they don't want to write - and for good reason. But then maybe Ms Sing knows better?

We've done a bit of research. Ms Sing apparently had a planned home birth after a caesarean and is proud of that, as reported in the *Canberra City News* (https://citynews.com.au/2018/midwives-to-march-against-new-limits-on-home-birthing/).

She took enormous risks for herself and her baby, including a risk of dying that very likely was well over 1:100. The fact that she and her baby are still alive is beside the point. Russian roulette is also survived quite commonly.

And this person seriously thinks she knows better than Linda McQueen and Sarah Hornblow?

Hans Peter Dietz, Professor of Obstetrics and Gynaecology.
Susanne Langer, Research Midwife.

Figure 1: Published Repsonse by Doctor Hans Peter Dietz

A number of women had contacted HAS both directly and through the survey tool to advise us that a particular practice in the Blue Mountains had a policy limiting their GPs from referring to PPMs. We were aware that a local PPM had been trying to engage this practice for the past five months to provide an in-service, as many of her clients were being refused referrals, yet she had had no success. Consequently, we tried multiple times to contact this practice beginning on the 7th February, 2018 in a hope that we could collaborate with them and obtain further information about their understanding of collaborative arrangements with PPMs. Unfortunately our calls and emails were ignored or unreturned, we were provided erroneous email addresses and twelve emails from local women, including patients, were ignored despite being received. Once we addressed the issue with our local MP, who had personal contact inside the practice, we received an email from the practice manager explaining that they would not provide these referrals as their GPs did not have obstetric qualifications, don't have insurance to attend homebirths and accordingly can't provide referrals to women in case something goes wrong at the birth. Despite continued efforts to explain why this reasoning wasn't in line with current expectations, recommendations and guidelines, we were told they would contact their insurer. After a further five months of no contact, and in an effort to hold off local women from conducting a protest, an article was released in the Blue Mountains Gazette in which a HAS representative and GPs from the practice were able to provide input (BMG, 2018). This article received severe and personalised backlash from both the GPs at the local practice and a local OB/gynaecologist, beginning an onslaught of letters to the editor from local women and a GP. Unfortunately, the referral refusal with this practice remains, and any potential for collaboration with the practice is likely destroyed.

DECEMBER 14 2018 - 8:14AM

Mums-to-be miss out of midwife referral

B.C Lewis Local News

SHARE TWEET

A group of Mid Mountains mothers is furious that a local doctor's surgery is refusing to refer expectant mothers to midwifery services covered by Medicare.

Aimee Sing, a consumer advocate with Homebirth Access Sydney and part of the Blue Mountains homebirth community, claims Hazelbrook General Practice has been refusing to refer women to privately practising midwives (PPMs) for their Medicare rebatable antenatal and postnatal care for the past 15 months. At least 10 women have been affected.

A protest in Sydney in May this year: The Mothers for Midwives March was "protesting situations like the need for PPMs to get referrals from GPs" said Dr Sing, who is second left in the second row at the bottom. Photo: Jerusha Sutton Photography

Under Department of Health guidelines for privately practising midwives, a collaborative arrangement with a medical practitioner and a midwife requires a written referral.

"HGP has recently implemented a blanket policy which stipulates that GPs working within the practice are not allowed to provide referrals to women seeking the care of a PPM," Dr Sing said.

"This blanket policy is not evidence-based, does not provide personalised care, is discriminatory against PPMs and is limiting women's pregnancy, birth and postnatal care options," she said.

But the practice said there is some confusion over the referrals, leading to them being "targeted by a local home birth supporter" and "singled out for criticism by doula Aimee Sing".

"This criticism seems to come from a misunderstanding of the legislation. The Medicare initiative requires home birth midwives to forge meaningful relationships with other local obstetric services," Dr Sarah Horniblow said in a statement to the *Gazette*.

"The intention is to make home birth safe and well supported for our mothers and babies. We absolutely support this initiative."

And Dr Linda McQueen added "We're just not in a position to assist with those obstetric emergencies if things were to go wrong".

Dr Horniblow said they were not interested in providing "token referrals". The practice is encouraging their "obstetric colleagues at referral hospitals to enter into dialogue with the home birth midwives and to support safe collaboration".

But Dr Sing said there was no confusion. "The Department of Health note that eligible midwives can treat their own patients in collaboration with other maternity care providers including GPs, GP obstetricians and specialist obstetricians".

"Since GP referrals to PPMs only cover antenatal and postnatal care, they do not require any action by the GP during the referred woman's birth. Nowhere in any regulation, legislation or guideline does it state that the referring GP would be expected to attend a homebirth, or to provide obstetric or emergency care to a woman during her birth."

