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1 # Birthing in regional Australia: Women's decision making surrounding
2 # birthplace

3 **Alexa Seal, Emma Hoban, Annette Panzera and Joe McGirr**

4 **Abstract**

5 Objective: Although there is some research on women's choice of birthplace, most of this research
6 has been conducted overseas. This study explored factors influencing the decision to use public or
7 private maternity services within regional Australia.
8 Methods: This cross-sectional study consists of a community-based, anonymous, online
9 questionnaire focussed on factors influencing a woman's choice of birth location and included adult
10 females who had given birth in the past 2 years within two regional areas. Descriptive statistics were
11 used to analyse demographic characteristics and factors influencing decisions regarding birthplace.
12 Pearson's Chi-squared test was used to compare public and private births for multiple variables.
13 Binary logistic regression was used to determine the odds ratio (OR) for each potential factor based
14 on whether participants with private health insurance (PHI) elected to birth in the public or private
15 regional hospitals. Open coding was used to group responses to open ended questions into themes.
16 Results: Data from 510 questionnaires were analysed. The three most frequently reported factors
17 influencing in a woman's decision about birthplace were financial reasons, the ability to choose their
18 doctor and not having PHI. Women with PHI who opted for birth in the public system were almost
19 four-fold more likely to select access to intensive care services and 2.6-fold more likely to select
20 preference for a low-intervention birth as one of their top five most influential factors. The results
21 highlight that women want access to midwifery continuity of care.
22 Conclusions: This study provides insights into the factors influencing a woman's complex decision
23 about where and with whom to birth and how health insurance affects that decision, an area where
24 there is a paucity of peer-reviewed literature. This research highlights the importance of being able to
25 choose one's doctor and the desire for access to midwife-led models of care, and provides evidence
26 to advocate for improved access to additional models of care in the private sector.
27

28 Key words: birthplace, continuity of care, maternity choices, model of care, private health insurance
29

30 **Key question summary**

31

32 **What is already known?** The viability of regional private maternity hospitals is in question because
33 once the birth rate goes below a certain threshold, providing private obstetric service becomes
34 unviable. Closure of regional private hospitals means less choice in regional areas. Minimal
35 information is available about the factors influencing a woman with PHI to give birth in the public
36 system, and much of the evidence is anecdotal.

37

38 **What does this paper add?** This study provides insight into how PHI status and other factors
39 influence a woman's decision to birth in the public versus private sector, an area where there is a
40 paucity of peer-reviewed literature. It also highlights a desire from women for access to midwifery
41 continuity of care in the private system.

42

43 **What are the implications for practitioners?** This research provides evidence to advocate for
44 improved access to additional models of care, especially for midwifery-led care in the private sector.

45

46 **Introduction**

47 A woman's decision about where she will birth and her preferred model of care is based on a complex
48 web of factors including socio-economic characteristics, attitudes towards childbirth, experiences and
49 preferences of family and friends with the healthcare system and the availability of healthcare
50 services.[1]

51 Although Australia has a universal public healthcare scheme (Medicare) providing access to
52 medical services, public hospitals and medicines for little to no cost,[2] citizens also have the choice of
53 purchasing additional private health insurance (PHI) which covers a proportion of the cost of
54 treatment in a public or private hospital with options to include cover for non-medical health
55 services.[2,3] Private obstetric services are not included in all PHI policies and many feature a 12-
56 month waiting period before pregnancy-related expenses can be claimed. Thus, many women face
57 barriers such as financial constraints and lack of pre-planning that prevent them from considering
58 private maternity care.

59 Australia has several models of maternity care and their availability is somewhat dependent
60 on whether the birth will occur within the public or private system (Table 1). In Australia, general
61 practitioners (GPs) are often the first point of contact for referral to maternity care. Stevens *et al.*[4]
62 conducted an Australian study on the breadth of maternity models of care that were discussed during
63 initial pregnancy consultations between GPs and pregnant women and found that around 27% of
64 women were only presented with a single model of maternity care during their initial consultation and
65 around 8% were presented with all available models of care. There were low rates of discussion for
66 midwifery-led models of care, especially in women aged ≥35 years and "women's health insurance
67 status was the strongest predictor of the presence of discussion about each model".[4] Women with
68 PHI were 17-fold more likely to receive information about private obstetric services, with significantly
69 lower odds of discussion about GP shared care, standard public care and midwifery-led care.[4]

