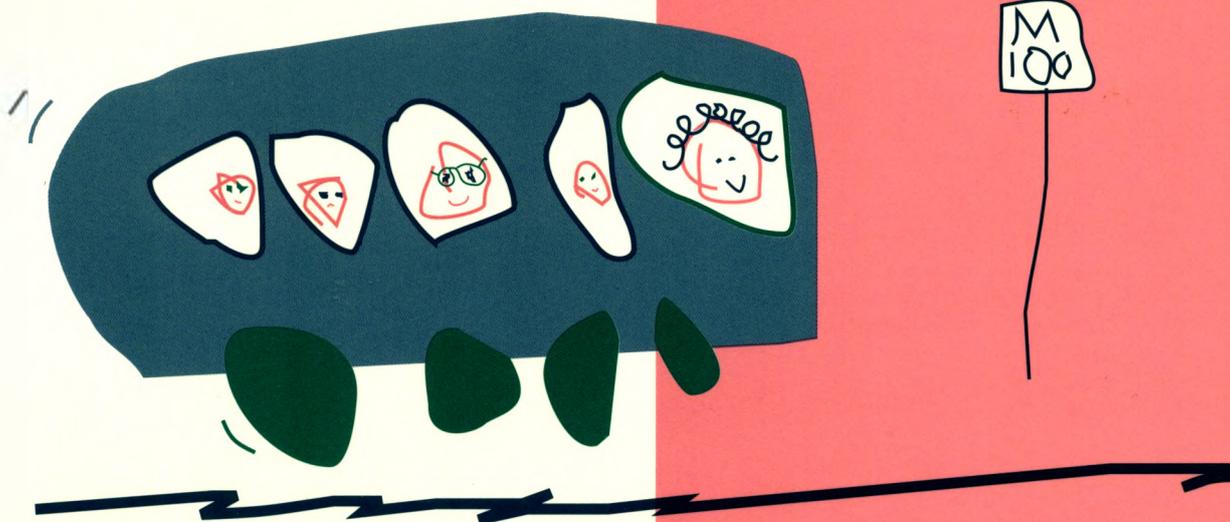


Brotherhood of St Laurence

BEYOND THE CITY

Access to
services
for mothers
and babies

Tim Gilley



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FOREWORD

Despite the massive demographic shifts within Australia over the past 20 years, the inner city still dominates popular images of poverty. Overcrowding, low-quality housing, large high-density estates whose residents lack good incomes are all features of these images, which pre-date the gentrification of these suburbs.

Over the 1980s, however, a new image of hardship developed. Rapidly rising property values priced younger and lower-income families out of the inner city. Unable to afford the affluent suburbs, they turned to the new growth areas on the urban fringe. The growth on the fringe has exceeded the expansion of infrastructure and services, giving rise to concerns that these families may have found their cheap land and housing at a high cost in terms of access to the facilities and services which underpin living standards.

Responding to these concerns, the Brotherhood of St Laurence established services in growth areas, such as Craigieburn, in the northern fringe of Melbourne. These services seek not only to meet immediate needs but to accelerate the provision of social infrastructure by governments and other community agencies.

Partly in response to the emerging understanding of 'locational disadvantage', governments have sought more consciously to redistribute human services from one part of the state to another, in some cases away from the inner city towards the under-resourced fringe. The re-allocation is most overt when funding of the programs ceases to grow: an example is to be found in the re-allocation of resources for maternal and child health services in Victoria in 1994, where a new formula shifted funds from low to high-growth areas.

But how strong is the evidence underlying this vision of locational disadvantage? How does location affect quality of life? Are residents in new developments missing out? Are they pushed into these areas by economic forces? Are people in country areas worse off?

This study is a small contribution to the debate over locational disadvantage. It builds on research undertaken by the Brotherhood of St Laurence on the use of health and community support services by mothers in inner Melbourne (Gilley 1993a). These findings are complemented in this report by the rather different experiences of 146 mothers from four non-metropolitan areas: the fringe growth areas of Cranbourne and Melton Shires, the rapidly growing Bellarine fringe of Geelong, and the major rural centre of Ballarat.

The results are in keeping with other studies such as those of the Australian Institute of Family Studies (McDonald 1993a, 1993b). Mothers were generally happy with their chosen area as a place to raise their child, emphasising the positive features of the area and the cost and quality of housing. Regardless of income, mothers were generally happy with services, the major exception being the lack of public transport. In terms of their ability to access the services needed for their babies, the most disadvantaged group which emerged were families who were living on a low income but had no access to the car. These families were often victims of the recession.

These findings match the overall socio-economic profiles. The inner-urban areas, despite the presence of higher income residents, have greater overall levels of need than do the growth areas: higher long-term unemployment, more sole-parent poverty, more people of non-English speaking background, all of which demands more services. Those from the high-growth areas outside the metropolitan area seemed better poised to benefit from future economic expansion and job growth.

The results of this study suggest that redistribution of resources based on demography alone is problematic. Governments need to build into their allocation formulae not just the shifting population balance but the depth of need and disadvantage in different areas and the implications that these might have for access to specific services. In at least some cases, extending public transport may be as much of a priority as redistributing family and community services.

Alison McClelland
Director
Social Policy and Research
July 1994

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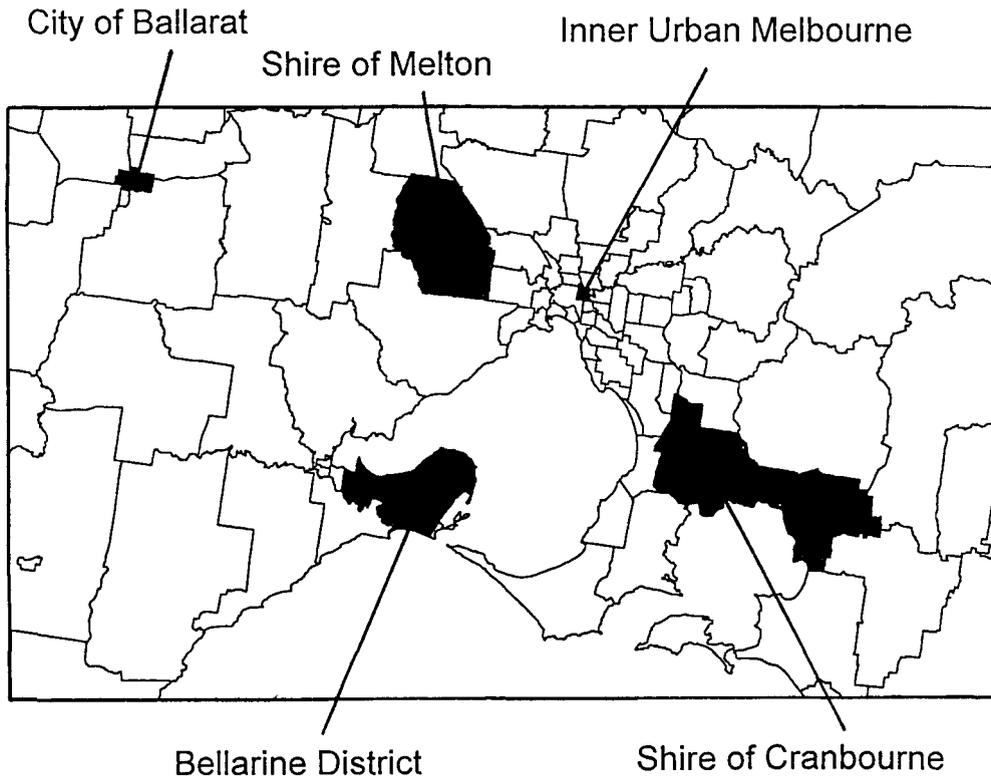
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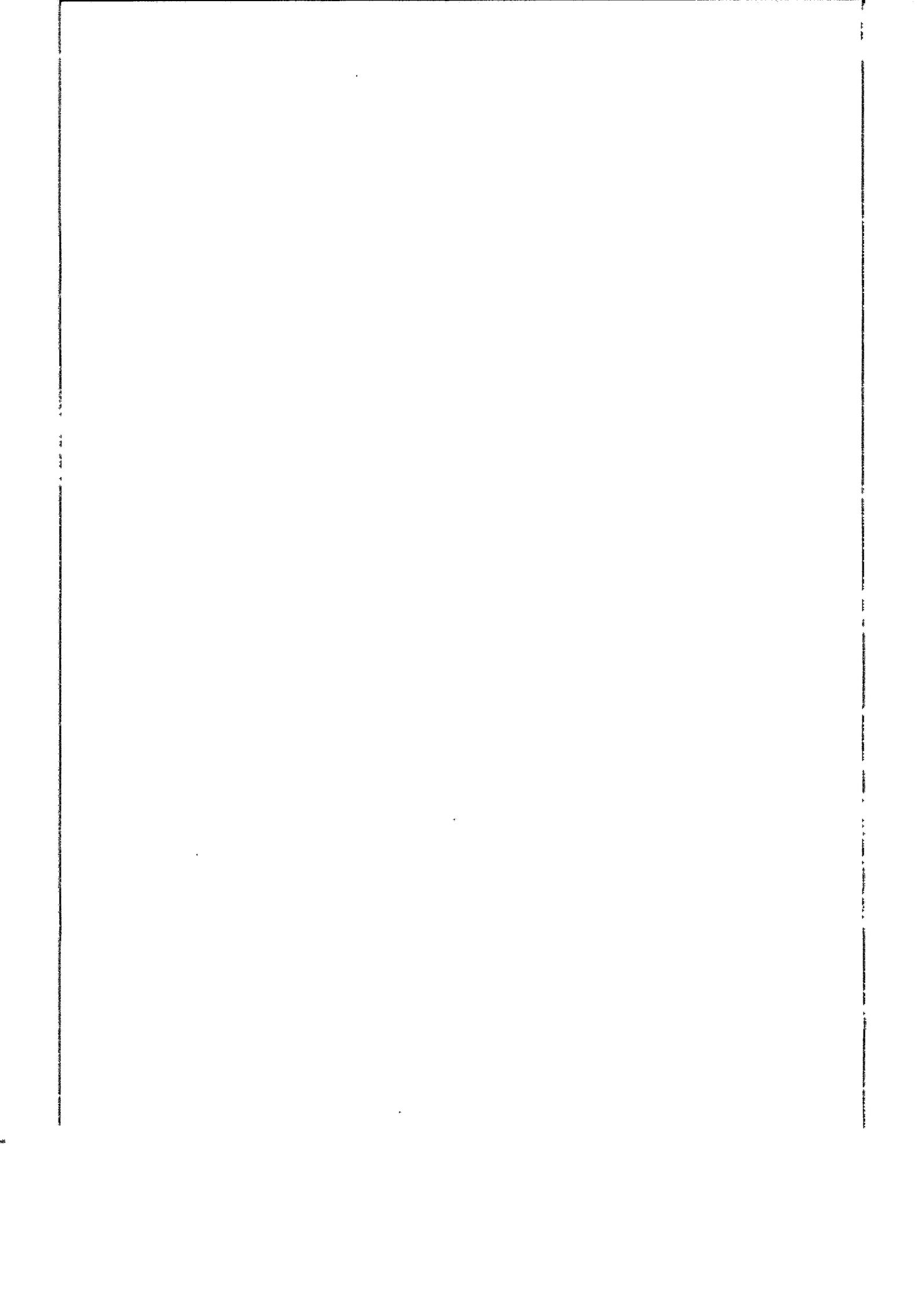
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The Brotherhood of St Laurence would also like to take the opportunity to acknowledge the generous support of the Victorian Health Promotion Foundation in funding this research.

MAP OF STUDY AREAS





The main focus of this paper is a consumer view of health and community services during pregnancy, at birth, and in the first few months after birth from the perspective of 146 mothers living in four areas of Victoria. These locations comprised two outer-urban growth areas, Cranbourne and Melton; a growth area on the outskirts of the major provincial centre of Geelong, the Bellarine District; and the provincial centre of Ballarat. The research was based on 23 small-group discussions in these four locations. To highlight issues of location, the mothers' experiences of birthing and early childhood services in these four areas are contrasted with those of 164 mothers with very young children from an inner-urban study (Gilley 1993a).

