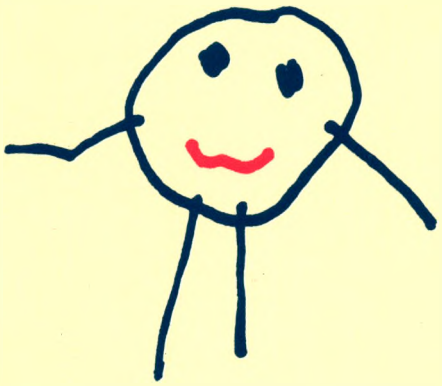
Australia stands at the crossroads in the provision of health and welfare services. The access of most parents and children to good quality birthing and early childhood services is threatened.

With cuts to funding and a shift to private provision, low income families could expect limited access to increasingly under-resourced public services.

In *Access for growth* 164 mothers with varied socio-economic and cultural backgrounds discuss the accessibility and equality of health and welfare services in inner urban Melbourne.



Brotherhood of St Laurence
Melbourne 1993

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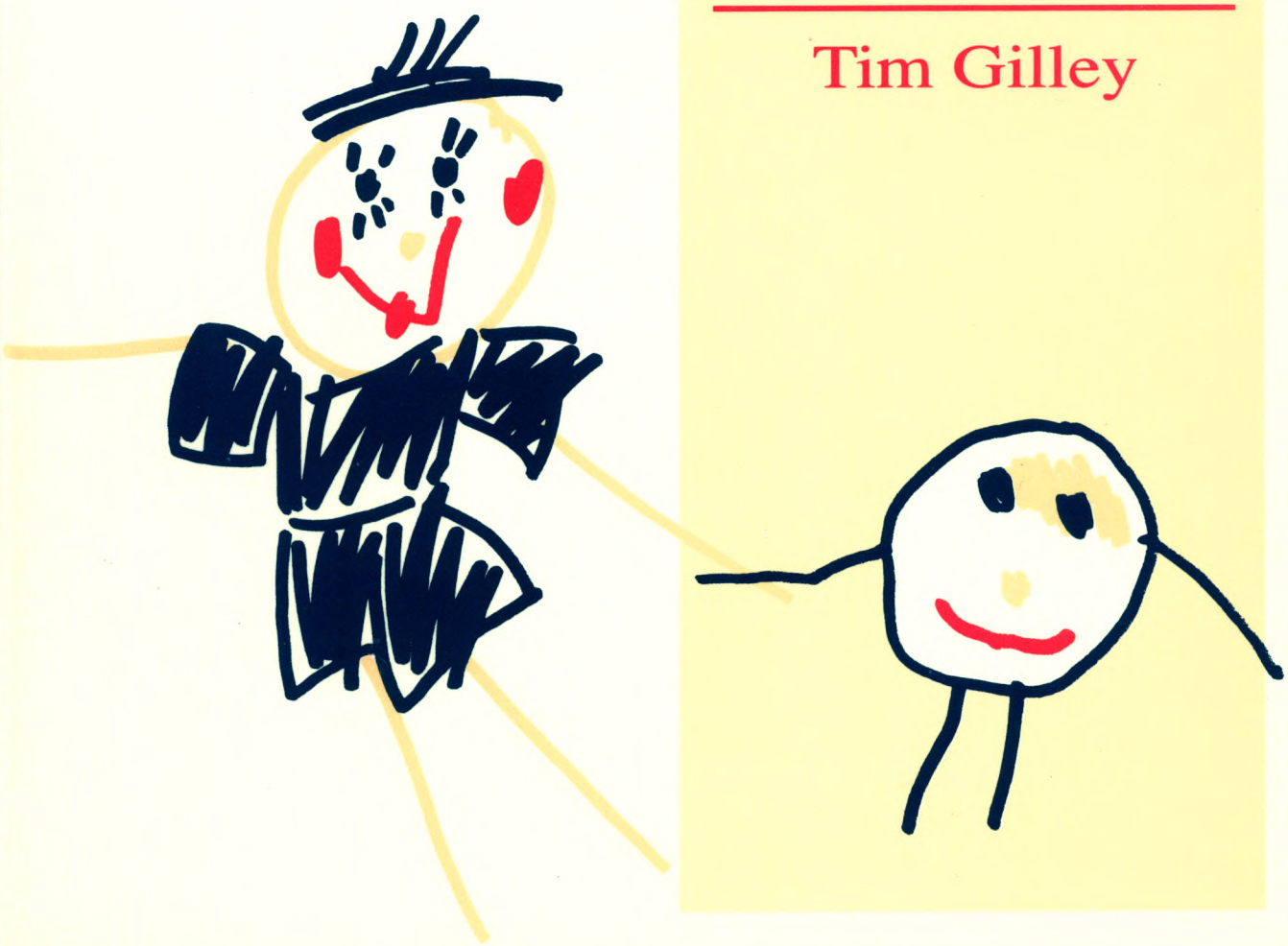
Brotherhood of St Laurence

