Tensions in maternal and child health policy in Victoria: looking back, looking forward

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Abstract

Since the late 1980s, Maternal and Child Health Services (MCHS) in Victoria have undergone significant change. This paper provides an historically-informed analysis of the complex intersection of policy, administrative restructuring and stakeholder interests. It draws on and extends the authors' previous research into MCH Service policy directions and administration, including the impact of Compulsory Competitive Tendering (CCT) on MCH nurses in the 1990s. Historically there has been little explicit debate about either organisational arrangements, or the policy objectives of the MCHS. The dominant focus on health surveillance of infants never adequately reflected nurses' wider role in the community and was not consistent with a wider social model of health. Tensions between professional, consumer and administrative stakeholders became heightened by the implementation of the 1990s neoliberal political agenda. During this period, when restructuring linked funding to service delivery through tendering arrangements, a political and policy settlement further institutionalised surveillance as the basis of the MCHS. The restructured Service has remained constrained by the dominance of health surveillance as the primary program goal even after more varied contracting arrangements replaced CCT. Although recent initiatives indicate signs of change, narrow surveillance-based guidelines for Victorian MCH Services are not consistent, we argue, with recent early years of life policy which calls for approaches derived from socio-ecological models of health.

Introduction

International health policy is increasingly attentive to the importance of maternal health and of early childhood in establishing the basis of health and well-being. In the last fifteen years, Victoria's long-established Maternal and Child Health Services (MCHS) have undergone significant change. This paper explores these developments in light of the emerging wider policy concerns, and provides an historically-informed analysis that shows how administrative restructuring, policy objectives and stakeholder interests intersect in complex ways. The paper draws on the authors' previous research on MCH history, policy and administration that is reported fully elsewhere (Reiger, 1985, 2001; Keleher, 2000; Reiger & Keleher, 2002, 2004). Here we extend our analysis in light of evidence from literature on the social determinants of health which has demonstrated convincingly that education, literacy and healthy early years of life establish the foundations for health.

In the Victorian MCHS, we argue, a longstanding tension over the orientation of the Service towards a medical or social model of health can be traced. In the neoliberal political context of the mid-1990s, political and professional agendas produced administrative arrangements that settled this tension in favour of a medically-oriented health surveillance rather than a socio-ecological approach. An emphasis on child health surveillance was not only established in MCH program guidelines, but became embedded in specifications for tendered

services and in state-local government funding formulas based on 'key ages and stages' of child development. Although the policy agenda is now moving away from a narrow surveillance approach to the early years of life, this objective remains compromised by the 1990s 'settlement' with regard to organisational and program structures that are still oriented to health surveillance. We suggest that the draft framework and guidelines (DHS 2003a, 2003b) for Victorian MCH Services remain narrowly cast as what Turrell, Oldenburg, McGoffin & Dent (1999) describe as 'downstream' intervention approaches, and are not yet consistent with the more 'upstream' socio-ecological potential of emerging early years of life policy.

Historical context of MCH policy

The paradigm of child health surveillance in relation to mothers and their infants has a long policy history. An historical perspective can inform contemporary struggles to define the role of MCH services and reveals differences between the interests of professional, consumer and administrative stakeholders. We give particular consideration to the processes involved in the reorganisation of Victoria's Maternal and Child Health Service (MCHS) during the 1990s, in which competing values and positions were evident. The concept of health surveillance as monitoring of populations and individuals by health service providers which became established in distinctive organisational form in the 1990s had already provided the general policy framework guiding the MCH Service for many years. It had also been contentious however and never adequately reflected the scope of nurses' actual practice. The strengthening of surveillance notions in the late 1980s and early 1990s drew on a longstanding frame of reference with origins in the pronatalist and eugenic concerns of the early twentieth century (Reiger 1985).

As in other western societies, Australian infant welfare services, as they were originally called, had their beginnings in attempts to alleviate maternal and infant mortality and morbidity among the urban poor. The agenda was largely medically driven but also reflected voluntary associations' charitable concern with the state of health of poor mothers and their infants (Reiger 1985; Mein-Smith 1986). As state auspicing of services began to supplement the work of the voluntary societies, early infant welfare services became responsible for integrating collection of data on infant and maternal health with the promotion of breastfeeding, hygiene, health education, environmental health, and family welfare.