Context of the study

Differences in living standards due to location is an important social issue (Walmsley 1980). Locational disadvantage has been defined as occurring:

... where people live in areas where there are deficiencies in physical and social infrastructure and inadequate access to jobs, training and educational opportunities and recreational facilities, thereby reducing the standard of living of those affected and exacerbating any other disadvantages they may face. (Commonwealth of Australia 1990, p.9)

Issues identified in the literature in relation to where people choose to live include:

- the importance of housing affordability, particularly in the early life-cycle stages;
- the higher value placed on the dwelling - rather than location - by many home-owners;
- an apparent lack of concern about access to services, with the possible exception of public transport (Burgess & Skeltys 1992, p.4).

An Australian survey on housing and locational choice concluded that:

Relatively few people perceive that they have difficulty gaining access to key services important to them, with hospitals, public transport and the houses of friends and relatives presenting most difficulty. However, older single people, sole parents and couples with young children report more access problems than the population as a whole. Thus, access difficulties appear to be related to life cycle stage, exacerbated by location and means of transport used to access services. (Burgess & Skeltys 1992, p.xiv)

A major government concern has been how to finance urban infrastructure, with one of the identified problems being 'how to curb the sprawl that has characterised much of the development undertaken during the last two decades' (Kirwan 1991, p.71). An allied concern has been 'that families may be forced to move to the urban fringes of the large cities because of cheaper housing costs, but have inadequate access to employment and services there' (Brownlee 1990, p.1).

One policy approach to the perceived problems associated with urban sprawl has been to seek to improve the efficiency of cities through consolidating population growth within major population centres with established service infrastructure, encouraging medium to high-density housing development. The Building Better Cities initiative of the Federal Government was, among other things, an attempt to respond to this issue (Commonwealth of Australia 1991, pp.4-5). The problem remains, however, that residential development continues to expand on the fringes of our major cities and there are legitimate demands for services by the people living there.

A second approach in relationship to health and community services has been to reduce or close down services in what have been described as 'services-rich areas' and to re-allocate resources to areas where there are fewer services, on the basis of population distribution. An example of this approach is provided in the Victorian Government's review of Family and Children's Services (Health and Community Services 1993a). While this may sometimes be justified as a response to demographic changes, it can also pose problems. How, for example, should the relative lack of accessible services for families in outer areas of Melbourne be assessed in comparison with the special needs of refugee groups living in the inner areas, many of whom speak little or no English?

A recent report emphasised the complexity of issues involved in re-allocation of resources, concluding that:

... in the middle and inner areas, existing services may be under-used because of less demand associated with declining population and changing community needs, but the situation is often not clear-cut ... there is a general lack of information about the nature and capacity of existing services in the middle and inner ring areas ... (Commonwealth of Australia 1992, p.49)

Access to health and community services should not be examined in isolation from related factors, such as the composition and needs of the population, provision of informal support to families, housing choices and employment opportunities. The issue of locational disadvantage also has to relate to what people want from their localities; for example, what are the qualities of local neighbourhoods that parents of very young children value? What importance do parents place on access to services in their assessment of the desirable qualities of where they live? By way of example, a recent report from a major national study of families, the Australian Living Standards Study, emphasised the primary importance with which families who had been deeply affected by the recession placed on employment opportunities:

Although some of the families had long experience of economic hardship, for most the experience was a direct consequence of the recession ... while public supports and services are crucial in the short-term, clearly what these people want and what they need are jobs. (McDonald & Brownlee 1992, pp.12-13)

Another report from the same study makes the following comment on the child-centred family lifestyle of the residents of Berwick, a neighbouring council area of Cranbourne (one of the locations for this research):

Critics of suburban expansion rarely refer to children, yet children are most important in determining the form of development we have on the urban fringe ... In choosing to live in Berwick, the families in this study (all of whom have children) stated that the two most important considerations they had were a place that was close to schools and a place that was safe for children to play outside. The third most important consideration was having a quiet neighbourhood but next in order of priority were having a large block of land and having a four-bedroom house, again reflecting a lifestyle which is child-focussed. The backyard was seen as a safe and secure place for young children to play. (McDonald 1993a, p.458)

As this Brotherhood of St Laurence research was undertaken in the second half of 1992 during a period of economic recession, mothers were asked about the effect of the recession on family life. It was felt that this would contribute to an understanding of the pressures faced by families. These pressures, in turn, could be expected to affect families' need for services and cause problems of access due to lack of money.

Inner-urban research

This research in outer areas was developed to complement an earlier study undertaken by the Brotherhood of St Laurence on mothers' use of birthing and early childhood services in two inner-urban Melbourne localities, as part of a longitudinal study on the life chances of children (Gilley 1993a). Would the difficulties identified by mothers in using birthing and early childhood

services in inner-Melbourne be the same or different for mothers with babies in outer areas? In particular, would there be differences in the impact of low family income on the use of services according to different locations?

The inner-urban research concluded that mothers in families on low income experienced difficulties in gaining access to some birthing and early childhood services, despite the fact that they lived in a 'services-rich' environment which included an extensive network of public transport. These difficulties are discussed later in this report and compared with mothers' experiences in the outer areas.

Study aims and method

The major aim of this paper is to explore the experiences of mothers in their use of birthing and early childhood services in four locations chosen on the basis that they were examples of areas that have been described as 'services-poor'. It also contrasts the experiences of these mothers with those of mothers in a 'services-rich' area.

The main questions considered in this report are:

1. How do mothers view these four areas as places in which to live and bring up children?
2. What problems of access to quality health and community services are encountered by mothers?
3. What is the relationship between low income and access to quality services?
4. How do mothers' experiences of service use in four outer areas compare with those of mothers in an inner-urban environment?

Research method

Twenty-three small-group discussions were held with between five and eight mothers in each group. There were six discussion groups in Cranbourne, Melton and Bellarine District and five in Ballarat. Mothers were also asked to fill in a short self-completion questionnaire covering family composition, housing tenure, housing costs, income, employment and use of health and community services.

The mothers in the four areas were approached by their local Maternal and Child Health (MCH) nurse to take part in the research. Each of the MCH nurses operated her service from a centre with a local catchment area; thus, the mothers attending each discussion group usually lived in the same small local community within the larger study areas.

MCH nurses were requested to include only those mothers with a child between four and seven months of age, and to include mothers on 'low' incomes as well as mothers in 'higher' income families. The location of

particular groups usually determined whether the mothers were predominantly on 'lower' or 'higher' incomes. For example, one of the group discussions included mothers from an area with public rental housing, most of whom were on social security incomes.

Because the mothers were initially contacted by the MCH nurses, it is conceivable that a bias towards selecting mothers who had a good opinion of this service and an exclusion of those who did not may have occurred. This does not, however, appear to have been the case for several reasons. The restriction of the age range of the child to between four and seven months required some MCH nurses to approach *all* mothers with children in this age range in the local catchment area of the service. When the additional criteria of low income was added, nurses often had to contact *all* mothers with children four to seven months of age using their service. However, in a discussion with MCH nurses in the Bellarine District, one nurse suggested that there was a slight bias to include more frequent users of the service in the group discussions because they were easier to contact. Another check on potential bias is the extent to which mothers' views of the service are consistent with other research, and this is discussed in the concluding chapter.

Two groups that the research failed to involve were mothers in full-time paid work, who were understandably hard to contact, and fathers who were principal carers of their children (whom MCH nurses identified as a small but emerging group with unmet needs). Sole parents generally were difficult to involve in the research, except in Ballarat, and thus appear to be under-represented.

Meetings were also held with local service providers in each area at the commencement and completion of the research. Local summary reports were prepared for the four areas and locally distributed (Gilley 1992a; Gilley 1992b; Taylor 1992; Gilley 1993b). More detailed discussion of the research method is provided as Appendix 1. A list of the questions asked in the group discussions is provided as Appendix 2, and a copy of the self-completion questionnaire as Appendix 3.

The strength of the focus-group method is that it allows for a concentration and elaboration of views held on the issues under discussion, either to reach consensus or to clarify the basis for different views. Its major limitation is that, while it is able to explore the nature of the issues, it does not quantify the extent of the identified experiences within the study area. This is best provided through survey research.

Comparison with inner urban study

In both the outer and inner areas, questionnaires formed the basis for the collection of demographic data and information about which services were used, and this made direct comparison of the two sets of data possible. A short self-completion questionnaire in the focus-group research and a personal interview used in the inner-urban study were employed.

Problems of access and quality of services identified in the inner-urban study were used as the basis for the interview guidelines for the focus-group discussions. In this sense, the findings were comparable at a thematic level - even though the methodologies, personal interviews and focus-group discussions varied. Because the recession was at different stages during the periods of data collection (1990-1991 for the inner-urban study, and the second half of 1992 for the outer research), no attempt has been made to compare families' experiences of the recession across these two studies.

INTRODUCING THE FAMILIES AND THE AREAS

CHAPTER 2

This chapter provides an introduction to the characteristics and situations of the families who participated in the focus-group discussions; some description of the nature of the study areas; mothers' views about these areas as places in which to bring up children; and the informal supports available to mothers. Comparisons are made with the inner urban research.

The families

Family size

The 146 mothers who participated in this research were most commonly either first-time mothers (40 per cent), had two children (30 per cent) or three children (22 per cent). There were five mothers with four children and only two mothers with five children. Most of the children were living in two-parent families, with only eight sole-parent families participating in the study.

Mothers' and fathers' ages

Mothers' ages ranged from 18 to 41, with 10 per cent of mothers aged 21 years or less, 60 per cent in the 22 to 29-year age range and 30 per cent 30 years or older. Fathers were usually slightly older than their partners, with an age range of 19 to 42.

Country of birth

Most of the mothers (84 per cent) and fathers (83 per cent) were Australian-born. Among those not born in Australia, only a small number of mothers (four) and fathers (seven) came from non-English speaking countries. All mothers spoke English well enough to freely take part in group discussions in English.

Housing

Just under two-thirds of the families (65 per cent) were home-purchasers or home-owners. Sixteen per cent of families were in private rental arrangements and another 16 per cent were living in public rental housing. Three families lived with relatives.

Families in private rental housing often faced direct housing costs similar to those incurred by the home-purchasers, with a median mortgage repayment figure of \$138 per week - compared with a median private rental charge of \$125 per week. Those families in public rental housing received a measure of financial protection against housing costs, with a median rental charge of \$60 per week. Those families who were home-purchasers and who had been able to maintain family income at pre-recession levels reported being better off financially than before the recession. This was due to reductions in mortgage interest rates (which have been further reduced since this research was completed in the second half of 1992).

However, several families had been unable to continue mortgage payments because of unemployment; their houses had been repossessed, and they were privately renting or living with relatives at the time this research was undertaken.

Employment

Most fathers were in paid work, but 32 (22 per cent) were not employed. Seven fathers were in part-time work. Major occupational categories for fathers in paid work were process work (29), trades (27), administrative/executive (12), services (12), sales (seven), professional (eight).

Twenty-seven mothers (18 per cent) were in paid work, with only three of these employed full-time. Occupational categories were clerical (10), professional (six), services (four), sales (three), administrative/executive (three) and process work (one). Twenty-three of these mothers had partners in paid work, so it was the exception for mothers to be employed when their partners were unemployed.

The recession had major impact on the employment situation of families; most significantly, unemployment of 32 fathers, although some mothers had also lost part-time employment. A more subtle impact was under-employment of fathers, with income of a number of those employed as tradespersons falling dramatically. For example, the income of one family in which the father was a builder had dropped from \$800 to \$250 per week, with the mother commenting: 'you can't live on that'. Some who were unable to find work as employees had become self-employed in order to generate work and were struggling to bring in a living wage. One mother in this situation said: 'we live from day to day. After paying the mortgage, there is little money left for food'.

Some mothers were attempting to find employment, or had decided to return to work, even though they would have preferred to stay at home with their baby. One mother in private rental housing said that she was planning to return to work 'because it is the only way to save up the deposit to buy a house'.

Education

Just under half of the fathers had a post-secondary qualification (46 per cent), comprising 32 per cent of the fathers with a trade qualification and 14 per cent with a tertiary qualification. Mothers' levels of post-secondary education were lower overall than that of their partners. Just under one-quarter (24 per cent) of mothers held a post-secondary qualification, including seven per cent of mothers with a trade or certificate, such as nursing, and 17 per cent with a tertiary qualification.