Dr Sing said they had made multiple attempts to contact the practice manager – through a local midwife, consumer advocates, clients of the practice, and they had even sought help from Blue Mountains MP, Trish Doyle's office.

The *Gazette* spoke to one mother who had two previous home births but was then refused a referral by the practice for a third. The mother said the clinic told her they were no longer able to give referrals "because our insurance doesn't cover it".

A spokeswoman from Ms Doyle's office said they were just trying to open up dialogue between the mothers and the clinic, but had to date not been successful. "We have an interest in making sure women have access to choices, they said they were trying to get clarification from their insurers."

Figure 1: Original Article in the Blue Mountains Gazette

DISCUSSION

WHY WOMEN ARE REFUSED GP REFERRALS TO OBTAIN CARE WITH A PPM

The reasons for GP referral refusal are mixed, however the top 3 reasons were that: a) the GP preferred pregnancy care to be undertaken by an OB or GP rather than a midwife, b) they believed care with a PPM to be unsafe, or c) they believed their insurance would not cover them to refer to a PPM (Figure 1). We discuss each of these topics separately.

a) GPs prefer pregnancy care to be undertaken by an OB or GP

Studies, policies and statements from various medical organisations have all supported the basis for this first finding, that GPs prefer pregnancy care to be undertaken by a GP or OB than a midwife. RACGP noted that pregnancy care can involve midwives, but only alongside OBs or GPs (RACGP, 2018), the AMA stated that "Midwife-led care should not become the standard" (AMA, 2018), and a study reported that the medical community favours OBs and GPs over PPMs for providing 'adequate' pregnancy care (Haertsch et al., 1998). Indeed, one of our GP interviews yielded that the GP believed that the medical community held greater respect for those in the 'medical profession', suggesting that midwives are always considered in these circles as being 'less than' other care professionals. This predisposition towards supporting OBs and GPs ahead of midwives has led to the Medicare guidelines that require women to obtain GP referrals to their PPM if they desire to obtain rebates for their care. Not only does this result in negative effects and experiences for women seeking referrals, but it also continues to degrade midwifery as a profession, removing the autonomy of midwives and further fuelling the belief that midwives are unable to provide autonomous, complete pregnancy care to women.

b) GPs believe care with a PPM to be unsafe

There are many studies supporting the safety of midwife-led continuity of antenatal, birth and postnatal care for mothers and babies (Sandall et al., 2016; Tracy et al., 2013; McLachlan et al., 2012). Despite these, there is still a deep-set belief that midwifery-led care is unsafe, and this is quite likely worsened by statements from organisations such as the AMA pushing women away from midwife-led care, and pushing GPs away from referring women to such care (AMA, 2018). It is becoming increasingly important that visible, highly regarded organisations like the AMA and RACGP provide statements and guidelines that are evidence-based rather than biased towards personal experiences, predilections and personal preferences. In the words of a GP who wrote in to the Blue Mountains Gazette in response to an article published on referral refusal (BMG, 2018), "GPs need to look at the evidence and re-think their traditional antipathy to women who choose the option of birthing at home." Beyond this, we believe this should extend to the midwives who provide women this option of care, and even further, to those who simply seek antenatal and postnatal care with a PPM.

c) The GPs insurance would not cover them to refer to a PPM

We are yet to be provided with the name of a single insurer who refuses to support GPs to provide referrals to women, perhaps because there is truly no desire to collaborate with us to sort through this issue. One of the main issues causing contention in this debate is whether birth at home is safe, but the referrals being provided to women seeking care with PPMs are ONLY for antenatal and postnatal care. Accordingly, GP referrals do not cover the intrapartum care provided by a PPM to the women, and accordingly they do not indicate an endorsement for homebirth by the referring GP. This is an aspect that was raised multiple times with the Blue Mountains GP practice when discussing this issue, as one of their main concerns was that their GPs were unable to provide intrapartum, obstetric care to women, despite this care not ever being assumed or expected. Nowhere in any guideline is it inferred that a referring GP would be expected to provide intrapartum care to a woman. It is extremely important that this aspect of referral is made clear to referring GPs as any concern around homebirth complicates the referral process and reduces the likelihood of referral. Furthermore, the guidelines within the regulatory documents (e.g. DOH, 2013) need to be clarified so that GPs can feel confident that they aren't precluded from referring to PPMs if they desire, and so that they are aware that they are only referring for antenatal and postnatal care.

HOW WIDESPREAD IS GP REFERRAL REFUSAL IN AUSTRALIA?