70 There is a trend towards a reduction in the use of private maternity services in Australia. In
71 2003, 31% of babies were born in private hospitals[5], whereas in 2011 29% of births occurred in
72 private hospitals.[6] By 2018, only 25% of babies were born in private hospitals.[7] In 2011-12,
73 approximately 55% of the region's babies were born at Wagga Wagga Base Hospital, with the
74 remaining 45% born at Calvary Riverina Hospital, the private hospital. Currently, only 20-25% of
75 babies are born at Calvary Riverina Hospital.[8]

76 There has also been a decline in the number of births in regional areas. In 2012, 77,573
77 births occurred in inner and outer regional areas, decreasing to 73,187 in 2019.[9] Providing obstetric
78 services in private maternity hospitals becomes unviable below a certain threshold. The closure of
79 such regional private hospitals means less choice in regional areas. Private hospitals also play an
80 important support role for public hospitals helping to meet community demand for services.[10] Closure
81 of regional private maternity services would increase the demand experienced by regional public
82 hospitals and may contribute to situations where local public services are unable to meet maternity
83 demand.[11] According to King[12], "24% of people with PHI chose not to be treated as a private patient
84 on their most recent visit". Little is known about the reasons for the trend towards reduced used of
85 private maternity services. Minimal information is available about the factors that influence a woman
86 with PHI to give birth in the public system, and much of the evidence is anecdotal.
87 Although there is some research on women's choice of birthplace, most of this research has
88 been conducted overseas where there are inherent differences in healthcare systems.[13,14] This aim of
89 this study was to explore factors influencing the decision to use public or private services for childbirth
90 within regional Australia, specifically within Wagga Wagga (NSW) and Ballarat (VIC) where patients
91 have the choice between public and private hospitals. In both study regions, the public hospital offers
92 shared maternity care (i.e. GP antenatal shared care), forms of midwifery-led care and the option of
93 using a private obstetrician in the public system. In the private hospitals, referral is solely by
94 obstetrician as there are no private midwives with admitting rights to either private regional hospital.
95

96 **Methods**

97 This cross-sectional study focussed on a purposely designed community-based, anonymous, online
98 questionnaire about factors influencing a woman's decision on whether to birth in a publicly-funded or
99 privately-funded facility. The survey consisted of tick-box demographic questions plus a ranking
100 question and open-ended questions about potential factors influencing the choice of birth location,
101 including the roles of models of care and cost. For the ranking question, women were asked to rank
102 the five factors (out of 20) that most influenced their decision surrounding birthplace with scope to
103 include a free-text 'other' choice. Open-ended questions focussed on women's preferred type of care
104 (ie mainly midwife or mainly doctor led) and on factors affecting their decision to birth in the public
105 versus private system.

106 To be eligible for inclusion in the study women had to be aged ≥18 years and to have given birth in
107 the last two years within the Wagga Wagga region. Participants were recruited by posting the Survey
108 Monkey link on relevant mother and baby-related Wagga Wagga-focussed Facebook pages (ie the
109 “Wagga Mums” Facebook page). Prior to accessing the survey questions, women were presented
110 with a participant information sheet detailing the study and providing contact details. Consent was
111 implied by ticking that they had read the participant information sheet and proceeding to the survey
112 questions. The link remained open for four weeks. Participants were sent an electronic supermarket
113 voucher (funded by Catholic Health Australia) to the email address they nominated to thank them for
114 participating. This same method was then used to survey new mothers from Ballarat, by posting the
115 link on relevant mother and baby-related Ballarate-specific Facebook pages. A new base hospital
116 was opened in Wagga Wagga in January 2016, which was included as a potential factor influencing
117 choice of birthplace in Wagga Wagga. However, this option was not relevant to Ballarat and was
118 removed from the list of possible factors in the Ballarat survey.
119 Descriptive statistics were used to analyse responses to questions about demographic
120 characteristics and factors influencing their decision regarding birthplace. Participants who did not
121 answer questions beyond the demographic section were excluded from the study. Pearson’s chi-
122 square test (Fisher’s Exact Test if cell numbers were low) was used to compare public and private
123 births for multiple variables. One-way analysis of variance was used to compare ages between the
124 groups. Univariate binary logistic regression was used to determine the odds ratio (OR) and 95%
125 confidence intervals (CI) for each potential factor based on whether participants with PHI elected to
126 birth in the public or private regional hospitals. Two researchers reviewed the responses to the open-
127 ended questions and grouped responses into themes (open coding). Unless indicated otherwise,
128 data are given as the mean +/- standard deviation. Ethics approval for this project was granted by
129 The University of Notre Dame Australia Human Research Ethics Committee (018132S).
130
131 **Results**
132 Approximately 1250 babies are born each year in Wagga Wagga and around 1350 in Ballarat and this
133 survey aimed to recruit around 10% of the women who had birthed within the region during the 2-year
134 study period. Of the 224 responses from Wagga Wagga and 340 from Ballarat, 24 surveys from
135 Wagga Wagga and 30 from Ballarat were repeat submissions or non-genuine participants (i.e.