As early as the 1920s the Australian agenda, like that in New Zealand, was marked by struggles both between health professionals and volunteers, and between doctors and nurses. Medical practitioners feared nurses stepping over the territorial boundaries of the cure-care division of labour (Thame 1974; Keleher, 2000; Bryder, 2003). The voluntary societies largely accepted doctors' insistence that Infant Welfare could only be a 'well-baby' health service. Nurses were expected to adhere to the directive of the British Medical Association (BMA) that any cases of illness found by the nurses were to be referred to medical practitioners (Keleher 2000). Medical directors were appointed to lead the Victorian Service from the 1920s right through to the 1980s and medical influence over infant welfare nurses' training maintained the superior status of doctors' knowledge and power (Keleher 2000). Nurses were generally under policy direction of the medical profession through the Department of Health, albeit at a distance.

From the 1920s, the Infant Welfare Service was delivered through and supported by partnerships between local communities, municipalities and the state government. Funding was shared between state and municipal authorities and the Service reflected the classic model of state-run bureaucracy characterised by a hierarchy of positions, established procedures and rules. Nurses looked for policy direction to the centralised state department (in which public health doctors and nursing advisors held authority), even though the nurses were located within a local government resources framework and worked in the community as largely independent practitioners (Keleher 2000, Reiger 2001). A name change from Infant Welfare to Maternal, Infant and Pre-School Welfare in the early 1950s signified the Department of Health's interest in the health of mothers, and the expectation of nurses' dual role of care for the mother and her child.

Maternal and infant welfare nursing work was nonetheless narrowly interpreted by state authorities. This is nicely illustrated by a complete set of records kept by Echuca Baby Health Centre, from its opening in 1925

until 1964[1]. The records show that standardised information was required by the Department of Health on attendances, home visits, referrals to doctors, general remarks (which were to be confined to the physical conditions at the Centre) and reporting of any lectures, demonstrations or 'postal instruction' given to mothers (Keleher 2000). The information required by the Department changed very little over time, with only minor changes to the format of the reports. However, oral sources and nurses' own reports provide evidence that their actual work was often about engagement in community development activities such as establishing playgroups, parenting support groups, mail delivery on visits to remote mothers, and community newsletters. For many decades from the 1920s, infant welfare nurses also provided social welfare relief for families through the distribution of food and clothing parcels provided by the local committees of the baby health centres. Social and community development work was in effect an important aspect of public health nursing practice (Keleher 2000). Although it was often 'invisible work' unseen in official recording of nurses' work (Keleher 2000), for both nurses and mothers it was an essential aspect of the MCHS.

As a key stakeholder group, mothers themselves have historically been active in promoting the Infant Welfare Service and its policies (Crockett 1997). Women, white and predominantly middle-class, lobbied councils to set up baby health centres in suburban areas and rural towns. Their interest was less in medical surveillance, though, than in care and support for mothers in childbearing and rearing. Baby health centres were seen by women as necessary to provide mothers with support, especially in view of the isolation in rural areas, and the breakdown of traditional kin and community ties. Working-class women were more suspicious, however, of what we might now term the 'biopolitics' of increased government control through the regular weighing and checking of infants, and exhortations to mothers concerning feeding and discipline (Reiger 1985). The Service became widely accepted throughout the community by the post WW2 years, adapting to the increasingly diverse cultural mix of the population but with little change in its basic rationale, policy orientation or administrative regime. There was a general congruence between the officially supported surveillance activities and the hierarchical organisational arrangements. At the community level though, both mothers and nurses also pursued other agendas. Not until the late 1980s, however, when the Service seemed in jeopardy, did mothers, and indeed some nurses, take the public stage as an articulate interest group.