ACCESS FOR GROWTH

Services for mothers and babies

Tim Gilley



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FOREWORD

People's standard of living and future life prospects are influenced by access to a range of services including education, labour market, health, and community services. Access to services can be especially critical to people on low incomes who may experience more problems, such as poorer health (National Health Strategy 1992) but are in a more vulnerable position in terms of purchasing necessary assistance through the market place.

This report reflects the needs and the experiences of 164 mothers in relation to birthing and early childhood services. It focuses on the extent to which families on low incomes have greater needs, less access to informal support networks, and are more likely to experience barriers to using services, than more financially affluent families. It is part of the Life Chances Study, a longitudinal study of children born in 1990 in inner urban Melbourne. The Study aims to explore how low income interacts with a range of social and cultural influences to affect how children develop. This report reflects the early experiences of mothers and babies.

The report documents that in comparison with high-income families, mothers in families on a low income:

- were more likely to experience problems such as poorer health for themselves and their children, difficulties in management of children, and to identify themselves as subject to a greater range of stressful life events such as serious marital and financial problems;
- had substantially less informal support from the child's father, their own parents, their partner's parents, or to have supportive friends;
- were less likely to use services such as antenatal classes, obstetricians, pediatricians, the Nursing Mothers' Association and child-care. They were more likely to use community health centres and public hospitals.

The National Health Strategy also found that people with a social-economic disadvantage were less likely to use early intervention and preventative services but had much poorer health. They were more likely to use primary

health services such as GPs and public hospitals (but not necessarily in relation to their greater needs) (National Health Strategy 1992).

It is essential that services are both effective and accessible in meeting all people's needs. Much more work needs to be undertaken to understand the effectiveness of services. In the health area Medicare has removed a number of cost barriers to the accessibility of health services for low-income people and the continued availability of free general practitioner and public hospital care is critical to the retention of this accessibility as is the service provided by Maternal and Child Health centres. Other services, such as pharmaceuticals, specialist medical and dental still present strong financial barriers (McClelland 1991b). Other access difficulties are created by factors such as location and the style of delivery of services. They are documented in the report and must be tackled if services are to be equitably accessed by all in the community.

Alison McClelland
Director
Social Policy and Research
April 1993

CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF SUMMARY DATA TABLES – APPENDIX 2

ACKNOWLEDGMENTS

As part of a longitudinal study, this paper owes a debt to a number of people: the families who have shared part of their lives with us; the four Maternal and Child Health Nurses without whose commitment and support this study would not have been possible; the interviewers; my colleagues who have worked with the project, which included a number of people who worked as volunteers; readers of this manuscript; and lastly, members of my Research Advisory Group.

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Thanks also to Maria Graca Veiga for typing the manuscript and to the Victorian Health Promotion Foundation who funded the continuation of this study into a second and third stage.

INTRODUCTION

CHAPTER 1

The purpose of this paper is to explore the adequacy of health and community services used during pregnancy and the first months after birth from the viewpoint of 164 mothers from two inner urban Melbourne suburbs. The experiences of a group of mothers in families on low incomes are compared with those of mothers in families on higher incomes.

Context of the study

People on low incomes are more likely to be in poor health and have a poorer sense of well-being than those in more affluent circumstances (Jolly 1990; Trethewey 1989; Carter 1991; National Health Strategy 1992). They are also more likely to experience inequalities in access to health, education, and community services (Harris 1990), including birthing services (Health Department Victoria 1990).