Family income

The Henderson poverty line, used here, is a widely used measure of income poverty which varies according to both family size and whether the head of the family is in the work force (Carter 1991). Henderson characterised his poverty line as being set at an austere or 'low level'. He described those below it as 'very poor' and those who were less than 20 per cent above it as 'rather poor' (Henderson 1975, p.13).

In this research, family income level was defined as 'low' if it was below 120 per cent of the Henderson poverty line and 'higher' if it was above this point. This definition of family income levels divides the families into two roughly equal-sized groups, with just under half of the families in the research (48 per cent) living on a low income.

The problem with using any income line as a dividing point is that families with incomes marginally above that line will be in a similar situation to those just below it. For example, 120 per cent of the Henderson poverty line for a couple with one child and the head of the family in the labour force was \$371 per week (for the March quarter 1992). A family of this size with an income of \$380 per week would be classed as being on a higher income for the purposes of this research, yet would be in a very similar financial situation. There were a number of families in this situation. Similarly, some families just missed out on being eligible for a Health Care Card because their income was slightly above the eligibility cut-off point. A mother whose income was \$10 above the eligibility limit made the point that she was now considerably worse off financially than some families who qualified for this assistance because she had high health care costs.

A small number of self-employed families on low income also experienced difficulties in formally establishing their exact income level with the Social

Security Department for purposes of qualifying for the Family Allowance Supplement (now Additional Family Payment). They had very low cash incomes but were not receiving any income support nor had they been issued with a Health Care Card.

It is important to emphasise, for the purpose of later discussion, that family size can have a major influence on whether family income is above or below 120 per cent of the Henderson poverty line; for example, as mentioned above, 120 per cent of the Henderson poverty line for a couple with one child (head in the labour force) was \$371 per week for the March quarter 1992; the corresponding figure for a couple with four children was \$558 per week.

Family characteristics and income

Younger parents were more likely to be on a low income, for example 12 of the 15 mothers aged 21 years or less were in families on a low income. Each of the sole-parent headed households (all women) were on a low income. Most of the families in public and private rental housing were on a low income, with home-purchase/ownership being seen as the desired housing state and rental housing as a second choice. Fathers with a post-secondary education qualification were more likely to be in higher-income families (58 per cent) than in low-income families (38 per cent).

Family characteristics not statistically associated with low income included family size, country of birth and mothers' post-secondary education qualifications.

Comparison with inner-urban families

There were considerable differences in the characteristics of the families in the inner-urban sample compared with families in the focus-group research. In the inner-urban sample there was a higher proportion of younger and of first-time mothers, a higher proportion of larger families with three or more children, as well as a higher proportion of sole parents. There was a much higher proportion of non-English speaking families in the inner area especially from Indo-China (just under one-third of the sample) and, in strong contrast to the overseas-born families in the outer-area research, many spoke little or no English. The proportion of families in private and public rental housing (usually high-rise flats) was higher, and the proportion in home-purchase/ownership was correspondingly lower.

There were much sharper contrasts in mothers' and fathers' education in the inner-urban sample at both the lower and upper ends of the scale. Ten per cent of the mothers had primary education only, and a higher proportion had post-secondary (usually university) qualifications. A similar proportion of fathers had post-secondary qualifications in both samples, but these were concentrated in university qualifications, in the inner-urban sample, and in

the trades area in the outer-area research. There were strong links between these differences in fathers' education levels with occupations, with a higher proportion of fathers employed in the professional category in the inner sample contrasted with higher proportions employed in the trades and production categories in the outer areas.

Differences in occupational status are reflected in a comment from a Melton Council employee during the course of this research. He observed that the Council was sometimes criticised for not employing professionals who lived in the local area, but that this was often not possible because there were so few professionals living there.

Many of these differences between the characteristics and situations of families with very young children participating in the outer and inner research were a reflection of differences in the populations of families with young children in these different areas, as discussed below. However, the higher proportion of families on low income in the focus-group research (almost one-half compared to about one-third of the families in the inner urban sample), was the result of a deliberate selection of greater numbers of low-income families. Indeed, as indicated in Table 1 below, the inner-urban study area had a higher rate of unemployment than three of the four areas in this research. The over-sampling of low-income families in the outer areas occurred because the primary focus of the research was the impact of low income on the use of services, with the experiences of the higher income families providing a point of contrast.

In common with the focus-group families, low income was associated in the inner-urban research with younger mothers and fathers, sole parenthood, fathers without post-secondary qualifications and with families living in rented accommodation. However, in contrast, low income in the inner area was also associated with a non-English speaking background, with these families also comprising most of the families with three or more children.

The areas

Some broad descriptors of the four areas in the focus-group research are provided below in Table 1. The outer areas of Cranbourne, Melton and the Bellarine District are all relatively large and have experienced rapid growth in population. In contrast, Ballarat city covers a relatively small area and experienced a slight drop in population between the 1986 and 1991 Census. Home-purchase/ownership is the dominant housing tenure in all four areas, and the proportion of public-rental housing is low.

Table 1 Some characteristics of the five study areas

Area	Population 1991	Population growth 1986-1991	Area sq. kms	Median house prices 1992	Proportion home purch- asers/public rental 1991	Unemployment level (rate), December quarter 1992	Sole parents with dependent children 1991
Cranbourne	70,821	23,216 (49%)	755	\$100,000	79%—3%	2779 (8%)	1467 (8%)
Melton	34,340	5,924 (21%)	450	\$90,000	82%—2%	1731 (11%)	878 (10%)
Bellarine	41,130	5,827 (17%)	332	\$97,000	78%—3%	2617 (13%)	848 (7%)
Ballarat City	34,806	-305 (-2%)	35	\$73,000	69%—4%	2834 (18%)	980 (12%)
Inner-urban*	31,273	-330 (-1%)	8	\$146,000	40%—26%	2834 (17%)	1047 (16%)

Source: Population and housing tenure statistics from ABS 1993; medium house prices from Valuer-General 1993; size of areas from Victorian Municipal Directory 1993; unemployment rates from DEET 1993.

* The two inner-urban municipalities combined.

Cranbourne and Melton Shires are examples of high-growth areas on the outer-urban fringe of Melbourne, and the Bellarine District is a growth area extending from urban Geelong. Most of the families in this research had moved into the areas within the last 10 years, with many of the families having lived there for less than five years. In contrast, Ballarat was an example of a major provincial centre 111 kms west of Melbourne. Most of the families participating in this research from Ballarat had lived there all their lives.

The Shires of Cranbourne and Melton and the Bellarine District all had areas in excess of 300 square kilometres. Although these areas had relatively large populations concentrated close to the town centre, there was also a pattern of relatively small pockets of population occurring often at a considerable distance from the town centre. In selecting the location of the group discussions an attempt was made to include the range of these communities, as it was expected that issues of access to services would at times vary considerably - depending on whether people lived close to major townships or further out in relatively small communities. In contrast, the mothers participating in the focus-groups in Ballarat either lived in the City of Ballarat or in the Ballarat Shire close to the city; thus most families were within half an hour's walk of the city centre.

Comparison with inner urban area

Some characteristics of the initial inner-urban location of the families (two adjoining municipalities) are also included in Table 1. The main contrasts between the descriptors for the inner-urban area compared with the three growth areas (Cranbourne Shire, Melton Shire and the Bellarine District) are the smaller size area, higher population density, lack of population growth (between the 1986 and 1991 Census), lower proportion of home-owners/purchasers, higher proportion of public rental housing, higher house purchase prices and a higher unemployment rate. In contrast with the City of Ballarat, the inner-urban area has a higher proportion of public rental housing and a higher proportion of sole parents. In common with Ballarat, the inner-urban area covers a relatively small geographic area, suffered a slight drop in population between the 1986 and 1991 Census and has a similarly high unemployment rate.

Mothers' views of the areas

Advantages

Most mothers had moved from more densely settled areas of Melbourne or Geelong and there was general agreement regarding the desirable qualities of the three outer-urban growth areas: the fresh and clean air; relaxed country feel and small size of communities within the larger study areas with comments such as 'always meeting people you know' and not having to 'fight for car parks'; the friendliness of the residents and feeling of safety and not having to lock everything up; the trees; greenness of the area and picturesque scenery. In four of the group discussions in the Bellarine District there was the added attraction of easy access to unpolluted beaches. In two of the local areas in Cranbourne the advantage of fresh air was offset by offensive odours when the 'wind blew in the wrong direction', in one case from a mushroom farm and in another case from a market garden. Similarly, mothers in one area of Ballarat (Rowan View) complained about the strong sewerage smells in summer.

Mothers living in areas closest to the townships placed less emphasis on the friendliness of their local area. In one of these areas in the Bellarine District there was agreement in the group discussion with one mother's comment that she felt safe because 'you always have police in the area', rather than because of the friendly nature of the local community. In one of the rapidly expanding areas in Cranbourne (Merinda Park) several mothers lamented that the area was becoming less friendly as it grew larger, and said they were considering moving further out to regain this quality.

A common theme in the comments of home purchasers as to why they chose to live in these areas was described by one mother as 'value for money' in housing: relatively cheap housing when compared to Melbourne prices, combined with houses in good condition (often new), with three or four bedrooms and 'good size' backyards.

Disadvantages

Although there was general agreement that all four areas were good places in which to bring up young children, there was also general concern about the lack of activities and opportunities for older children.

A number of sub-themes in mothers' concern about young people emerged. One was an immediate concern, expressed as discomfort or anger, about acts of vandalism. These acts ranged from destruction of letter boxes (a regular pastime in some local areas) to breaking park equipment. Another common complaint related to misuse of motor vehicles, with young male drivers speeding down residential streets doing 'wheelies', or riding motor bikes through parkland. Mothers often commented that they thought that the local police were not doing enough to control this behaviour. Several mothers

in Cranbourne also talked about feeling intimidated when groups of male teenagers 'hung around' local milkbars, even though they had not said or done anything threatening. Several mothers in one area in the Bellarine District expressed similar feelings about seeing groups of teenagers congregating around local schools.

Mothers usually saw the 'teenage problem' as the result of a 'lack of things for teenagers to do', especially for those not interested in participating in sport. Some mothers linked this to the inadequacy of public transport which prevented young people from travelling out of their areas for social and recreational pursuits. Mothers were generally concerned about what would be available locally for their own children when they became teenagers. As one mother who lived in the Cranbourne Shire commented, 'Cranbourne is a nice place to live with young kids but the future for our kids is uncertain'. Thus while mothers were very content with the choice of location for bringing up young children they had concerns about its appropriateness for older children.

Some other anxieties that mothers expressed about their children's future were linked more to economic issues than to location. A number of mothers expressed concern about whether they would be able to afford to pay for private education, viewed as necessary for obtaining employment in an increasingly competitive labour market; about future shortages of employment opportunities for their children; and whether their children would be able to afford to buy a house.

The other disadvantage most commonly identified by mothers was inadequate public transport services, which is discussed later as a barrier to the access of services. Concerns about lack of access to ambulance and police services are also discussed later.

There were a number of complaints about unsealed roads and the associated problems of dust. Unmade footpaths in a number of areas meant that mothers had to walk on roads with their prams and they were concerned about the danger involved. A small number of mothers complained about having to pay to have their road sealed and sewerage connected, and not being made aware of these costs when they purchased their house.

In Cranbourne, Bellarine District and Ballarat there were areas of public housing and therefore a greater concentration of families on low income. Mothers in two of these areas identified what they described as 'good and bad residential pockets', with bad pockets characterised by difficult and noisy neighbours. There was concern from people who lived in these areas that negative judgments were made about them simply because of where they lived.

Mothers' views about the advantages and disadvantages of living in Ballarat shared some common themes with the three growth areas. One difference was a common complaint about Ballarat's very cold weather. This was a particular issue for mothers living in what they described as sub-standard private rental accommodation that was difficult to heat,

especially when they had children with health problems such as asthma and when they felt it was too cold to take their children out. Mothers liked the fresh air, though many had never lived in a heavily polluted city. While mothers in Ballarat were generally happier with public transport services than mothers in the other areas, they reported the common problem of difficulty in getting prams on and off buses with an added problem being that buses sometimes did not stop. Some mothers described where they lived as a friendly place, while others said the same place was unfriendly and felt unsafe, especially at night.