Stakeholder struggles and emerging neoliberal agendas

By the 1980s, the role of public health doctors in central policy-making had declined and the professional status of nurses increased, enhanced by the move to tertiary education in the 1970s (Keleher 2000). Trained (until the 1970s) within the hierarchical and medicalised authority structure of hospitals, nurses found much greater autonomy of practice working in the MCHS (Keleher 2000). Yet their MCH certification and in-service preparation maintained the culture of the MCH Service as a distinctively 'health' service ostensibly under medical supervision. However, university-based maternal and child health courses gave greater emphasis to a social model of health and nurses' role in the community was rapidly expanding, especially in view of immigration and family change. The appropriate direction of the Maternal and Child Health Services, as they were now termed, was still not overtly debated within Health Department policy-making and at least some nurses were dissatisfied with their lack of voice at the policy-making level (Reiger: personal communication with MCH nurses' group 1988). Nonetheless, even into the 1990s, many maintained strong allegiance to a familiar, centralised health bureaucracy, which was perceived to provide policy direction and support for their practice, as compared with a local government environment that did not really understand the MCHS (Reiger & Keleher 2002).

The circumstances of failure of a projected review of the MCHS in 1988 to even get off the ground are revealing (Reiger 2001). An orientation to social health policy and practice was articulated by mothers in consumer advocacy groups and by at least a proportion of the nursing workforce. They clearly saw health surveillance activities as only one aspect of the Service even though they were the most administratively visible because they were more readily measurable. Consumers lobbied both local and state governments saying how much they

[1] The Public Records Office in Victoria has destroyed its stores of maternal and child health records of this type, for all years prior to 1950. The Echuca Baby Health Centre records are, therefore, especially valuable.

valued the nurses' role, not just in health surveillance, but in formal and informal community initiatives (Friends of Little Kids, 1987-9).

However, both mothers' and nurses' voices were soon drowned in debates between local and state governments over areas of funding responsibility. Local councils became increasingly frustrated during the 1980s by state government expectations that they should play an increased planning and policy role in managing the MCH Service but without provision of additional resources (Municipal Association of Victoria 1988). Dissatisfaction about funding arrangements was not new, but pay rises for nursing staff brought matters to a head. In 1988 a discussion paper argued that, as there had been a 'lack of clearly articulated and agreed service objectives' and of 'effective evaluation of the service for over half a century', a full-scale review was required (Municipal Association of Victoria 1988 p 20). When the review became a 'political hot potato' with consumers demanding fuller representation, the Minister's sudden announcement of its cancellation caught everyone by surprise, including the chairperson nominated to lead the review process.

This was a missed chance to address the tension in policy direction and the professional issues increasingly facing nurses in a changed educational and community environment. Contradictory developments continued, eventually taking new form as neoliberal political concerns with service rationalisation emerged. On the one hand, health surveillance remained the dominant official policy, further strengthened by the influence of 1984 National Health and Medical Research Council (NHMRC) recommendations that interpreted child health primarily in terms of the reduction of injury and illness. '[E]nhanced family and social functioning' was included as merely the last of five objectives (Commonwealth Department of Health, Housing and Community Services 1992). On the other hand, under late 1980s-early 1990s Labor governments, the surveillance model was tempered by a social justice agenda stressing improved access to health care for socially disadvantaged groups. In this light the MCH Service was increasingly perceived by Victorian Health and Community Service Department authorities as being caught in a 'timewarp' _ out of step with changing community needs, too isolated from other services and inflexible in terms of opening hours. It needed therefore to be made more responsive to changing demographic patterns, greater ethnic and household diversity and women's increased paid work commitments (Parliament of Victoria 1995). The administrative relocation of responsibility for MCHS from the Health Commission to Community Services in 1985 under the Cain Labor government had already attempted to encourage closer links with other community-based services but by the early 1990s, these administrative developments were overshadowed by emerging political objectives.

By 1992, the policy environment was being reshaped by corporate management strategies, especially under the influence of John Paterson, the Director of Community Services Victoria. Reflecting managerial concerns to delineate MCH program objectives and improve measurable outcomes, the MCH Service was encouraged to strengthen its primary focus on health surveillance. New program guidelines recommended that all pre-school children, not only infants, were to be screened at 'key ages and stages' of development. Child health surveillance was to be the general policy direction, with maternal health and a more social analysis of family well-being downplayed as a focus of service provision. The most significant move at this point was the linking of policy direction to accountability requirements, a development already under way but given dramatic impetus by the election of the zealous neoliberal Kennett government in late 1992.