GP referral refusal occurs Australia wide, with the largest number of refusals occurring in New South Wales (18), Victoria (13) and Western Australia (8; Figure 3). Large discrepancies were observed between states, and while part of this may have been due to increased survey infiltration in states nearer to our organisation (HAS is based in Sydney, NSW), it is more likely explained by differences in collaboration observed between states. We were made aware that many of the PPMs in Queensland and South Australia have collaborative agreements set up with local OBs, so women seeking care with these particular PPMs don't have to ask for a referral. The lack of survey responses from the Northern Territory is because there are no PPMs able to work in the Northern Territory due to the current political climate. The only way midwifery care at home can be received is through the hospital, thus women don't seek referrals from their GPs or OBs.

HOW DOES GP REFERRAL REFUSAL IMPACT WOMEN?

Given 50% of respondents had been a patient of their GP for at least 1 year prior to being refused a referral (Figure 4), and the majority of these women expressed they felt emotional distress and/or had to find an alternative GP to make the referral, this suggests a breakdown of relationship with one of their main care providers. If the woman was one of the many who received a referral from a different GP, it is questionable whether this promotes safety for women and babies given all of the collaborative information throughout the woman's pregnancy, birth and postpartum would be forwarded to a GP who otherwise has no knowledge of the woman's medical history. From a safety standpoint based on continuity of care alone, it is arguable that regardless of the GP's stance towards PPMs, they should refer their patient to whoever the woman desires so that they can continue to provide that woman and her baby care. One woman surveyed noted she addressed the GPs concerns directly, yet they were unwilling to discuss the situation. Another noted that she lied to her GP in order to obtain the referral, which does not show mutual collaboration, decreasing safety further.

The majority of women noted that the largest impact they experienced from referral refusal was one of emotional distress, but further, some women responded that they were unable to obtain care from a PPM. There is evidence to suggest that freebirth is becoming more common in Australia than it once was (Newman, 2008; Dahlen et al., 2011). Oftentimes women birthing outside the system is attributed to a general dissatisfaction with the birthing options offered (Dahlen et al., 2011) as well as the perception that hospital actually presents more risk to the mother and baby than does birthing at home (Jackson et al., 2012; Jackson, 2014). In these instances, a mother who is experiencing emotional distress at the beginning of their pregnancy journey, and is being told they will not obtain a referral to their chosen care provider, who they believe presents less risk than hospital, may choose the option to freebirth and seek no antenatal and postnatal care at all. Indeed, 4% of the women surveyed noted that they chose to freebirth after being refused a referral from their GP. While there is little research on the impacts of pregnancy, birth and postpartum without medical care, informed women who choose this from a place of empowerment are almost certainly more likely to have better outcomes than those who are forced to due to lack of acceptable birthing options (Turton, 2007).

It is not only GP referral refusal that limits accessibility to pregnancy and postnatal care options in Australia, 5% of women surveyed reported they were unable to access a PPM. There are fewer PPMs available due to an ever decreasing pool of practising PPMs, restrictions in the areas they cover, in part due to the requirement of a second midwife attending all homebirths (NMBA, 2017), restrictions in the women PPMs are able to support due to ever tightening guidelines and regulations (ACM, 2014) and fear of litigation and/or reporting, and further, PPMs are inundated with paperwork, with regular audits being undertaken. While decreasing access to PPMs may not seem like an issue, survey respondents detailed the various ways this affected them, with one respondent noting they felt 'strangled' by the limitations on access to PPM care that they had experienced.

HOW DO GPS INTERPRET THE COLLABORATIVE GUIDELINES? ARE THESE PART OF THE ISSUE WITH REFERRAL REFUSAL?

A large part of this project was hinged on the ability to interview and speak with GPs who had chosen to refuse referrals to women, but unfortunately none of these would speak with us. The only contact with any GP refusing referral that we received was unnecessarily negative. Based on this encounter and the few GPs interviewed who do choose to refer to PPMs, we report that it is a combination of fear of litigation, lack of clarity in referral guidelines and lack of transparency with governing bodies and insurers that is driving GPs to refuse PPM referrals to women.

CONCLUSION

GP referral refusal impacts women Australia-wide with most women being refused due to GPs preferring pregnancy care with a GP/OB, GPs believing midwife-led care to be unsafe, or GPs being in fear of litigation and/or lack of insurance coverage. We suggest that clarification in guidelines for GPs, transparency from insurers, further information provided to GPs on the benefits of midwife-led continuity of care, and building collaborative PPM-GP relationships may alleviate some of the referral refusal observed in this study. We believe that the information provided here, including the negative emotional impacts being sustained by women and the potential for them to choose not to seek antenatal and/or post-natal care at all, warrant further investigation. We hope that these sorts of investigations will contribute to changes in thinking, policies and guidelines, with the potential to positively affect Australian women's pregnancy care options and thus, women and babies safety.

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