A number of complaints were relevant only to particular areas. In some of the outlying areas of Cranbourne, such as Merinda Park, phone calls to Melbourne were at an STD rate. Several mothers talked about the high cost entailed in keeping in close phone contact with family in Melbourne, with one mother saying 'it costs me a fortune'. In another discussion group involving mothers from Carrum Downs and Botany Park in the Cranbourne Shire, mothers complained about the prevalence of mosquitoes; the general dampness of the area, with some of the houses being built on a land-fill area, and a recent case of sediment in the local water supply (since rectified) which caused some local illness.

In Melton, mothers were generally unhappy with the planning of the main shopping area which one mother described as 'a mess'. They complained of having to visit different areas of the city for different tasks such as shopping, banking and going to the post office (described as being in a 'hopeless position'), with no pedestrian access between the two main shopping areas. For mothers with cars, this was an inconvenience; while it made shopping very difficult for mothers reliant on public transport.

Mothers in Ocean Grove said the summer-holiday visitors, referred to without affection as 'thrip', were a disturbance in their use of local services and amenities.

Support of relatives and friends

In discussing the support provided to mothers by their partners, close relatives, friends and neighbours, a distinction is made between aspects that relate to location and those that might apply to any group of families with very young children.

Partners

The most common situation was for mothers to have partners who were supportive but who were unable to provide assistance during the week because they were away at work for long hours. A typical example of this was one father who left for work at 8 a.m. and returned at 8 p.m. One mother quoted her young son as saying 'Daddy's hardly here for tea', and it was a common story for children to be in bed by the time fathers returned home from work.

This sometimes included long travelling times; for example, one father lived in Melton and worked in Dandenong. In a few instances, fathers combined full-time work with evening study. Sometimes fathers were present in the evening, but mothers felt they could not 'dump' the children on tired fathers, and would only ask for assistance 'when desperate', as one mother commented. Mothers in one small-group discussion likened themselves to sole parents in the lack of practical assistance they received with their children during the week.

Other aspects of assistance from fathers were not related to locational issues. A small number of mothers, for example, attributed their partners' increased working hours directly to the recession. The reasons mothers gave were either that their partners were afraid of losing their job or that, if self-employed, they needed to work longer hours because of reduced income.

A small number of mothers said their partners participated equally in the child-care responsibilities. Other mothers in these group discussions offered an immediate swap of partners whenever these rare specimens emerged! In contrast, some fathers were described as extremely unhelpful, such as a father of a 'crying baby' who provided no assistance in the first six months, or the young father of another child who left the mother because he could not stand the child crying. A small number of fathers were not only unhelpful but also a source of stress. This included an alcoholic father, a physically violent father from whom the mother was separating, and a father who insisted that the mother provide all the child-care with no outside assistance.

Close relatives

The importance of assistance from close relatives was stressed by most mothers, either when it was there or because it was missing. Mothers' own mothers were the most important figures, though other close relatives were sometimes also an important source of help. Both emotional support, through having somebody sympathetic to talk things over with, and practical support were regarded as important. The most common form of practical assistance mentioned was child-care.

Distance was the major factor interfering with support from close relatives and thus was directly related to the issue of location. At one extreme were overseas-born mothers whose close relatives did not live in Australia. There were strong emotional expressions from these mothers about how much they missed the support of their relatives, especially when they were first-time mothers. A small number of mothers had parents living interstate. In small group discussions in the more outlying areas of Cranbourne, a number of mothers lamented that where they lived was considered too far to travel by their parents who lived in metropolitan Melbourne, with Cranbourne being regarded as 'in the bush'.

Where close relatives did not live locally, mothers commented on the lack of practical assistance though emotional support was sometimes still there, especially if the relatives lived in Victoria. Thus one woman living in Ballarat said 'I couldn't do without my parents' support', despite the fact that they lived 200 miles away.

Other aspects connected with lack of support from close relatives were not related to location. In one family practical support was lacking because the child's grandmother was in paid work, while another grandmother was heavily involved in community work. Another regarded herself as too young to be a grandmother and would not help. In one small group discussion, the parents of several mothers had retired and, although they lived locally, travelled extensively, especially in the winter months, and were absent for lengthy periods. This was an interesting example of affluence as a barrier to social support.

Friends and neighbours

Some mothers had strong networks of friends while others were socially isolated. In the three growth areas, mothers who had recently moved into the areas often had not established local networks of friends. This was especially the case for those with their first child who had been in full-time work before the birth and regarded where they lived as primarily a 'place to sleep', with one mother in this situation commenting 'it takes a while to break in'. Where friendships were maintained outside the local area, access to a car was regarded by mothers as essential for maintaining good contact.

Other comments were not related to location. A number of younger mothers commented on feeling deserted by those of their friends who did not have children. A small number of mothers had extremely helpful neighbours who, they said, were of more assistance than their own family, or who substituted for their lack of family. However, the availability of friends or neighbours to assist mothers with babies was generally secondary to the importance of close relatives. A small number of mothers had neighbours who were a major source of stress; for example, an alcoholic man who was violent.

Support of relatives and friends and low income

Access to support from partners, relatives or friends did not appear to be strongly related to low family income. The major exception was mothers who felt isolated because they did not have access to a car. Another exception was the cost of phone calls to Melbourne from some areas of Cranbourne Shire at STD rates, which was a potential barrier to maintaining good contact with extended family members. Also, all mothers without partners were on low incomes.

Comparison with inner urban sample

Although the difference in methods of data collection – group discussion and individual interview – creates some problems in comparing mothers' views on the advantages and disadvantages of inner and outer locations as places in which to bring up children, there were a few clear points of contrast.

One strong indication of mothers' overall view of the inner location was that the majority rated the areas as an average, poor or very poor place to bring up children. The most commonly expressed concerns were the effects of pollution and the streets being unsafe at night, though traffic, noise levels and lack of playgrounds for children were also problems for some mothers.

Likewise, there were strong contrasts with the outer areas in what mothers saw as the advantages of living in inner Melbourne. There was almost universal agreement that good public transport, closeness to shops and good services for both children and adults were advantages of living in the inner location.

Views also differed according to which sub-locations families lived in within the inner area. There were two typical kinds of local neighbourhoods: high-rise public rental housing estates and areas of mostly owner-occupied terrace cottages, with a concentration of families on low incomes in public rental housing and more affluent families living in owner-occupied housing. Concern was expressed by a number of mothers in the high-rise estates regarding lack of safe playing areas for children, seeing 'needles' (hypodermic syringes) left in the lifts and on the surrounding grounds, and general feelings that the local area was not safe particularly at night. In contrast, mothers living in Victorian cottage housing were more concerned about what they perceived as the inadequate size of their dwelling now that they had children. A number of these mothers had plans to purchase larger houses, usually further out from the city centre.

Three years after their child's birth, over half of the families from the inner-area sample had 'voted with their feet' and moved usually to larger houses outside the inner-urban area. Some of the mothers in families on low income who were living in high-rise public rental housing flats expressed a desire to move but were prevented from doing so by financial reasons. Some were on waiting lists for transfers to three or four-bedroom public rental houses in other areas.

Families on low income were less likely to have strong informal supports than more affluent families in the inner-urban sample. This included lack of support from the child's father and from relatives and friends, especially for a number of the non-English speaking background families with parents living overseas.

MOTHERS' VIEWS OF SERVICES

CHAPTER 3

This chapter explores mothers' use of health and community services, beginning with their patterns of service use, their views about the quality of services and any problems they encountered in gaining access to services. The relationship between low family income and mothers' experiences in the use of services is examined. A comparison is made with mothers' experiences in the use of services in the inner-urban Melbourne study.

Patterns of service use

The patterns of service use in the outer areas is indicated in Table 2 below. As mentioned earlier, this information was collected from a short self-completion questionnaire. What is most notable in this table is the universal use of hospital and MCH services, the division between private and public patient care in hospitals, the high use of general practitioner and chemist services and the less common use of a number of other services.

Table 2 Patterns of service use in outer areas (collected 1992)

Type of service	Used		Not used		Missing		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
MCH service	146	(100)	0	(0)	0	(0)	146	(100)
General practitioner for self	139	(95)	6	(4)	1	(1)	146	(100)
Chemist	139	(95)	5	(4)	2	(1)	146	(100)
General practitioner for baby	136	(93)	9	(6)	1	(1)	146	(100)
Public hospital care	98	(67)	46	(32)	2	(1)	146	(100)
Obstetrician	96	(66)	48	(33)	2	(1)	146	(100)
Birth classes	75	(52)	69	(47)	2	(1)	146	(100)
Private hospital care	46	(32)	98	(67)	2	(1)	146	(100)
Hospital care for baby	40	(28)	104	(71)	2	(1)	146	(100)
Nursing Mothers' Association	26	(18)	118	(81)	2	(1)	146	(100)
Child care	24	(16)	119	(82)	3	(2)	146	(100)
Alternative health practitioner	21	(14)	120	(82)	5	(4)	146	(100)

In the group discussions mothers identified a number of additional services they used. Although no attempt was made to count the number of users, the indications were that only a small number of mothers used these services with the exception of the health check six weeks after the birth, which was very common. During pregnancy, additional services mentioned were: exercise classes (yoga and water aerobics), in-vitro fertilisation programs (IVF) and the Twins Club. After the birth, mothers identified a range of additional medical specialists for their own or their child's health and well-being including paediatricians and eye, ear and throat specialists. Paramedical services included the Royal District Nursing Service (RDNS) and physiotherapy. Other services mentioned were: Community Health Centres, Neighbourhood Houses, Crying Mothers' Association, home help through local councils (usually for cleaning once a week in the first month after the birth) and emergency aid through organisations such as the Salvation Army. Social Security, the Commonwealth Employment Service and Medicare offices were Federal Government services accessed by mothers.

Patterns of service use by mothers on low income

Mothers in families on low income were less likely to use the Nursing Mothers' Association. They were much more likely to be public rather than private patients when using hospitals and were less likely to use the services of an obstetrician, which was often associated with private hospital care.

Mothers were just as likely to use the following services regardless of whether they were on a low or higher income: general practitioners for self and baby, birth classes, MCH services, chemists, child-care services and alternative health practitioners.

Comparison with inner urban sample

Mothers in families on low income in the inner urban sample were also more likely to be public patients than were mothers in more affluent families, and were also less likely to use the Nursing Mothers' Association. In addition, they were less likely than higher income families to attend birthing classes, use child-care services or alternative health practitioners a distinction not present in the outer groups.

Quality of services

The issue of quality of services was explored in the focus groups through open discussions with mothers on what they valued about the services they used and what they were unhappy with. The approach was intended to be balanced, with mothers encouraged to identify positive and negative aspects of the services they used. As far as possible, services are discussed below in

the order in which mothers used them, beginning with antenatal care, birth classes, hospital care at the birth, follow-up care at home, MCH services, six-week check-up, general practitioners, hospital care for child, chemists and other services.

Antenatal care

Various forms of health care were used by mothers during pregnancy, including local general practitioners, private obstetricians, public hospital clinics (including a special clinic for teenage mothers, the Little Clinic in Ballarat) and 'shared care' schemes involving a general practitioner in conjunction with either a private obstetrician or public hospital care.

Comments on antenatal care were generally favourable, with most critical comments concerning the long waiting times, lack of privacy and discontinuity of care experienced in the public system.

Mothers who used one public clinic complained about waiting times of up to three and a half hours. In another public clinic all mothers were weighed and had urine samples taken in the one room, and mothers were unhappy with the lack of privacy. The most common complaint concerned having to see a different doctor at each visit (and at the birth). In contrast, several mothers using the Little Clinic in Ballarat (a public clinic targeted to the needs of young mothers), enjoyed meeting other young mothers and were satisfied with the quality of the service, which included an arrangement whereby they saw the same doctor at each visit. Similarly, one group of mothers using a shared care scheme, which included the combination of a public clinic and seeing their own doctors at home, found this to be a better, more 'personalised' service than just attending the clinic. As one mother commented: 'you have help all the time with your own GP. They keep a closer eye on you than the hospital'.

Two mothers had negative experiences of shared-care arrangements. One mother who used a combination of local general practitioner and Melbourne specialist in a shared-care arrangement found the service to be poor because the two doctors 'did not get on' and gave her conflicting advice. Another mother had a medical condition that required her child to be delivered by caesarean section. When she was admitted to hospital, doctors first attempted to have the birth induced, because the mother's general practitioner's records specifying this procedure had not been received by the hospital.