Implications of organisational restructuring

Over the decades there had been little administrative change in the structures of the MCHS, save the move from health to community services departments, until radical reforms were set in train by the Kennett government. The 1990s was a decade of unprecedented upheaval in Victoria's human services, involving complex changes in public sector management, local government amalgamations and service delivery reforms.

By the mid 1990s, as local government boundaries were dissolved and re-established with far fewer Local Government Areas (LGAs), the number of MCH Services was also dramatically reduced. The introduction of a market model of service delivery was then enforced in the local government sector through the mechanism of compulsory competitive tendering (CCT). CCT processes caused immense upheaval to local government (Ernst

& Glanville 1995; Ernst, Glanville & Murfitt 1997) with diverse outcomes for MCH Services. Tendering processes were quickly put in place, creating the need for rapid learning in organisations already reeling from the restructuring associated with municipal rationalisation, and with little understanding of the complexities of implementing contractualism in human services.

Almost all MCH Services across Victoria were put out to tender at least once, and sometimes twice, between 1996-8. A variety of contractual and 'pseudo-market' mechanisms emerged in response to local political pressures. The overwhelming majority of Services remained 'in-house', as internal bids won contracts for the service they already delivered. However by 1998, 11% of contracts had been won by organisations outside local government. In metropolitan Melbourne, two MCH Services went to Community Health Services (CHS). In rural areas, three rural city hospitals and three CHSs won tenders as well as one private contractor in a rural shire (Reiger & Keleher 2002). This process occurred in an ad hoc manner, without any significant policy discussion about the most appropriate location for MCH Services. Nevertheless, while a small number of councils saw the tendering process as an opportunity to divest themselves of the MCH Service, the majority were committed to giving MCH nurses the necessary support allow them to win the tender (Reiger & Keleher 2002). After all, CCT was about administrative restructuring of all kinds of services delivered through government – it was not about maternal and child health policy which merely got caught up in the whirlwind. It was a tumultuous period with far-reaching effects on nurses' work, on the implementation of surveillance health policy and on consumer participation in service planning.

While nurses were, at first, overtly resistant to the dramatic changes associated with CCT they also discovered some advantages (Reiger & Keleher 2002). Although the tendering processes produced much personal stress for staff, changes in actual service delivery and practice varied. Nurses' location in multi-nurse centres became more common, replacing the 'stand-alone' centres operated by one nurse. In order to manage workloads, most centres moved further from a system of open access according to perceived client need to an appointment-based system.

Contracting processes necessitated transparency of budgets and financial procedures and facilitated ownership of the budget by MCH business units. They were now increasingly linked in to new management structures with increased accountability but also enhanced responsibility within their own MCH team. Although they often had to cope with managers (perhaps engineers or environmental health officers) with little, if any, understanding of maternal and child health, the introduction of business models of management offered new opportunities for enterprising MCH coordinators. Rather than the traditional top-down bureaucratic style of management of the MCH Service, coordinators moved towards more of what has become known as a 'network bureaucracy' (Considine 1999). Through regular formal and informal meetings, processes to share information and provide mutual support developed.

Coordinators emerged as a source of leadership, one especially important in view of the vacuum left by the Department of Human Services' (DHS) retreat to a 'steering not rowing' philosophy of service management. Widespread frustration with DHS at state and regional levels was expressed by both nurses and coordinators (Reiger & Keleher 2002), with professional leadership sought at local level from peers and coordinators, and from academic leaders. Many nurses, however, continued to resist integration with other local government services, maintaining their historically-developed ethos of being a distinctive primary health service.

The 1990s agenda of service rationalisation went hand in hand with a policy framework that was becoming dominated by new health surveillance discourses (Community Services Victoria 1991a; 1991b; 1992). The concept of child health surveillance at key 'ages and stages' fitted neatly with a technical approach to the measurement of family health, offering a highly rationalised, output/outcomes focus, and threatening to downplay other aspects of the nurses' role. In 1994 the 'Healthy Futures Program' aroused intense controversy amongst nurses and mothers who resisted its limited 'ages and stages' model for the Service (Craven 1997; Mellor & Griffin 1995; Reiger 2001).