136 reported birthing in metropolitan regions) and were excluded. Thus, data from 510 questionnaires
137 were analysed. Participants ranged in age from 18-47 years [mean age=29.5 years (SD5.0)]. Wagga
138 Wagga respondents were younger than Ballarat respondents [28.6 (SD5.2) versus 30.0 (SD4.8)
139 years, p=0.004] (Table 2). For 51.7% of participants, this was their first birth and 95.3% of women
140 were Australian-born with no difference between regions.

141 Women ticked five factors that had the greatest influence on their decision about whether to
142 birth in the public or private system. The three factors with the highest frequencies were financial
143 reasons (cost of obstetrician) (46.6%), the ability to choose your doctor (39.0%) and no PHI (37.6%)
144 (Figure 1).

145 Overall, 57.3% of all respondents reported that they had no PHI, whereas 17.2% had PHI but
146 opted for a public hospital birth, and 25.5% of respondents had PHI and had birthed in the private
147 hospital. There were differences in the PHI status of participants between towns. Wagga Wagga had
148 a greater proportion of participants with PHI who chose to birth in the public hospital (23.7% versus
149 13.0% in Ballarat, p=0.003). The mean age for participants without PHI was 28.2 years (SD5.4),
150 which was younger than participants with PHI who opted to birth in the public [30.4 years (SD4.2)] or
151 private [31.6 years (SD3.6)] hospitals (p=0.001 for both).

152 More than 80% of women with PHI who opted for a private hospital birth indicated that the
153 option of a private room (83.2%) and the ability to choose their doctor (94.4%) were key factors
154 influencing their decision about birthplace. More than 60% highlighted the option of a longer stay in
155 hospital as a key factor. Similarly, for women with PHI who opted to birth in the public system (did not
156 use their PHI), the most frequently cited key factors included the option of a private room (51.2%) and
157 the ability to choose their doctor (42.7%). However, the most frequently cited factor (57.3%) in this
158 group was related to financial reasons (cost of obstetrician). The most frequently cited factors for
159 women without PHI (birthed within the public system) were no PHI (66.9%), financial reasons (cost of
160 obstetrician) (65.9%), and cost of tests and health facility (44.7%). None of the five most cited factors
161 for public patients were ranked as key factors for women who birthed within the private system
162 (Figure 2).

163 When only women with PHI were analysed, those who opted for a private hospital birth were
164 22.6-fold (95%CI 9.4-54.5) more likely to rank the ability to choose their doctor (p<0.001) and 4.7-fold
165 (95%CI 2.5-8.9) more likely to rank the option of a private room (p<0.001) as key factors influencing

166 their decision on birthplace. They were also 2.8-fold (95%CI 1.4-5.8) more likely to rank familiarity
167 with the facility staff (p=0.004), 20.3-fold (95%CI 8.2-50.3) more likely to rank the option of a longer
168 stay in hospital (p<0.001) and 3.5-fold (95%CI 1.9-6.5) more likely to rank continuity of care (p<0.001)
169 as key factors influencing their decision about birthplace (Table 3a).

170 Women with PHI who opted to birth in the public system were more likely to rank financial
171 reasons (cost of obstetrician, p<0.001), cost of tests and health facility (p<0.001), flexibility of birth
172 options in public hospital (p<0.001), access to intensive care services (p<0.001) and preference for a
173 low intervention birth (p=0.006) as key factors influencing their decision (Table 3b). Via open-ended
174 questions, these participants cited three key reasons for their choice; cost: they did not feel like they
175 needed to use their PHI because of the quality of the public system, and trusting midwives' expertise
176 and/or not being able to access midwifery-led continuity of care in the private system.

177 In addition to cost, there were several key factors that separated women with PHI who opted
178 for a public versus private hospital birth. Women with PHI who opted to birth in the public system
179 were 3.7-fold more likely to select access to intensive care services as one of their top five most
180 influential factors. "In Ballarat they don't have a NICU and you would be transferred to public if
181 anything happened so what's the point." These women were also more likely to select preference for
182 a low intervention birth and the flexibility of birth options available in the public hospital as key factors.