This research concerns the extent to which families on low income have greater needs, less access to informal support networks, and are more likely to experience barriers to using the services they need than financially better off families. It includes a consideration of important issues in service provision such as the contribution of services to health and well-being, locational disadvantage in gaining access to services, and whether services to people on low income are best delivered through universal or targeted services.

Central ideas and issues

Life chances of children

This report analyses information from the first stage of a longitudinal study of children, the Life Chances of Children Study. The research was developed as a response to a perceived lack of Australian studies exploring the impact

of poverty on children over time (Carter 1991, p.96), despite the range of cross sectional studies of poverty in Australia (Jolly 1990; Trethewey 1989; Carter 1991), and a range of overseas longitudinal poverty studies (Shepherd 1987; Duncan 1984).

The Life Chances Study extends beyond the concept of a snapshot of poverty to examine the 'life chances of children' on the basis that it is important to explore how having a low income might interact with a range of social and cultural influences to affect how children develop. Fishkin has described the concept of the equality of life chances as follows:

> According to this notion [equality of life chances], I should not be able to enter a hospital ward of healthy newborn babies and, on the basis of class, race, or sex, or other arbitrary native characteristics, predict the eventual positions in society of these children. (Fishkin 1983, p.4)

This report uses information collected from interviews with the mothers of 167 children born in 1990, when the children were between four to seven months of age (stage one). The first report from stage one interviews focused on the needs of immigrant children and their families (Taylor & MacDonald 1992).

A brief follow-up interview with the mothers (stage two) was undertaken when the children were between 14 and 20 months of age. Analysis of employment, income and housing information collected in stages one and two is being undertaken and a report on these findings will be published in 1993.

A third follow-up of children is planned for 1993 when the children are between two and a half and three years of age. Focus group discussions with 23 small groups of mothers with babies in two outer urban areas of Melbourne and two Victorian country towns was completed in 1992, and will provide information on the issue of locational disadvantage in access to services.

Health and well-being of mothers

In the first months of a child's life the mother is usually the central influence as main care giver, and she is also the medium through which the child experiences other influences (Slee 1983). Thus the health and well-being of the child is closely linked to the health and well-being of his or her mother. Information was therefore collected on the mother's health and well-being and on potential influences on this, including the availability of informal support networks and use of services. The interview also included questions on how the mothers viewed their children's health and well-being, and how influential they felt their own state of well-being was on the children.

Although the primary purpose of collecting information on the mothers' health and well-being and the use of health and community services was to explore the actual (or potential) influence on their children, it also provided a 'slice of life' of the experiences of a group of mothers and their families. These experiences also have immediate relevance to public policies affecting the

provision of health and community services, and provide important feedback to service providers. The period of pregnancy, birth, and the first months of caring for a new life is one of relatively intensive service use, and could be expected to provide a rich source of material.

Availability of health and community services

It is likely that in any research about the use of services the responses of participants will relate to the range and quality of services available in the study area. In this research the two adjoining study areas are within what could be described as a 'services rich' area with an extensive network of commercial, health and community services. The areas are also well serviced by an extensive public transport system which includes trams, trains, light rail, and buses.

Mothers live close to the city and are within relatively easy reach of a number of hospitals including the Royal Women's Hospital, the Royal Children's Hospital, Mercy Maternity Hospital, and a number of smaller private hospitals. They are also close to a range of medical services, including general practitioners, paediatricians, and obstetricians as well as paramedical services such as physiotherapists and alternative health practitioners such as naturopaths. Chemists are also nearby.

Two Community Health Centres in the study area provide a range of health and welfare services, including provision for people from non-English speaking backgrounds (NESB) through the employment of bilingual staff.

Four Maternal and Child Health (MCH) nurses operate from five centres within the two adjoining suburbs. Each local council has the responsibility for employing these nurses, though their funding is a shared responsibility between local councils and the Victorian State Government. Nurses see mothers at their centres and also conduct home visits. The focus of the MCH service is the health and well-being of children ranging from birth to five years, though most contact is in the first six months. The most common services they provide are the regular weighing and measurement of the baby, the identification of any health and developmental delays in the children, and appropriate referrals to other services. The two local councils also provide a considerable range of additional family support services, including child-care, home help, finance and family counselling and accommodation services. There are also a number of voluntary welfare agencies such as the Brotherhood of St Laurence (BSL) which provide emergency relief and other services. The BSL provides a small scale child-care service which is targeted to disadvantaged children within a context of family support.