Some of the mothers who were private patients of obstetricians were unhappy with aspects of the service they received, though most were satisfied. On the positive side, what mothers valued in obstetricians were a caring manner and approach, correct diagnosis and treatment and explanations of what was happening. Criticisms included: one with an 'abrupt manner'; one who ordered ultrasounds, giving no explanation; one who was always 'too busy' and thus difficult to see; one who failed to arrive for the birth; one who

used forceps in delivery without asking the mother's permission and then left the final stage of the delivery to two interns; and one who wrongly advised the mother that she had 'two weeks to go' (she had her baby several hours later).

Birth classes

The majority of birth classes that mothers attended were held in hospitals. Most mothers were happy with the quality of the classes overall and most regarded them as essential for first-time mothers. Some mothers who already had children also found it useful as a 'refresher', with one mother commenting 'it was good to go back to reassure myself'. The major qualities mothers found valuable in the classes were:

- gaining familiarity with the hospital staff, the hospital wards, the equipment, the use of pain-killing drugs during labour and generally with choices available during labour;
- psychological preparation for the birth, including what occurs in a normal birth and what might go wrong at birth; for example, unforeseen need for a caesarian section;
- the opportunity to meet other mothers, with some mothers developing lasting friendships;
- involvement of fathers in the birth process and their development of interest in the unborn child; and
- learning parent craft, covering topics such as breastfeeding, folding nappies, handling and bathing babies and what to buy for babies.

Comments critical of the classes were often the obverse of the positive comments. The major themes were:

- lack of information about what happens at birth, including one class with a mixture of first-time mothers and mothers with older children where it was assumed that 'everyone understood';
- lack of preparation for problems that might occur during labour, and an emphasis on normal birth which made mothers feel inadequate and depressed when they gave birth by caesarian section; and
- lack of parent craft.

Some interesting individual criticisms of birth classes were made: one mother attended six sessions of videos and found them boring; another said the classes finished too late in the evening; while another wanted locally run, rather than hospital-based, classes. One mother said that learning what might go wrong at birth in classes she attended for her first child, who was delivered normally, assisted her to understand what was happening when there were birth complications with her second child. In contrast, another mother, who

was given information on what might go wrong at the birth, said that this made her 'scared and unprepared'.

Hospital care at birth

Mothers' length of stay in hospital ranged from two days to three months, with the most common period being between three and five days. A number of mothers in Cranbourne complained about being either 'kicked out' or pressured to leave hospital before they were ready, during periods when apparently there was a high demand for hospital maternity beds. Only one mother in the other three areas said that this was a problem. Mothers commented on the importance of being able to stay as long as they wanted, with one hospital insisting that mothers were well rested before they returned home. Several mothers living in Melton chose to return home two days after the birth and said they were happy to either return to hospital for the phenylketonuria (PKU) test for metabolic disorders in babies or receive a visit from the RDNS.

Overall mothers were satisfied with the quality of hospital care. The main things mothers valued about the care were:

- friendly and supportive staff;
- continuity of care, especially during labour;
- good quality information on what was happening during labour and hospital procedures;
- privacy, such as having a room to oneself with private facilities (toilet, shower and, in one case, a spa bath);
- the option of not having the baby (or babies) in the room when mothers wanted to sleep;
- helpful advice on feeding, whether bottle-feeding or breastfeeding; and
- high quality food.

Criticisms of hospital care at the birth were again often the obverse of the positive comments. Major themes were:

- having unpleasant staff, or staff who stuck rigidly to routines;
- constantly changing staff, especially at crucial moments during labour;
- not being told what was happening;
- overcrowding, (for example, six mothers and their newly-born babies accommodated in the same ward), and feeling uncomfortable and anxious about disturbing other mothers; and
- not being supported in the choice to bottle-feed (several complaints) and being given conflicting advice on how to breastfeed (a most common complaint).

Although mothers were generally satisfied with the quality of hospital care, some differences were expressed according to whether mothers were private

or public patients. The major advantage of private hospital care was greater privacy, with positive comments being made by women who were private patients and complaints about lack of privacy from women who were public patients. Mothers who were in private hospital care were more likely to make positive comments about continuity of care and the quality of food.

There were only two stories out of 146 births of extremely poor hospital practice. This is consistent with the overall satisfaction with hospital maternity services of mothers participating in this research in the four areas.

Follow-up care at home

A number of first-time mothers without immediate family supports spoke about the trauma of arriving home from hospital after the birth and not knowing how to care for this new life, especially if they had left hospital two or three days after the birth and there were delays in seeing the MCH nurse. As one mother put it: 'I had no idea how to look after the baby, change her nappies or bathe her'.

A number of mothers who had discharged themselves two or three days after the birth had received a follow-up visit after the birth to check on the health of mother and baby as part of the hospital service. Some hospitals sent a midwife, while others contracted the RDNS to provide the service. Mothers were happy with the quality of this follow-up service. One mother with a baby who was losing weight had the RDNS service available to her daily in the first week, and every second day in the second week, and found the 'reassurance and guidance' to be very helpful. Mothers particularly valued the follow-up service from the Ballarat Base Hospital, Dom Care, especially when they were 'grounded' because they were coping with older children as well as a new baby. One mother whose baby had jaundice was visited daily for a fortnight and said the service was 'wonderful'.

Maternal and Child Health (MCH) services

Of all the services used, mothers were most affirming of the quality of the MCH service. Two very typical comments were: 'she [the nurse] is very informative, she always has time for you' and 'she's excellent, she's so good to talk to'. The major themes in what they valued about the services were as follows:

- the manner and approach of the nurses their ability to listen and not judge; to provide advice or choices but not to 'push' advice; to give praise, be open, and treat mothers as friends;
- the availability of nurses that they always had time for mothers, even when very busy, that they could be contacted by phone (including after-hours by phone, or alternatively on the 008 Melbourne-based phone service) and would make home visits;

- nurses' concern with the health and well-being of mothers that they would ask mothers about their own health, whether they were eating and sleeping properly, and generally provide moral support; and
- the nurses' provision of good advice in the right manner providing choices and objective advice: mothers were able to check health concerns with nurses before consulting with a doctor and to ask about things that seemed 'silly' but which were causing them anxiety and which they would not talk over with their doctor.

Some mothers without immediate family or close friends said they were particularly reliant on the strong relationship they formed with the nurse. Mothers in very small communities with few other services, such as Diggers Rest in Melton, said that the service was particularly important. In this area mothers pointed to the important role the nurse played in giving advice on toddlers, and argued therefore that the hours this service was open should not be 'tied to the birth rate'. In the current system the number of hours that an MCH centre is open is usually closely linked to the birth rate in the area.

Most mothers knew about the after-hours Melbourne-based MCH phone service, though not all of them knew the phone number or how to find it. In a number of groups, mothers commented that they did not use it because their nurse provided her home number for after-hours consultation. Those mothers who had used the Melbourne after-hours service spoke highly of it. They valued being able to talk to the nurse for as long as they needed (40 minutes in one case) and what they described as good advice and moral support.

Most criticisms of the MCH service were about problems of access (discussed below). There were, however, two strong criticisms of the quality of the service. One came from several mothers who found a particular relieving nurse to be 'rude, rigid and pushy' the antithesis of most mothers' experience of MCH nurses in this research. A mother with a perpetually crying baby felt she did not receive help when she asked for it, and said she could have hurt her baby out of frustration.

Interestingly, the qualities mothers valued in the MCH service were similar to those which they valued in the 'family doctor' (see below). However, while many mothers did not have access to a doctor who provided these qualities of service, most mothers had access to an MCH nurse who did.

Six-week check-up

While most mothers had a six-week check-up after the birth, the nature of the service provided varied considerably. Some mothers had the check-up visit at the hospital, some saw a specialist gynaecologist in private practice, while others went to a general practitioner. While some mothers had their own and their baby's health checked, others had only their own health or their baby's health examined. Some mothers had a pap smear taken, while others did not.

The most frequent comment on the value of the service was that it was reassuring to know that 'there was nothing wrong'. Some described the check-up as very thorough while others complained that it was either very rushed or cursory. A number of mothers were not convinced that it was 'value for money', with a typical fee being \$30 or \$35 for the mother's examination and a similar amount for the baby's check-up. There was only one mother in the study who pointed to a health problem that was identified in this examination.

General practitioner services

As mentioned earlier, most mothers used general practitioner services for their own and their child's health. While the majority of mothers used one particular general practitioner, a number used group practices or medical centres where it was usually not possible to see the same doctor at each visit. Several mothers quoted delays of up to one week to see the doctor of their choice. Doctors in group practices were more likely to direct bill patients who were not Health Care Card holders, so there was a financial incentive for mothers to use these practices, even if they were not always happy with the standard of care.

Mothers clearly expressed the qualities they were looking for in a general practitioner in what they termed the 'family doctor'. A typical comment was: 'he always has time for me, he talks things over'. The range of desirable qualities in such a doctor identified by mothers included:

- a pleasant manner and approach - remembers patients' names, 'treats you as a person';
- a genuine interest in the health of all family members;
- availability (including for phone consultations) and willingness to home-visit when necessary (including at night); and
- recognition of own limitations and referral to appropriate specialist when necessary.

While the majority of mothers were generally satisfied with the general practitioners they used, only a minority had access to this 'ideal' family doctor. A number of barriers to gaining access to the 'ideal' family doctor were identified: that they were very popular and therefore there were long waiting times; that they usually did not direct bill and were therefore more expensive and that the service was more inconvenient and costly if their doctor lived outside their local area.

Criticisms of general practitioner services included:

- having 'rushed' visits with little explanation of the diagnosis and the only treatment being antibiotics; or, as one mother commented: 'you are in the door then out again';
- difficulties in getting doctors to home-visit at night;

- lack of continuity of care in medical centres seeing different doctors at each visit meant that each doctor had to learn the patient's medical history, and mothers and children had difficulties in adjusting to new doctors;
- doctors whose behaviour left mothers with the feeling that they were uneasy treating babies; and
- wrong diagnoses and treatment through doctors (in the mothers' opinion) failing to refer mothers to appropriate medical specialists (see below).

A number of instances of incorrect diagnoses were described. These included: a very ill child who was admitted to hospital after six different general practitioners had failed to make a diagnosis; a mother on her sixth course of antibiotics before an obstetrician diagnosed that she had retained a portion of the placenta, and a 16-week-old child on its sixth course of antibiotics before a paediatrician diagnosed the problem as asthma.

Hospital care for child

As shown in Table 2, over a quarter of the mothers had returned to hospital with sick children at some stage in the early months following the birth. Hospital services for sick children were a mixture of positive and negative experiences and appeared to relate to the services provided in particular hospitals. Thus one hospital was criticised by all mothers who used it. A common criticism was lengthy delays in receiving attention; for example, one mother with a baby with irregular breathing who had to wait two hours before being assisted. Other mothers were unhappy with in-patient conditions for sick babies. One mother graphically described the situation as: 'cramped with eight cots in a small room, under-staffed with only one nurse and the babies crying all the time'. There was also agreement among mothers that staff at one particular hospital regarded all first-time mothers as 'paranoid' women and discounted the children's presenting health problems as maternal anxiety. One mother commented that medical staff did not believe that her baby had been having fits, until her daughter had a fit while being examined. In contrast, mothers commented very positively on their use of other hospitals, with staff whom they described as 'sensitive' and 'caring'. A small number of mothers also said they valued the fact that they were provided with accommodation in the hospital themselves when their babies were admitted.

Chemists

Most mothers used chemist shops for standard purposes such as filling medical prescriptions and had no comments on the quality of the services, with most critical comments pertaining to problems of access after hours and pharmaceutical costs (discussed later). However, mothers in one group discussion identified a local chemist whom they described as 'kind and caring' and whom they used regularly for advice on health matters. The most interesting example was one mother who consulted a local general

practitioner because she thought she was pregnant. He prescribed antibiotics! After discussing this with the chemist, she bought a pregnancy test instead (for \$3.50) and she tested positive.

Other services

Positive comments about the Nursing Mothers' Association included satisfaction with useful advice and support on breastfeeding problems, such as needing to increase milk supply. They also valued the organisation's coffee mornings as a means of establishing contact with other mothers. Criticisms of the service included one mother who had difficulty in getting the use of a breast pump, despite making phone calls to six mothers, and another mother who contacted several counsellors (all volunteers) who said they did not have time to talk.