183 All participants were asked "what factors might increase the likelihood of you choosing to give
184 birth within the private system in terms of types of care, costs, facilities and services?" Table 4
185 contains key quotes from participants highlighting what it would take for women to choose to birth
186 within the private system. Common themes were lower cost, private room and continuity of care.

187 Women were also given the opportunity to comment on their preferred model of maternity
188 care. There was an overwhelming sense of the value of midwifery-led care. There were also several
189 comments about the availability of certain models of care. One woman with PHI chose to birth in the
190 public system as she wanted "shared care, between the midwives at the hospital and GP" which
191 wasn't available in the private system.

192

193 **Discussion**

194 With decreasing birth rates, the viability of providing obstetric services in private regional hospitals is
195 uncertain. This is a concern for the future sustainability of the regional health system because the

196 closure of private maternity services in regional areas will increase the pressure on public services
197 necessitating the increased allocation of government and taxpayers' resources for additional staff
198 recruitment and service provision.[11] It is, therefore, important to determine what influences women to
199 birth within the private versus public system. In the present study, financial considerations were a key
200 issue for women when deciding where to birth. This is not surprising as there are substantial out-of-
201 pocket expenses for maternity services in Australia.[15] Since 1993, out-of-pocket charges for out of
202 hospital items increased by 1035% and out-of-pocket charges for in-hospital items increased by
203 77%.[16] The following quote highlights the influence of cost on a woman's choice of birthplace and the
204 need for innovative programs that lower out-of-pocket costs.

205 "I don't think it's worth the financial cost…you have to pay for PHI for the preceding 12
206 months at a minimum, and then the out-of-pocket costs are still huge. All the scans, tests and
207 appts cost money, then if you need to have the baby in ICU, it's not worth it when Ballarat
208 Health Services offer such a good experience…so for me, it all comes down to costs."

209 In addition, the option of a longer stay in hospital was a key factor influencing their decision
210 about birthplace for more than 60% of women with PHI who opted for a private hospital birth.
211 According to the Australian Institute of Health and Welfare[17], the mean length of stay following the
212 birth of a child in Australia is decreasing. In 2010, 42.5% of women stayed in hospital for >3days
213 following birth, but, in 2018, only 33.1% stayed in hospital for >3days. The proportion of women
214 staying in hospital for <2days has increased from 15.3% in 2010 to 21.1% in 2018.[17] The following
215 quote highlights the importance placed on an increased length of stay post-birth. "The length of stay
216 after delivery would be a major factor. 2 days vs 5 makes a big difference to recovery."
217 There were also many comments about wanting access to midwifery-led models of care in
218 private hospitals. Interestingly, McKellar *et al.*[18] found that "the majority of participants who had
219 received care through a medical model had not been provided information or offered a choice about
220 midwifery care options". It is unknown whether this information was not provided because of medical
221 bias or because alternatives were not available in the private sector. In Wagga Wagga and Ballarat,
222 midwifery-led care is only available in the public system. Models of care offered at the private
223 hospitals are limited and medically-oriented. The fact that women are not choosing this is an
224 important finding. In Wagga Wagga Base Hospital, midwife care involves women having regular visits
225 with a midwife at the Pregnancy Care Centre and appointments with an obstetrician at 36 and 40

226 weeks. In Ballarat Base Hospital, there are two midwife-led models of care: midwife antenatal care in
227 maternity outpatient clinics for low-risk pregnancies and the midwife continuity of care option with a
228 small group of midwives.

229 Previous research supports the view that there are benefits of midwifery continuity of care
230 with no-worse outcomes compared with other models.[19,20] A systematic Cochrane review found that
231 women under a midwife-led continuity of care model were less likely to undergo intervention and more
232 likely to report being satisfied with their care.[19] Although there was some inconsistency among the 15
233 trials involved in that review, there was a trend towards cost-saving for the midwifery continuity of care
234 model.[19] It has been suggested that "innovative funding models in the public and private sectors need
235 to be developed so that women can access the maternity care provider they need and want".[21]

236 Currently, Queensland is the only state wherein private midwives can admit clients and
237 provide inpatient services. Because the flexibility of birth options in public hospitals was one of the
238 top factors for women with PHI who chose to birth in the public system, this is an important issue.
239 Midwives in Queensland can now claim Medicare rebates for a range of private midwifery services
240 including: antenatal consultations, midwifery care planning visits, birth care in hospital in Queensland
241 and postnatal consultations.[22] Other states should consider providing credentialing rights to midwives
242 that would enable them to admit women to private facilities. This would allow private hospitals to offer
243 the additional model of care options that users want and encourage more women to use their PHI in
244 the private system.