The Nursing Mothers' Association is an Australia-wide organisation which trains volunteer counsellors to provide advice and support to mothers on breastfeeding.

In such a 'services rich' location the study seeks to explore those services the mothers found to be the most accessible and useful to their needs.

Usefulness of health and community services

The central issue in health and community services is the extent to which services contribute to people's health and well-being. Despite considerable research on the value of a broad range of services, the issue is still largely unresolved. In addition, the equitable distribution of health and welfare services is relevant to discussion of children's life chances. McClelland (1991a) provides a useful framework for analysis by identifying three equity-related goals for health services.

Equity goals for health and community services

McClelland (1991a) identified three potential equity goals for the health system:

1 Equalising health outcomes.
2 Equalising access to services on the basis of need.
3 Equalising use of services on the basis of need.

The first two goals are used here for discussing both health *and* community services, and both health *and* well-being outcomes. The goal of equality in the use of services is discussed as part of the issue of access to services.

Equalising health and well-being outcomes

It is clearly beyond the scope of the health and community services system to deliver equality in health and well-being outcomes given that there are numerous social and economic factors which also influence such outcomes. A recent research report, for example, argues that the key determinant of health outcomes in Western societies is the distribution of income and 'that the most effective way of improving health is to make incomes more equal' (Quick & Wilkinson 1991, p.5). This leads to the further point (McClelland 1991a, p.10) that equality of health outcomes could still be a goal of overall public policy, even though it requires more than improved health services but also action across a range of areas.

This study collected information on a range of health and well-being outcomes for mothers including a number of self-reported measures of the mothers' health and well-being, and mothers' views of their children's health. It also included questions on a number of potential influences on these health and well-being outcomes, such as stressful life events.

Equalising access to services

The concept of equity in access to services means that all people have the same opportunity to obtain services in relation to their need for those services. The problem in measuring equity of access is that it is not a simple matter of

recording people's use of services, as unequal use does not necessarily mean that there are problems with access. It could mean, for example, that people have access to services but choose not to use them. Discussions about lack of access to services therefore often focus on identifying barriers that would prevent different groups of people from using services.

Some barriers in access to services have been identified as:

- financial (especially for services provided on a 'fee for service', basis),
- geographic isolation,
- socio-cultural and language,
- asymmetric power relationships (Harris 1990, p.19). People on low incomes often receive inferior treatment because of their relative powerlessness (Gilley 1990; Taylor 1990).

This research does not assess the impact of geographic isolation in access to services, as the families live in an inner urban setting. However, as already mentioned, additional research has been undertaken in two outer areas of Melbourne and in two Victorian country towns to explore the effects of locational disadvantage. The provision of adequate services to people in rapidly expanding areas of our major cities and to rural populations is a major current debate (Commonwealth of Australia 1992). In contrast, this paper presents a view of health and community services from mothers living in a relatively 'services rich', environment.

The goal of equal access incorporates the idea that such access should be provided according to need. People with the same health problems should have the same access to services that will meet their needs regardless of income or language or other disadvantage. This study explores whether income is a factor in access to services for 164 women and their children.

Another important issue in assessing the needs of mothers and babies and their access to services, is the level of informal support available to them. Critics of the Welfare State argue that people should use their own resources rather than rely on government-funded services. The use of informal supports by people on low income becomes an important issue in this debate. If it could be demonstrated that people on low income had stronger informal supports than those in more affluent circumstances, then they would not necessarily require greater access to support services, even if it could be demonstrated that their needs were greater. It has, for example, been a popular view in Australia that immigrants have extended family support networks despite considerable evidence to the contrary (Taylor & MacDonald 1992).

Informal supports can sometimes be directly substituted for services, or vice versa. A mother in a family on a low income who cannot afford paid child-care may suffer no disadvantage if her own mother is available to mind the children. A woman with severe maternal depression who has a very supportive spouse may have a lesser need for services than a severely depressed woman experiencing serious marital conflict.