A small number of mothers used local council home help services for house cleaning once a week in the first four to six weeks. They found this very helpful, as they lacked the energy and time to do this to their own standards.

Two mothers who had consulted private psychologists were highly critical of the service they received. They were both angered by the explanation given of their relationship to someone close: one being told that she hated her mother and the other being told that she hated her daughter.

One mother had used the Crying Mothers' Association and had found this very helpful, both in linking her with other mothers with 'crying babies' (while providing child-care) and through organising a priority child-care centre placement to provide her with respite.

Mothers in Whittington and Newton in the Bellarine District were particularly satisfied with the quality and availability of child care.

Quality of services and low income

Mothers' views of birthing and early-childhood services suggest general satisfaction with their overall quality. The major criticism related to income was lack of continuity of care in the public health system: in public antenatal care, public hospital care at the birth and in the use of doctors in medical centres (who were used because they direct-billed patients). Lack of privacy was also a point of distinction between public and private antenatal care and hospital care at the birth. The MCH service stood out in mothers' comments as the most helpful service regardless of family income.

Comparison with inner-urban study

Mothers' overall satisfaction with the quality of services in the inner-urban sample was very similar to that of those in the focus group research. Mothers identified the MCH service as the most helpful service in the inner-urban study. The main distinction was the greater choice of services for mothers in

the inner-urban area, especially in regard to doctors who bulk-billed, hospital care, and local community health centres.

Access to services

Mothers were also asked about any problems they experienced in gaining access to appropriate services. The major themes in mothers' comments can be grouped under lack of information about services, services not available, the cost of services and transport to services.

Lack of information about services

All mothers knew or could find out about the major services, such as general practitioner services, hospital care at birth, MCH services and chemists. However, the small focus group discussions provided opportunities for the sharing of information that often led to mothers learning from other group members about less well-known services that could have helped them with problems they were having.

In some cases, this was simply a matter of mothers not knowing the service existed; for example, exercise classes for pregnant women, the Crying Mothers' Association, the possibility of shared-care arrangements during pregnancy, or the availability of local birth classes. Sometimes mothers knew of a service but did not know that they were eligible to receive it, such as a local council home help service. Sometimes, while knowing the service existed, mothers did not know whether it would be helpful or were not sure how to obtain information about it. Such services included the Nursing Mothers' Association and alternative health practitioners. Several mothers commented that in the first months after birth they had lacked the mental energy to track down a service and assess whether it could help them.

Services not available

Mothers complained about a number of services that were simply not available in their own local areas. The smaller, more remote communities had fewer services than those with larger populations close to major town centres. For example, Diggers Rest in the Melton Shire had one general practitioner, no chemist and a part-time MCH service.

A common theme in newly developing communities was a lack of after-hours services, particularly locally available emergency medical treatment and chemist services. A number of mothers told stories of having to bundle their very sick child (and other children) into cars and drive considerable distances in the middle of the night to attend a general practitioner or a hospital. Lack of after-hours chemist services was also a problem. One mother commented on her need for this service when 'you have

run out of infant formula, or you think you have some Panadol left and you haven't'.

Some mothers approached their local council for home help after the birth and were told the service was not available due to lack of resources.

In some areas there would be only one gynaecologist or one paediatrician, and thus lengthy waiting times, except for emergencies. This meant mothers sometimes had to travel out of the local area for the service. Those mothers who were unhappy with the quality of the service provided by the local practitioner had little choice, especially if there were difficulties with transport.

A common complaint in the more outlying areas of the three growth areas in this research was the slowness of emergency services to respond, especially police and ambulance services. Mothers referred to their own experiences of reporting intruders or domestic violence to police and to incidents that had happened to neighbours or friends. For example, one mother in Merinda Park in the Shire of Cranbourne rang the police about a suspected intruder and the police took 50 minutes to arrive. The location of the nearest ambulance and the time it might take to reach residents was often well known. Apart from the actual problem of slowness to respond, mothers generally felt anxious that the services would not be there when they needed them.

Mothers in Melton and Ballarat complained about the lack of places to breastfeed their babies or to change nappies when they were shopping. Service providers in Melton explained that there was a facility in the main shopping area but it was being used as a storeroom.

Complaints about lack of access to MCH services came usually from mothers in small communities where the centre was only open one or two days per week.

Transport to services

Transport to services was a major access issue, as few services were within walking distance of where most mothers lived. Mothers' access to private transport was usually directly related to car-ownership and the fathers' employment situation and mode of transport to work. The failure of the public transport system to provide a satisfactory mode of transport for fathers' travel to and from work was the major reason that about half of the families had two or more motor vehicles. About two-thirds of the fathers used their private motor car as their mode of travel to work and only five fathers used public transport as their sole means of transport. The other fathers used other forms or combinations of transport methods such as bicycles, motor bikes, lifts with friends, company cars, or a combination of private and public transport.

The reliance on private transport for mothers' employment was equally pronounced with only one of the 27 employed mothers using public transport to travel to work.

The lack of public transport was a major issue in most of the small group discussions, although mothers in some areas, such as Whittington in the Bellarine District, which is close to Geelong, and Merinda Park in Cranbourne, which is close to the main road to Dandenong, had relatively frequent services. In Melton and Cranbourne public transport to Melbourne during peak hours was generally seen as adequate, though there was often a lack of bus services from outlying areas to connect with peak-hour train services. One mother spoke of getting herself and her children out of bed at 5.30 a.m. in order that she could drop her husband at the train station and so have the use of the family car during the day. Off-peak services were seen either as poor or non-existent. Cross-suburban services were also virtually non-existent. Diggers Rest in the Shire of Melton, for example, had no public transport service into the Melton township at the time of the research (though it was linked to other major shopping and commercial centres).

Twenty-seven mothers (18 per cent) did not have access to a car during the day, including two mothers who did not drive. Twice as many mothers in families on low income (18) had no access to a car during the day as mothers on higher incomes (nine). These mothers relied either on walking or public transport to get to services and to see friends and family. As mentioned earlier, the infrequency of public transport in the more remote communities was the most common disadvantage identified by mothers living in these areas.

Not only were public transport services infrequent, but mothers in all four areas reported that drivers (and passengers) usually did not assist them to lift prams or pushers on and off buses. Only in the Bellarine District and Ballarat did some mothers make mention of helpful drivers. Moreover, Ballarat mothers were sometimes charged an additional fee if they had prams. A small number of mothers, including one with twins, said that they did not use public transport for this reason, despite the fact that they did not have access to a car during the day.

Infrequent public transport on weekends was also a problem when parents wanted to pursue different interests, such as fathers coming to Melbourne for a football game.

Cost of services

Cost of services can render them inaccessible when people cannot afford to pay. It can also have a detrimental impact on people's standard of living when they have to go without other things in order to pay for services. Because of the low incomes of many of the families in this research, payment for services was often a considerable struggle. While it was rare for mothers to state that they did not use services because they could not afford them, they talked freely about the stress it caused them and sometimes spoke of people they knew for whom cost was a deterrent to service use.

Families receiving social security pensions or allowances and those on very low wages who receive the Additional Family Payment are eligible for the Health Care Card and thus pay \$2.60 for prescriptions rather than \$16 under the Pharmaceutical Benefits Scheme. The cost of medically prescribed drugs was a major problem for families on relatively low incomes who were not eligible for a Health Care Card. One mother spoke of spending \$50 for sick children during one weekend, while another family spent \$150 over a two-week period. Several mothers spoke about doctors who required payment 'up front' at the time of the visit, with one of these mothers having to spend \$100 for two doctor's visits and prescriptions over the one weekend. One mother, whose husband had lost a relatively low-paying job, said they were 'better off' having the social security payment and the Health Care Card. Additionally, a number of chemist items were not available on prescription, and therefore mothers either had to pay the full purchase price or go without. Mothers mentioned items such as Panadol, colic mixture, cream for baby rash and infant formula as falling into this category. These were sometimes a major expense in very tight family budgets.

Mothers made the point that the cost of using general practitioners who did not direct bill could be high when several members in the household were ill. Mothers also complained about medical specialists who charged substantially above the scheduled fee, leading to the increase in the gap payment even when families had private health insurance.

Mothers in paid work with very young babies were very conscious of the trade-off between spending time with their babies and bringing additional income into the family. A number also complained that what they earned in part-time work was almost offset by the cost of child-care. A small number of mothers said they had decided not to return to paid work for this reason.

In Cranbourne a small number of mothers who returned home from hospital two or three days after the birth had been upset by the unexpected charge of \$15 for a home visit from the RDNS, provided as a follow-up service from the hospital in cases of early discharge. Mothers were not told about the charge until the end of the visit, and the basis of a reduced charge (of \$3) for families on low income was not clearly explained. This was not a problem in three other study areas and the RDNS undertook to rectify this when advised of the problem.

Other complaints about the cost of services included: payment of \$20 for baby clothes in hospital whereas they had previously been free; and payment for ultrasounds and specialist medical fees - for example, \$1,000 for an operation during pregnancy.

The lack of local Medicare offices in some of the more remote areas meant mothers either faced the inconvenience of travelling outside the area to receive payment or relied on sending bills and obtaining payment by mail, which sometimes meant delays of up to two months. This in turn sometimes led to

significant delays in receiving reimbursement for medical bills already paid or a series of embarrassing reminder notes from their doctors (when payment was deferred until receipt of the Medicare cheque).

In a more general sense, cost of private hospital care and general practitioner services often determined which services mothers used. Thus mothers in families on low income would choose public antenatal care, would be public patients at the birth and might take a 'second choice' doctor (for example, through a direct-billing medical centre), rather than choosing a 'family doctor' who did not direct-bill them.

Mothers who used alternative health practitioners, such as naturopaths, had to pay the full price, with no rebates provided through the Medicare system. They saw this as an anomaly, given the usefulness of the service provided.

Access to services and low income

Difficulty in accessing services was a function of income, both where mothers were unable to afford the use of a car during week days, and where cost of services was prohibitive, especially when it came to choice of health care and cost of pharmaceutical items.

Comparison with inner-urban study

Cost of health care was also a concern for mothers in families on low income in the inner urban area.

In the inner area mothers had good physical access to services, with a large range of services within relatively close proximity and serviced by an extensive public transport network. Therefore the 16 per cent of families with no private transport did not have major problems with physical access to services. Although the proportion of families with two or more cars was considerably less, this was offset by the much higher proportion of fathers who used public transport to travel to work and thus left the family car with the mother. Similarly, a number of the employed mothers were able to use public transport to travel to work. While public transport was more readily available in the inner-urban area, mothers shared similar problems in obtaining assistance in lifting prams on and off public transport.

In the inner-urban research, low income often occurred in tandem with greater unmet needs, less support from relatives and friends, and less frequent use of a number of important services such as birth classes and medical specialists. What can be termed socio-cultural barriers to the use of services were also prevalent. These included language especially for recent immigrants with little or no English. Barriers also existed for young mothers with low levels of education who either did not know about certain services or who did not understand how such services might be of use. These

additional needs justified special assistance that discriminated in favour of these disadvantaged group, such as provision of interpreters, a community health centre service with bilingual staff, and outreach programs (Gilley 1993a). These same issues were not evident among families in the outer areas, except perhaps amongst some of the very young mothers in Ballarat.

SUMMARY AND CONCLUSIONS

CHAPTER 4

This research set out to explore mothers' experiences of living in four outer locations with the major focus on the use of birthing and early childhood services, and to contrast these findings with already published results from an inner-urban study (Gilley 1993a). A key issue was the extent to which there were problems in access and quality of services due to low family income and where families lived.

Summary of findings

The first of four questions posed by this study was: how do mothers view these four areas as places in which to live and bring up their children? In most cases, families had made a deliberate decision to live in these areas. For home-purchasers/owners, who comprised about two-thirds of the families, the relatively low cost of housing compared with Melbourne prices had been a major consideration, together with the newness of the housing and large house and block size. A pleasant country environment, removed from the 'hustle and bustle' and pollution of Melbourne was also a factor in this choice. Overall, mothers were very happy with the areas as places in which to bring up their children. The two major concerns were with the lack of recreational and employment opportunities for teenagers, and the inadequacy of public transport. These findings are generally consistent with the findings of other research studies discussed in the introduction to this report.