245 Traditional key incentives such as the ability to choose one's doctor and consistency through
246 pregnancy and birth remain highly-valued and influential factors. It is apparent, however, that women
247 want more from their birth experience and do not feel that PHI is providing value for money as the
248 public system in Australia provides high-quality and safe maternity care. Evidence of this sentiment
249 can be seen in the declining usage of private maternity services. "Unless suddenly the private system
250 received the reputation of having the best healthcare on offer and the best professionals and
251 resources available for complex and emergency healthcare, then I wouldn't consider paying extra for
252 something that's not even as good as what I can get for free."

253 Results from this study suggest that the extras offered by private facilities, and the availability
254 of services such as high-quality food options, room service and double beds for partners, can affect a
255 woman's choice of birthplace. Private facilities that are able to capitalise on this desire and develop

256 models of care that integrate these services and promote a holistic birth experience for a woman and
257 her family may help to entice this generation to choose a private birth. At the Mater Hospital operated
258 by St Vincents Health Australia in Sydney, maternity services provide one such enhanced experience.
259 They provide room service to order on request, twice-weekly high teas in the maternity unit allowing
260 new mothers and grandparents to meet and mingle, partner meals and a celebration dinner where
261 couples can enjoy dinner together on their last night knowing that their baby is safe with Mater staff.[23]
262 Such value-adding could be an important component to increasing birth rates in the private sector.
263 This warrants further research as the authors could find little published literature, highlighting the
264 importance of the present study.

265 There is the potential for non-response bias in the present study. For example, almost 95%
266 of participants were Australian-born yet approximately 9% of both the Wagga Wagga and Ballarat
267 population (men and women of all ages) were born overseas according to online community profiles.
268 In the present study, 21.8% of participants in Wagga Wagga birthed at the private hospital (Calvary
269 Riverina Hospital), which is similar to the 22.3% reportedly born at Calvary Riverina Hospital in 2018.[8]
270 Although this information was not available for Ballarat, "most women in Victoria choose to have their
271 babies through the public hospital system"[24]. Thus, the PHI status of participants was representative
272 of the wider community, which increases the relevance of these results. The opening of the new
273 public hospital in Wagga Wagga had a negative impact on PHI use in the region. However, the
274 research was extended to another region with similarly aged public and private facilities, and the
275 results indicated that there were similarities in the factors across the regions. Wagga Wagga had a
276 greater proportion of participants who had PHI but chose to give birth in the public hospital and this is
277 likely also related to the opening of the new hospital.

278

279 **Conclusion**

280 This study provides useful information about what factors influence a woman's decision to use public
281 or private birthing services within regional Australia, a field in which there is a paucity of peer-
282 reviewed literature. This research provides insight into how PHI fits into a woman's complex decision
283 about where and with whom to birth. Although financial reasons were highly ranked, the ability to
284 choose a doctor and access to midwife-led models of care were also key factors. This research
285 provides evidence to advocate for improving access to additional models of care in the private sector.

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354

355 Table 1: Models of maternity care in Australia and caregivers associated with pregnancy care

Model of care	Antenatal care	Intrapartum care	Postnatal care
Private care			
Private maternity care	specialist OB	specialist OB	specialist OB
Private maternity care	GP obstetrician	GP obstetrician	GP obstetrician
Public care			
Public hospital clinic care	hospital outpatient clinic	hospital staff	hospital staff
Public hospital midwives clinic	small group of midwives	hospital staff	hospital staff
Shared maternity care	public hospital and a local GP, OB or midwife	hospital staff	hospital staff
Combined maternity care	local GPs and OBs	hospital staff	hospital staff
Team midwifery care	small group of midwives	small group of midwives	small group of midwives
Caseload midwifery care	single midwife	single midwife (1-2 backups)	single midwife involved
GP/Midwife public care	GPs in private practice and hospital midwives	hospital staff	hospital staff
Outreach midwifery care	midwifery care in woman's home/other location	hospital staff	hospital staff
Other			
Birth centre (public/private)	midwifery care	midwifery care: transfer to OB if needed	midwifery care
Planned home birth	single midwife	single midwife: pre-arranged transfer to hospital as private patient under GP or specialist OB	single midwife