While never fully implemented, Healthy Futures crystallised the interpretation of MCH Services in terms of surveillance of pre-school children, interpreted largely as the reduction of illness and disability. The Program Standards developed then for MCH Services (Department of Human Services 1996b) advanced this framework

in the increasingly competitive environment of amalgamations and CCT. They formulated agreed and uniform standards for professional practice and service delivery – which were well-overdue – and articulated specific indicators for aspects of service delivery. Commercial discourse pervaded style and content, from the language of performance indicators, quality assurance, 'mission' and 'vision' statements to the text presentation and the characterisation of mothers as free market individuals able to 'choose' to access services in pseudo-markets.

During the market-oriented regime established in the 1990s, the publications from the DHS became more glossy, and actual detail of MCH activities diminished. Few central or even regional staff remained who knew much about MCH issues and they were hard to find (Reiger & Keleher 2002).

In line with promotion of the goal of 'intelligent competitive outsourcing in human services' (Department of Human Services, 1996b p 2), responsibility for the 1995 Program Standards, and MCH staff development and quality assurance, were contracted to a university professor of child health and a research team. Similarly, parenting program development was outsourced to the newly-established Victorian Parenting Centre. The professional collaboration forged then, and with the Centre of Community Child Health, has continued to influence policy initiatives after the demise of CCT. The role of the DHS in establishing policy directions is exerted in less direct ways than in earlier centralised health department regimes, and thus accountability for directions is less transparent.

Furthermore, whereas in the early 1990s state-level policy-making allowed space for consumers, by the end of the decade MCH service-users' access to information and involvement in decision-making became mostly confined to the local level through customer satisfaction surveys. As many nurses reported to us, devolution of responsibility for service delivery as a result of tendering can easily mean that no one, let alone service-users, has much grasp of the broader picture (Reiger and Keleher 2002).

By the late 1990s, under a new Labor government, Victorian MCH Services emerged from a tumultuous period of administrative restructuring. The longstanding tension in the Service between surveillance and a social orientation to primary health care had been formally settled in favour of the former.

Various contractual arrangements continued after compulsory tendering was abolished. Coordinators reported continued confusion in the early 2000s about the status of contracts with little consistency across the state. State-local government funding arrangements established in the previous regime as the basis of contracting have been maintained. Health surveillance at 'key ages and stages' of childhood had been embedded in MCHS in more specific ways than in earlier years as the service that the DHS 'purchased' from providers.

Council and community health-provided services have not been limited to those funded by the state government, but funding for other aspects of service, such as parenting groups, has to be actively sought. Yet as the MCH Service has had strong political and community support, some funding for what are defined as 'enhanced' services has been achieved, such as increased home visiting and special initiatives for targeted groups. Coordinators reported welcoming the way such new programs take MCH nurses outside the traditional roles of MCH Services, especially into outreach programs for young and socially disadvantaged mothers (Reiger & Keleher 2002). Developments such as multi-nurse centres, improved team relationships and an orientation to professional networking in a new bureaucratic environment have created opportunities for new forms of service delivery.

While administrative restructuring and some funding adjustments thus encouraged more flexible services and greater responsiveness to diverse community need, in our view, the historical tension between health surveillance and other aspects of nurses' community role was not adequately addressed. A new 'Strategic Framework for the Maternal and Child Health Services' (Department of Human Services 2003b) indicates change towards a more comprehensive framework for this primary health service. Nonetheless, given the continued dominance of health surveillance as the primary program goal legitimated by funding formulas, it appears to us that innovation is possibly 'old wine in new bottles' and a more consistent approach needs to be formulated.

Contemporary policy for early years of life

Simultaneously with the administrative reforms that have affected MCHS, child health policy has become increasingly focused on determinants of health related to social disadvantage. The developing interest, both locally and internationally, in the early years of life as one of the most influential social determinants of health (Marmot & Wilkinson, 2003) is producing new initiatives. The social model of health, given recognition through the Alma Ata Declaration of Primary Health Care (WHO 1978) and strengthened through the Ottawa Charter for Health Promotion (WHO 1986), has acquired a much stronger evidence base through research on the determinants of health. In practice, the 'social' model is now expressed in terms of socio-ecological models of health care that are concerned with social inequalities, community engagement and participation and empowerment of individuals and communities. A socio-ecological model of health is increasingly perceived to be the most appropriate approach for early years of life agendas. It delineates both 'upstream' (macro level, community engagement, government policy) and 'downstream' (micro level, surveillance, personal health care, disease management) approaches, in order to assist with the development of mixed interventions in service delivery (Turrell et al 1999).