Mothers' views of where they lived were not, however, uniform and varied to some extent with sub-locations within the study areas. Mothers living in areas close to major shopping and commercial centres had easier access to services and were usually better served by public transport. Mothers living in public rental housing areas in Ballarat were concerned about the stigma

attached, and in the Bellarine District identified what they described as 'good and bad pockets' of housing within the estates. In three areas (two in Cranbourne and one in Ballarat), mothers complained about noxious odours. In the inner area, mothers' views of their local area as a place to live sometimes differed strongly according to sub-locations, with two typical types of local neighbourhoods being those associated with high-rise public rental housing estates and areas of predominantly owner-occupied Victorian terrace housing.

The recession of the early 1990s had led to a major reduction in income for some of the families in the outer areas, either because of unemployment or a drop in self-employment income. Some mothers linked this problem to where they lived, being areas with few employment opportunities, but most saw it as part of the general economic downturn. If this research had been undertaken before the economic recession, it is likely that unemployment and low income would have been largely confined to sole-parent families and parents who lacked any post-secondary qualifications. The cost of services would probably have been less of a problem. It was the substantial falls in the incomes of many of the families, as a result of the recession, that made it difficult for them to meet the additional costs associated with having a baby.

The second research question concerned the overall quality of and access to health and community services. The majority of mothers were generally happy with both the quality of services and their access to them, which is consistent with the findings of a Victoria-wide survey of mothers with babies (Brown & Lumley 1993). The major exceptions to this were the lack of availability of public transport and lack of assistance with prams when using it; the slowness of emergency services to respond; a dearth of after-hours medical and chemist services; the complete absence of some services in some of the smaller communities; limited choice of services and lengthy waiting times for some local medical specialists, such as paediatricians (except in an emergency). These problems were more commonly experienced by mothers in the smaller communities in outlying areas.

The MCH service stood out as the most helpful service in mothers' comments, regardless of income level. Mothers in the inner-urban research expressed similar overall satisfaction (Gilley 1993a). This high level of maternal satisfaction with the MCH service is consistent with the findings of other research (Ochiltree 1991; McDonald 1993a, pp.177-180; McDonald 1993b, pp.146-150). Mothers had similar levels of satisfaction with what they identified as a good 'family doctor', but it was only a minority of mothers who said they had access to such a doctor.

There were differences in mothers' experiences of services according to family income level (the third research question). The major problems for mothers in families on low income were the cost of services and the lack of public transport for those without the use of a car on week days. Medical bills

and pharmaceutical prescriptions for families who were not Health Care Card holders, and non-prescription pharmaceuticals for all low-income families emerged as the major cost problems. Two-thirds of the 27 mothers without use of a car on weekdays were on a low income.

For mothers in low-income families the cost of services led to the use of public health care, both in antenatal care and at birth, and the use of general practitioners who direct-billed. A major problem which mothers identified with these health services was the lack of continuity of care, and lack of privacy in public antenatal clinics and public hospital care at the birth. The reasons for dissatisfaction with public antenatal and hospital care were again consistent with the findings of the Victoria-wide survey mentioned above (Brown & Lumley 1993).

What lessons can be learnt from the particularly high level of satisfaction with MCH services, regardless of family income level? To begin with, there were few access problems: the service was free; mothers usually had short waiting times and could also ring for advice (including an after-hours service) and the MCH centres were usually quite close to where mothers lived, often within walking distance. This is in contrast to mothers' criticism in the use of other health services where there was a fee for service, lengthy waiting times, telephone advice was not available and to reach the services required public and private transport.

Mothers' comments on the quality of the MCH service emphasised continuity of care through seeing the same MCH nurse; having as much time with the nurse as they wanted, even when the nurse was very busy; being listened to; receiving choices rather than being told what to do, and the nurse's responsiveness to their own needs as well as their child's. Criticism of the standard of other services, stressed the absence of these qualities: lack of continuity of care; lack of privacy; rushed visits; not being listened to; being told what to do; and the overall absence of a caring attitude.

The MCH service was distinguished by its availability for use by all mothers, regardless of family income level. In contrast a clear differentiation between public and private care, in the use of other health services, according to income level often emerged. Thus, for example, while all mothers were free to use public hospital care, many mothers on higher incomes chose to be private patients. Some mothers in low-income families chose doctors who direct-billed, rather than a doctor whom they would have preferred to use but who did not direct-bill. Similarly, mothers' reliance on public, rather than private, transport was usually linked to low family income level. Mothers' dissatisfaction with services was concentrated in those which they used because they could not afford to use their preferred service. An important question for further research is whether the key to provision of good quality services to people on low income is through services used by all mothers, such as the MCH service, where use is not determined by ability to pay (Harris 1990).

The fourth research question concerned the extent to which families with very young children in the four outer areas experienced greater or fewer difficulties in accessing health and community services, compared with a group of mothers in the inner area of Melbourne. The cost of services was felt to be a barrier to access of good quality services and health care for mothers in low-income families regardless of where they lived. Cost as a barrier was thus more an issue relating to the families' financial circumstances than to location. Mothers in the inner-urban area had easier access to a wider range of health and community services many at no direct cost than mothers in the outer areas. However, no major problems with access to appropriate services for mothers in the outer areas were encountered, provided they had access to private transport. Lack of private transport was considerably less important for mothers in the inner area, which has a more highly developed public transport system. The difficulties of finding parking spaces for their car was a problem for mothers in the inner area but not in the outer area. Problems in using public transport in conjunction with prams or pushers existed, regardless of location.

Another difference between inner and outer areas related to socio-cultural differences between the two populations. This included higher proportions of younger, less well educated mothers, sole parents, and people from non-English speaking backgrounds with little or no English, in the inner area. In comparison with the outer areas, families in the inner areas were more likely to experience what can be described as socio-cultural barriers to use of services. These barriers included a greater lack of knowledge about some services, lacking the confidence to use services or finding them culturally inappropriate or inaccessible because of language problems. While a number of additional health and community services in the inner area are specifically targeted to the particular needs of these groups, these services appear to be a major target for current 1993 state government cuts in expenditure including reduction in funding to community health centres.

The findings of this and previous research do not support the assumption that inner (and middle) areas of our major cities are over-resourced at the expense of under-resourcing of outer areas in the provision of services. At a local or regional level, assessment of funding requirements needs to take into account the degree of disadvantage of local populations as well as existing service infrastructure and population numbers. Any strategy considering the transfer of resources from inner to outer areas must consider the respective needs of their populations.

Mothers' views about the advantages and disadvantages pertaining to these four outer areas as places in which to live and bring up children challenges the image of people forced to live in outer-fringe areas without adequate services because of the lower cost of housing. Mothers were generally very happy with where they lived, the choices they had made and

their access to quality services with the major exception of public transport. Whether their concerns about these outer areas as places in which to bring up older children are justified remains to be seen. It also needs to be acknowledged that there are sub-locations within outer and inner areas that are seen to have advantages and disadvantages as places to live and bring up children, and these add to the complexities of debates about locational disadvantage. The most important conclusion is, however, that the negative effects of low family income on access to quality services, and on family life generally, were more important than any negative effects associated with location.

Emerging issues

Two important issues have emerged since this research was undertaken in 1992. One is the major changes to the MCH service proposed under the Healthy Futures Program (Health and Community Services 1993b). The Brotherhood of St Laurence has expressed concerns that this new framework will introduce a very different kind of service approach: the switch from a local service responsive to the needs of mothers and babies to a health surveillance system with goals and programs determined at the state level (Gilley 1993c). This could have a substantially detrimental effect on ease of access and on quality features of the service as identified by mothers. In terms of locational disadvantage, the main concern is the Healthy Futures Program's failure to adequately recognise the additional needs of low-income families in the inner-urban areas of Melbourne. These include: the particularly high unemployment levels, high proportions of sole parents and of families with non-English speaking backgrounds with little or no English. Despite some attempt to incorporate various aspects of family disadvantage in the funding, in essence it re-allocates funds according to birth rates.

The second issue is the substantial reduction in Victorian State Government funding to health and community services. The effects of many of these reductions in funding are yet to be felt. However, in the inner-urban study area, funding for the two community health centres has been halved. The development of early-discharge policies from hospital care after birth is linked to reductions in government spending on health. There is a concern that mothers will return home without a basic understanding of how to care for a new life and without feeding patterns established (the experience of a small number of mothers in the outer-area research). The importance of these issues is acknowledged in a recent discussion paper on post-acute maternity services (Health and Community Services 1993c). If early discharge is to become the norm, then the development of high-quality follow-up services, probably through the hospital system, is essential. As yet it is not at all clear that sufficient resources will be allocated to ensure that this happens, nor that

essential consumer and professional input into the development of guidelines for such a service will occur.

Concluding comment

This research suggests four major issues that need to be considered in improving the quality of birthing and early-childhood services for families on low income in the four outer areas: level of family income, cost of services, public transport and other problems of quality and access to services.

Family income and cost of services are closely related. The low income of unemployed and under-employed families meant that the cost of services was a significant problem. The major solution for improving families income lies in economic recovery and reductions in levels of unemployment, especially in the blue-collar and lower paid white-collar occupations. A barrier to women's employment clearly identified by mothers in this research was the cost of child-care.

In the interim, the level of social security payments and ensuring easy access to these payments remains crucial. Although this research did not specifically investigate access to social security payments, this was an issue raised by a number of mothers in the group discussions. A small number of self-employed families found it a difficult and lengthy process to establish their income level for purposes of eligibility for the Family Allowance Supplement (Additional Family Payment) and for a Health Care Card with associated concessions.

While family incomes remain low, it is important that costs of services do not escalate and that there are no increases in 'fee for services' for families whose finances are already stretched to breaking point. Families on relatively low incomes who did not qualify for a Health Care Card experienced considerable difficulties in meeting health care costs for their children. The needs of this group need to be carefully considered in future planning for delivery of health care.

The major strategy suggested for improving access to services is to improve public transport. A clear priority to emerge from this research is that of subsidies to public transport services in new growth areas prior to such time as population numbers commercially warrant a more frequent service. This is particularly important when the lack of locally available services requires mothers to travel outside their area.

In more remote communities in the outer areas, where there were very few services, mothers felt that the MCH centres should increase their hours of operation and adopt a broader role of support to families with pre-school-age children. This suggestion also merits consideration on the basis of need and efficiency (in that the centre and the service are already established). In one of the local areas the service had in fact partly developed in that direction as the MCH nurse responded to locally expressed need.

The broader question of how to overcome problems of access and quality of services experienced by families because of their low income strikes at the heart of equity issues in relation to how health and community services are developed and delivered in this country. Action on this issue is essential if we are to provide a decent future for all our children. The challenge remains as to how to achieve this in a system that is suffering substantial cuts to resources.

The first decision was to select four areas in Victoria which presented aspects of locational disadvantage in access to services. Two areas were chosen because of their very rapid population growth on the Melbourne urban fringe: Cranbourne had the fastest population growth of any local government area in Melbourne (1991 Census) and Melton was another example of a fast-growing outer-urban area. The Bellarine District on the outskirts of Geelong was chosen as the fastest growing non-metropolitan area in Victoria. Ballarat was chosen as an example of a regional city where at least some issues of access to services in rural Victoria might be explored.

Maternal and Child Health (MCH) nurses were then approached by the researcher and asked to act as the initial contact point for mothers who might participate in the research. MCH nurses spoke to mothers on an individual basis, providing them with a letter explaining the purpose of the research and offering a \$30 payment.

Information was mainly collected through a process of focus-group discussions of about an hour and a half's duration, with anywhere between five and eight mothers participating in each group. The plan was to hold six group discussions in each of the four areas, with a mixture of low and higher-income families. In practice, only five group discussions took place in Ballarat because of problems in organising one of the groups (a group of young single mothers). In total, 23 group discussions were held with a total of 146 participants.

The group discussions, with one exception, took place in MCH centres with two facilitators. MCH nurses were not present at these discussions as it was felt that this might introduce a bias in mothers' responses. The discussions were taped and a typed summary of each group discussion was prepared. This was then sent to all participants to check for accuracy and completeness. The major themes were then drawn from these summaries to provide the basis for a report for each of the four local areas.

Two meetings were held with local health and community service providers in each area. The first meeting took place prior to the group discussions being undertaken in order to explain the purpose and method of the research, gain local co-operation and identify local issues. The purpose of the second meeting was to obtain service providers' comments on a draft report for their area, and to encourage local action on issues raised by the research.