356 OB: obstetrician

357 *hospital staff can include nurses, midwives, doctors and other relevant medical staff

358 Adapted from: Australian Medical Workforce Advisory Committee (2004)[25]

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361 Table 2: Characteristics of participants from Wagga Wagga and Ballarat

Characteristic	Wagga Wagga (n=200)	Ballarat (n=310)	*p*-value
Born in Australia (%)	95.0	95.5	0.791
Aboriginal or Torres Strait Islander (%)	7.5	1.9	0.002
Age [years (SD)]	28.6 (5.2)	30.0 (4.8)	0.004
First child (%)	52.6	51.1	0.749
Birth experience (%)			
negative	13.0	12.1	
neutral	20.0	22.5	0.788
positive	67.0	65.5	
Health insurance status (%)			
public hospital birth	54.5	59.1	
used PHI in public system	23.7	13.0	0.006
used PHI in private system	21.7	27.9	

362 PHI – private health insurance; SD – standard deviation

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365 Table 3: Association between factors and choice of birthplace for participants with private health

366 insurance

a) Factors associated with choosing a private birth	**Odds ratio (95% CI)**	***p*-value**
The ability to choose your doctor	22.6 (9.4-54.5)	<0.001
The option of a longer stay in hospital	20.3 (8.2-50.3)	<0.001
The option of a private room	4.7 (2.5-8.9)	<0.001
Continuity of care	3.5 (1.9-6.5)	<0.001
Familiarity with the facility staff	2.8 (1.4-5.8)	0.004
Type of care during birth (doctor/midwife)	2.3 (1.3-4.1)	0.004
Type of post-natal care	3.2 (1.4-7.3)	0.006
Quality of the food	5.0 (1.1-22.8)	0.036

b) Factors associated with choosing a public birth	**Odds ratio (95%CI)**	***p*-value**
Cost of tests and health facility	87.8 (11.7-660.0)	<0.001
Financial reasons (cost of obstetrician)	82.6 (19.1-357.0)	<0.001
The opening of the new base hospital [A]	61.5 (7.7-488.1)	<0.001
Flexibility of birth options in public hospital	27.4 (8.0-93.5)	<0.001
Access to intensive care services (mum & baby)	3.7 (1.8-7.6)	<0.001
Preference for a low intervention birth	2.6 (1.3-5.2)	0.006

367 [A] for Wagga Wagga participants only

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370 Table 4: Key quotes from participants highlighting what it would take to increase the likelihood that women would choose to give birth in the private system

Theme	Key quotes
Lower cost	'it shouldn't cost an arm & leg to get such amazing care in a health system' 'Minimal gaps/low cost would entice me to go public' 'Cost is the main factor stopping me from birthing privately. Even with health insurance the costs are excessive'. 'cost is expensive as extra tests not always included and extra costs that your unaware about such as private paediatrician' 'If the private hospital in Wagga was known to out-perform the public hospital and the stay would be wholly covered by the private insurance (no out of pocket expenses post birth) then it could be a consideration.'
Newer private hospital/ better facilities	'Newer hospital. Needs renovations as it is very old.' 'If the facilities were better and also if I heard more positive things about the care in private. I haven't heard any terrible stories but have just heard much more positive stories about Wagga Base' 'The private hospital in Wagga really needs to undertake renovations so that I feel like I gain something from paying so much more as the facilities at the moment are run down and the rooms look tired and sad.'
Guaranteed private room	'The only aspect that would make me consider using the private system is a guarantee of a private room.' 'Having a private room I feel should be essential after giving birth to have that one on one time with your new child to find each other's groove without being disturbed by other babies.' "I also liked the freedom and feeling of knowing that I would have my own private room, it made me lass anxious about the hospital experience."
Option of a longer length of stay	'I also felt like I was pushed out of the public hospital quite early with my second, leaving less than 24 hours after delivery and being able to stay for a longer period of time is quite important to me' "The length of stay after delivery would be a major factor. 2 days vs 5 makes a big difference to recovery."