In Victoria and several other Australian states, early childhood policy initiatives are moving towards an approach using upstream and downstream interventions, based on an understanding of determinants. In New South Wales, the Families First initiative includes a policy framework for child health, called *The Start of Good Health* (New South Wales Health 1999), In South Australia the Healthy Start Program (South Australian Department of Human Services 2003) seeks to integrate child health and welfare services, and Victoria has launched the $7.6 million Best Start initiative and the Children First (DHS 2002) policy documents. The background papers for the Victorian programs suggest a more deliberate shift to primary health, and towards more midstream-upstream interventions.

For the MCHS however, the legacy of defining child health primarily in terms of professional monitoring of developmental problems continues. The new Strategic Framework for the Maternal and Child Health Services (2003b) and its accompanying Maternal and Child Health Program Resource Guide (2003a) discuss the 'critical role the Maternal and Child Health Service has in supporting families' (DHS 2003a p 3). A Service Improvement Project is advocated which 'aims to identify improvements to the Maternal and Child Health Service to strengthen its contribution to the improvement in health, development and wellbeing outcomes for young children and their families' (DHS 2003a p 3). These documents are far less managerialist than 1990s MCHS policy documents, and place great emphasis on connecting the MCHS with other services, particularly linkages between MCHS and Best Start.

However, the reporting framework and central state funding for MCHS still revolve around surveillance at 'key ages and stages'. Objectives therefore remain individualistic and very focused on downstream interventions. The degree of surveillance of MCH nurses' professional practice, first imposed on them through the reporting requirements intrinsic to a contractual environment, is also quite extraordinary compared to those for other professional staff in the community and primary care sectors. Further, the strategic framework gives no sign of consultation with the parents who use the MCHS. We argue that the legacy of a narrow surveillance model, as institutionalised in the MCHS administrative regime that emerged with the 1990s tendering system, sits uneasily with current early childhood policy objectives.

Conclusions

Victoria's MCH Services have undergone dramatic administrative and organisational restructuring in the last decade. Contracting arrangements and the linking of the state government's partial funding of Services to a tightly defined set of program standards brought together neoliberal managerialist goals and a strong orientation towards child health surveillance. In spite of this, the historical tension outlined in this paper between child health surveillance and a social model of health remains unresolved.

Influenced by international early years of life policy agendas, a greater orientation to socio-ecological factors has been emerging in Australia as elsewhere. It is increasingly recognised that childhood experiences, competence and coping skills learned in the early years provide the basis of learning, behaviour and health through the life course (McCain & Mustard 1999, Centre for Community Child Health 2000). Parenting education and adult learning programs are known to increase health literacy and awareness that leads to improved care of children. Gender based or gender sensitive analysis is also necessary because of the critical relationship between a mother's health and wellbeing and that of her children. Family relationships are in turn shaped by wider social factors, particularly employment and housing conditions and community support structures, These social factors have been under-recognised, we believe, in the historical processes of formulating MCHS policy, although many nurses 'on the ground' have been more cognisant of them.

Victoria's MCHS is a longstanding universal, primary health care system for mothers and children, but to maximise its potential, its policy framework and administrative arrangements need to be congruent both with each other and with socio-ecological approaches to health. The diversity of local service delivery established under the 1990s contractual regime has advantages. It needs, however, to be balanced by coherent state-wide policy direction, established through processes involving all stakeholders.

The new understandings about the early years of life offer an opportunity to move beyond the long-standing tension between child health surveillance and a social model of health. Healthy public policy for infants, children and their parents is dependent on integrated, multidisciplinary and intersectoral policies that recognise that surveillance approaches are an inadequate basis for health care provision. This kind of policy approach for MCH Services would be of more long-term value to families and the community than the economic rationalist notions which drove public sector changes in the 1990s. Whether they will continue to shape the MCHS remains to be seen.

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