Meetings with service providers were useful for the provision of local information and for providing direct feedback on any gaps or inaccuracies in the first draft of the research report problems inherent in a consumer report of service use. This process also appears to have fostered local 'ownership' of the report. The researcher has since received feedback on action taken to correct some problems connected with access to services (particularly MCH services) as identified in the reports, and has been informed that the reports have been used for advocacy aimed at developing and maintaining services.

GROUP DISCUSSION GUIDE

APPENDIX 2

Group No. _____

Life Chances of Children Study

Focus group discussions **Notes to presenter**

Welcome. Thank you for coming.

Could we begin by introducing ourselves. My name is (where I live, number of children).

The purpose of today's discussion is to get your views on what it is like to live in the Cranbourne Shire for mothers with very young children. I'd like to leave 15 minutes at the end to fill in a short individual questionnaire. At the end of the two hours I will give each person an envelope with \$30 as payment for your time.

Any questions?

I want to tape this discussion so I don't have to take a lot of notes about what you say. Does anyone have any objections?

I want to emphasise that in the discussion today there are no right or wrong answers. If you disagree with what somebody says I'd like to know that, if you agree with somebody, I'd also like to know. If somebody talks too much, I may ask them to give somebody else a turn. If somebody isn't saying anything, I may ask their opinion. Because the session is being taped, it is important that only one person speaks at a time.

- To begin with, how many mothers here have older children?
- How many people have moved here in the last 10 years or so?
- Why did you move here?
- What are the good things about living in the area?
 - Is there anyone here who thinks there aren't any advantages?
- What are the disadvantages of living in the area?
 - Is there anyone here who thinks there aren't any disadvantages?
- What sort of place is it to bring up children?
- I want you to think back to when you first knew you were pregnant.
 - what was the first service everybody used?
 - how far into your pregnancy were you when you used this service?
 - were there any services you found to be particularly helpful?
 - which ones?
 - why?
 - were there any services that you thought weren't of much help?
 - which ones?
 - why?
 - were there any times when you felt you needed help but weren't able to get it?
 - please explain.
- Coming now to your experiences of the birth, could I have your view of how good the services were for the birth?
- I want you to think about services you have used for yourself or your child since the birth.
 - What was your first contact with services after the birth? Were there any problems here?
 - Who here had the usual six-weekly check-up? What did it cover and how useful was it?
 - What services have you mainly used for yourself or your child?
 - Have there been ones that were particularly helpful?
 - which ones?
 - why?
 - Have there been services that you thought weren't of much help?
 - which ones?
 - why?
 - Have there been times when you needed help but didn't get it?

- I want people now to comment on how important it is for mothers with young babies to have good support from:
 - relatives
 - friends
 - partner or husband
 - services.
- Which is the most important form of support?
- What are the main problems with services in the area?
- What do people think about the public transport system in the area? How adequate is it?
- Are costs of services a problem?
- One last question on services: from your own experience, are there any additional services that are needed, or existing services that need to be improved? What do you think?
- How many people here were working before the birth? How many are planning to return to work? How do you all feel about your employment situation?
- What things do you think will influence the future for your child?
- What effect has the recession had on your family?
- Has the recession changed your outlook on the future for your child?
- Any last questions or comments before we go on to the questionnaire?
- Does anybody here want to be kept in touch with that we do with the research? If so, I will keep the copy of your name and address from the form you filled out.
- I will hand out a copy of the questionnaire. The information you give us will be confidential. If you have any questions about filling it in please ask me.

Thanks very much for all your help. Please collect an envelope as you leave and sign your name so we know you have received it.

QUESTIONNAIRE

APPENDIX 3

LIFE CHANCES OF CHILDREN STUDY

Group No. _____

The information we are asking for will be treated as strictly confidential.

Simply circle the appropriate number, tick the appropriate box or write a short answer.

1. How old is your baby (in months)
3 4 5 6 7 8
2. Is your baby a boy or a girl
 Girl Boy
- 3a. Does your baby have any major health problems
 Yes No
- b. Please describe major health problems (if any) _____

4. Please fill in the following information about who lives in your household
 - a. How many people live there
1 2 3 4 5 6 7 8+
 - b. Are you living with a partner/husband
 Yes No
 - c. Age of partner/husband (if applicable) _____
 - d. Country of birth of partner _____
 - e. If he was born overseas, number of years in Australia _____
 - f. Your own age _____
 - g. Your country of birth _____
 - h. If you were born overseas, number of years in Australia _____
 - i. How many dependant children in household
0 1 2 3 4 5 6+

5. What is your housing situation
 home owner
 home purchase
 private rental
 public rental
 other (please explain) _____
6. Are you in paid work
 Yes No
- a. Is your work
 full-time
 part-time
 casual
- b. Please describe type of work _____
- c: Where is work located (write the suburb/town) _____
- d. How do you get to work
 own car
 public transport
 other (please explain)
7. Is your partner in paid employment
 Yes No
- a. If unemployed, for how long _____
- b. If employed, is that
 full-time
 part-time
 casual
- c. Please describe the type of work _____
- d. Where is work located (write the suburb/town) _____
- e. How does he get to work
 own car
 public transport
 other (please explain)
8. How many cars are there in your household
 0 1 2 3
9. Do you normally have the use of a car during the day
 Yes No
10. Have you used the following services during pregnancy, at birth or after the birth
- | | Yes | No |
|-------------------------------------------------------------------|--------------------------|--------------------------|
| a. GP (for yourself) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. GP (for your baby) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Alternative health practitioner
(naturopath/homeopath etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | |
|----|-----------------------------------------|--------------------------|--------------------------|
| d. | Obstetrician/gynaecologist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | Birth classes | <input type="checkbox"/> | <input type="checkbox"/> |
| f. | Private hospital for birth | <input type="checkbox"/> | <input type="checkbox"/> |
| g. | Public hospital for birth | <input type="checkbox"/> | <input type="checkbox"/> |
| h. | Birthing centre (private hospital) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. | Birthing centre (public hospital) | <input type="checkbox"/> | <input type="checkbox"/> |
| j. | Use of hospital for child (since birth) | <input type="checkbox"/> | <input type="checkbox"/> |
| k. | Chemist | <input type="checkbox"/> | <input type="checkbox"/> |
| l. | Child-care | <input type="checkbox"/> | <input type="checkbox"/> |
| m. | Nursing Mothers' Association | <input type="checkbox"/> | <input type="checkbox"/> |
| n. | Maternal and Child Health Centre | <input type="checkbox"/> | <input type="checkbox"/> |

11. What is your own and your partner's highest education level

- | | Self | Partner |
|----------------------------------|--------------------------|--------------------------|
| a. Primary school | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Secondary school (year _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tertiary | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Trade qualifications | <input type="checkbox"/> | <input type="checkbox"/> |

12a. Could you please estimate your total family income from all sources (just choose **one** option below)

per week _____
 or per fortnight _____
 or per month _____
 or per year _____

- b. Is that gross (before tax) or net (after tax)
- c. If you don't know the exact amount, please indicate the range of income
- | | | |
|-------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> \$1 - 4,000 | <input type="checkbox"/> \$12,001 - 15,000 | <input type="checkbox"/> \$26,001 - 32,000 |
| <input type="checkbox"/> \$4,001 - 6,000 | <input type="checkbox"/> \$15,001 - 18,000 | <input type="checkbox"/> \$32,001 - 40,000 |
| <input type="checkbox"/> \$6,001 - 9,000 | <input type="checkbox"/> \$18,001 - 22,000 | <input type="checkbox"/> \$40,001 - 50,000 |
| <input type="checkbox"/> \$9,001 - 12,000 | <input type="checkbox"/> \$23,001 - 26,000 | <input type="checkbox"/> \$50,001 - 59,554 |
| | | <input type="checkbox"/> over \$59,554 |

- d. Is that gross (before tax) or net (after tax)

13. How much does your housing cost (just choose **one** option below)

per week _____
 or per fortnight _____
 or per month _____
 or per year _____

Thank you for your help

REFERENCES

- Australian Bureau of Statistics (ABS) 1993, *1991 Census of population and housing, community profile*, Cat. No. 2772.0, ABS, Canberra.
- Brown, S Lumley, J 1993, 'Antenatal care: a case of the inverse care law', in *Australian Journal of Public Health*, Vol.17, No.2, pp. 95-103.
- Brownlee, H 1990, *Measuring Living Standards*, AIFS Australian Living Standards Paper No.1, Australian Institute of Family Studies, Melbourne.
- Burgess, R & Skeltys, N 1992, *The findings of the housing and location choice survey: an overview*, National Housing Strategy, Background Paper 11, AGPS, Canberra.
- Carter, J (ed.) 1991, *Measuring child poverty*, Child Poverty Policy Review No.6, Brotherhood of St Laurence, Melbourne.
- Commonwealth of Australia 1990, *Towards a fairer Australia: Social Justice Strategy*, AGPS, Canberra.
- Commonwealth of Australia 1991, *Towards a fairer Australia: Social Justice Strategy*, AGPS, Canberra.
- Commonwealth of Australia 1992, *The National Housing Strategy, housing location and access to services*, Issues Paper No.1. AGPS, Canberra.
- Department of Employment, Education and Training (DEET) 1993, *Small area labour markets Australia, December quarter 1992*, Economic and Policy Analysis Division, Canberra.
- Gilley, T 1992a, *Issues for mothers and babies, Shire of Cranbourne*, Brotherhood of St Laurence, Melbourne.
- Gilley, T 1992b, *Issues for mothers and babies, Shire of Melton*, Brotherhood of St Laurence, Melbourne.
- Gilley, T 1993a, *Access for growth, services for mothers and babies*, Brotherhood of St Laurence, Melbourne.
- Gilley, T 1993b, *Issues for mothers and babies, Bellarine District*, Brotherhood of St Laurence, Melbourne.

- Gilley, T 1993c, 'Changes to Victorian Maternal and Child Health services', in *Brotherhood Comment, a newsletter of social policy and research*, November 1993, pp.5-6, Brotherhood of St Laurence, Melbourne.
- Harris, P 1990, *All our children: children's entitlements to health, education and community services*, Child Poverty Policy Review 4, Brotherhood of St Laurence, Melbourne.
- Henderson, R 1975, *Poverty in Australia. First main report, Commission of Inquiry into Poverty*, AGPS, Canberra.
- Health and Community Services 1993a, *Scoping review, family and children's services*, Melbourne.
- Health and Community Services 1993b, *Healthy future program*, Information Kit, Melbourne.
- Health and Community Services 1993c, *Post acute maternity services*, a discussion paper, Melbourne.
- Kirwan, R 1991, *Financing urban infrastructure: equity and efficiency considerations*, The National Housing Strategy, Background Paper 4, AGPS, Canberra.
- McDonald, P & Brownlee, H 1992, 'Living day to day: families in the recession' in *Family Matters*, Australian Institute of Family Studies, Issue No.31, April, pp.8-13, Melbourne.
- McDonald, P (ed.) 1993a, *The Australian living standards study, Berwick report, Part 1: the household survey*, Australian Institute of Family Studies, Melbourne.
- McDonald, P (ed.) 1993b, *The Australian living standards study, Box Hill report*, Australian Institute of Family Studies, Melbourne.
- Ochiltree, G 1991, *An ear to listen and a shoulder to cry on, the use of child health services in Melbourne, Adelaide and Perth*, Australian Institute of Family Studies, Melbourne.
- Taylor, J 1992, *Issues for mothers and babies, Ballarat*, Brotherhood of St Laurence, Melbourne.
- Valuer-General 1993, *Property Sales Statistics 1992*, Victoria.
- Victorian Municipal Directory 1993, Arnall and Jackson, Melbourne.
- Walmsley, D 1980, *Social justice and Australian federalism, an inquiry into territorial justice and life chances in Australia*, Department of Geography, University of New England, Armidale, NSW.

Residents on the fringe of large cities face very different problems and opportunities to those of residents of the inner suburbs.

This study reports on the different experiences of mothers in accessing health and community services during their pregnancies, at birth, and for their babies.

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Lack of access was marked when lack of a car left the mother dependent on poor public transport.

Beyond the city will be of value to students, policy-makers and community sector organisations with an interest in the way services, particularly those for families, are distributed and used.

Beyond the city is the third book in the series based on the Brotherhood's longitudinal study into the life chances of children.

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