Higher level of care	‘Level of care/patient to nurse ratio’ ‘If private was deemed safer and better care…and if it had all services that the Wagga base has’
Access to intensive care for babies in private hospital	‘If they have all the equipment they need to be able to help you and be able to keep Mums and Babies in Wagga, especially when babies come early’
More birth options	‘Would prefer access to water birth and midwife led care’ ‘I would only choose private if I had access to midwifery-led continuity of care with potential option for a home birth’
More time with and access to health professionals	‘having access to the midwifes whenever I needed assistance’ ‘Less strained midwives…assistance with breastfeeding’ ‘24/7 contact access with OB. Same doctor/place every time so not repeating myself or getting told different things.’ ‘Private doctor that is accessible around the clock.’ ‘out-patient assistance by physio, breastfeeding consultants and midwives when needing extra assistance.’
Continuity of care	‘Continuity of care would still probably be one of my main deciding factors’ ‘Risk factors during pregnancy - importance of having one person overseeing the entirety of my pregnancy’ ‘Seeing the same doctor each time avoids the feeling of "being lost in the system" “Having given birth in both public and private, if I had my time again I would never of used the public system. Whilst the costs are more in a private system, the continuity of care and the personalised knowledge provided by using the same doctor would outweigh the cost for me.”
Ability to choose doctor	‘Services such as choosing your doctor and obstetrician’ ‘Having the choice of obstetrician. Our faith in the obstetrician was incredibly reassuring when the emotions of my first birth resurfaced at various times throughout the pregnancies. He also predicted and planned for those emotions before I even knew they would be coming and ensured that there were strategies in place’

372 Figures

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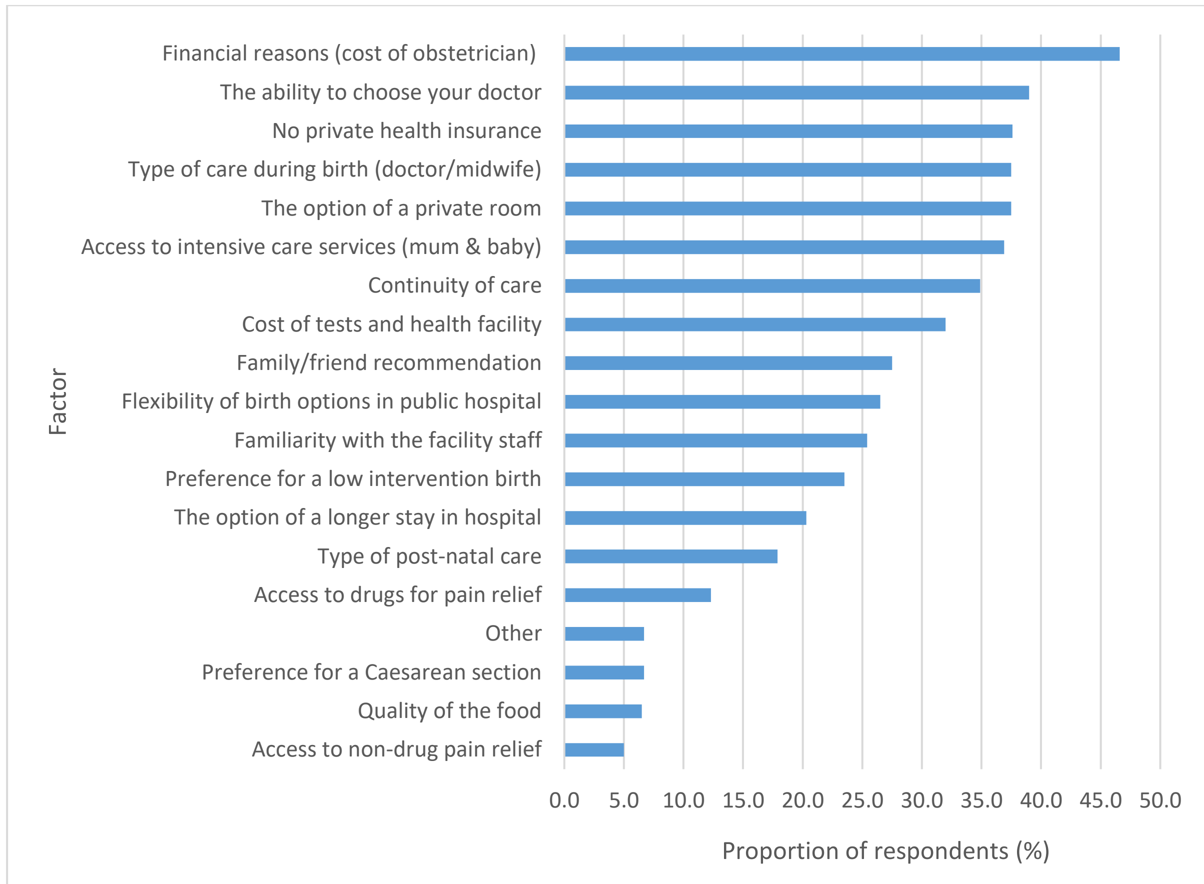

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375 Figure 1: Frequency of being ranked as one of the top five factors that influenced a woman's decision

376 to give birth in the public or private system for all participants

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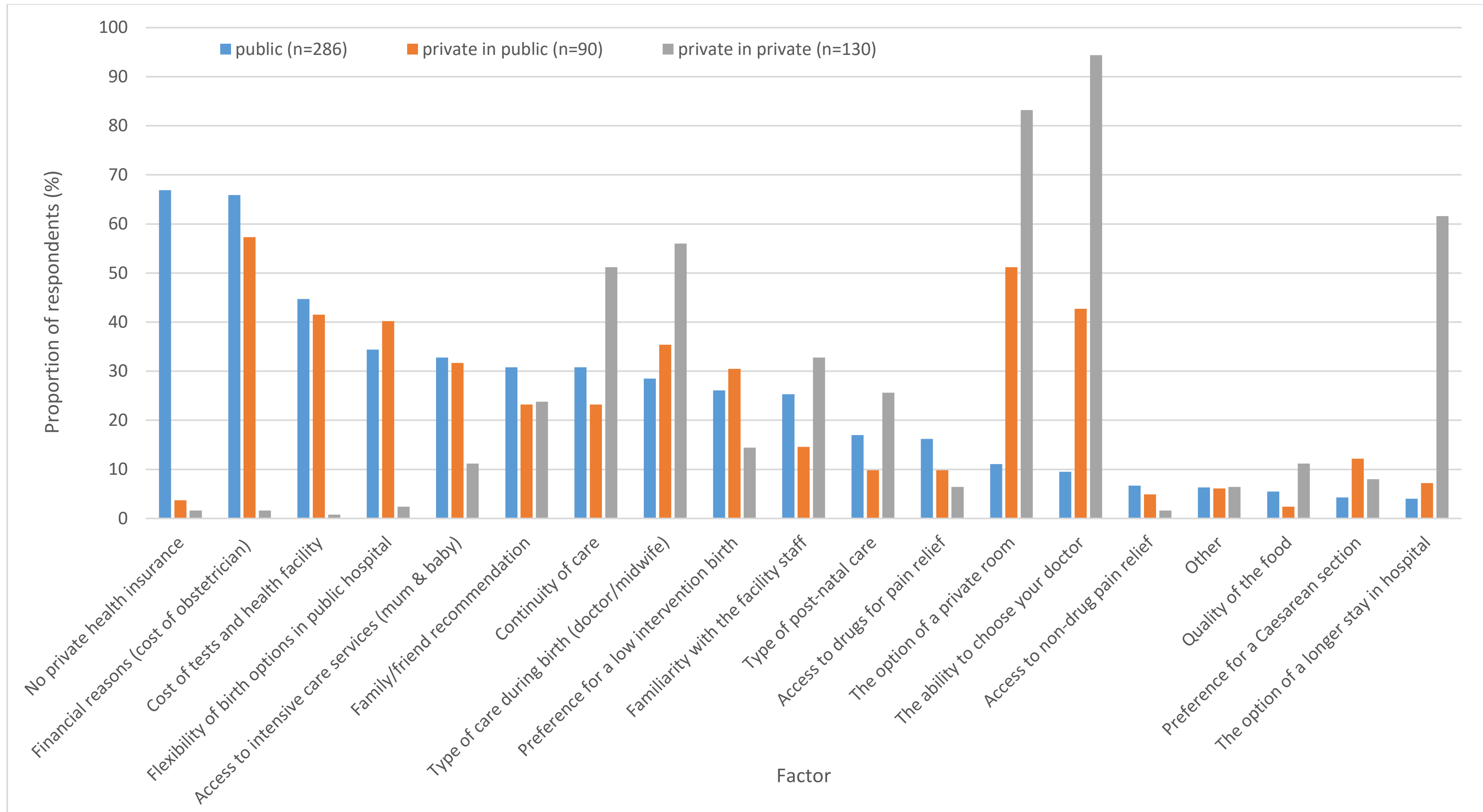

379 Figure 2: Frequency of being ranked as one of the top five factors that influenced a woman's decision to give birth in the public or private system based on

380 private health insurance status

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