Stresses in the informal support network can also create a need for services. For example, a woman who has to care for an invalid parent may need access to additional health and community services.

Delivery of services to families on low incomes

An important issue is how best to deliver services to families on low incomes; whether they are best provided through universal services, in the sense of 'free or uniform services to all those who have a need for them' (Harris 1990, p.5), or through services particularly targeted to the needs of people on low income.

The MCH service, for example, is provided to all mothers and babies without charge. General practitioner services have a strong element of universality, though there is a potential financial barrier in access to their services when doctors do not direct bill. Similarly there is a division in the provision of hospital services between those provided free to public patients, and those which can only be accessed by private patients. Services which are more targeted to the needs of people on low income in this study include social work and youth work services.

One writer, in trying to come to terms with the fact that most services are not universally available and that people on low income and other disadvantaged groups often have additional needs, has argued for a system of 'progressive universality' which has the following elements:

- adequate and guaranteed income and secure housing as a pre-requisite;
- a universal framework of services, which is free of financial barriers, geographically accessible and well publicised;
- positive discrimination measures to allocate extra resources on the basis of need;
- counter-discrimination strategies to eradicate social and cultural barriers and to promote equality of participation;
- measures to ensure that health, education and community services evolve from the community which they serve (Harris 1990, p.5).

Analysis by income

Because the focus of this study is on low income and poverty a brief discussion of the Henderson poverty line is provided here, followed by the definition of the three income levels used as a basis for analysis in this report.

Henderson described his poverty line as being set at an austere or 'low level'. He described those below it as being 'very poor', and those who were less than 20 per cent above it as 'rather poor', (Henderson 1975, p.13). This study uses the 'rather poor', definition of low income.

The Henderson poverty line recognised that poverty in Australia needs to be defined in relation to general community standards of living, rather than the absolute poverty that exists in many third world countries, amongst some

Aboriginal communities (Choo 1990) and some homeless young people in Australia (Human Rights and Equal Opportunity Commission 1989). The focus of this paper is therefore on relative deprivation, through contrasting a range of family needs and use of services across different levels of family income.

Three income levels

The following table describes the three levels of family income used as a basis for analysis in this study. The main sources of income for the families on low income were social security pensions or benefits (64 per cent), or low wages (34 per cent), with one family living on their savings.

Table 1 **Three income levels**

Income level	Definition	Example*
Low income	Below Henderson poverty line plus 20 per cent	Below $18,778 p.a.
Medium income	Above Henderson poverty line plus 20 per cent Below cut off point where other income would exclude family from a social security pension/allowance	$18,779 - $31,257 p.a.
Higher income	Above point where other income would exclude family from a social security pension/ allowance	Above $31,257 p.a.

* N.B The income ranges are for a couple with one child with the head of the family in the labour force as at September 1990. These income levels vary according to the number of dependants and workplace status of head of the family. The Henderson poverty line used here is before housing costs.

Research questions

The research questions for this paper reflect the nature of the sample of families, with a mixture of income groups, which allow for a comparison of family needs and use of services across different levels of income. They also reflect the fact that, as a consumer study, this research presents mothers' views of their own needs and their use of birthing and early childhood services. The three major research questions are:

1 To what extent did mothers in families in the lowest income group report greater needs, both for themselves and their children?
2 To what extent did mothers in families in the lowest income group report less informal support (from friends, relatives and partners)?
3 To what extent did mothers in families in the lowest income group report poorer access to services?

Research method

The methodology of this study is described in Appendix 1.

In late 1990, the Brotherhood of St Laurence research staff began interviewing mothers with babies (four to seven months of age) living in one local council area in inner urban Melbourne. Mothers were contacted through their local Maternal and Child Health (MCH) service which receives all birth notifications for babies in their area. All mothers with babies born between March and August 1990 were approached to take part in the study which was later extended to include children born to mothers living in an adjoining suburb. These children were also born in 1990, between July and December.

The two adjoining suburbs were chosen because of the particular characteristics of their population and their mix of housing tenures. This meant that the sample of children was likely to include families in more affluent circumstances as well as those with a low income, a mixture of housing tenures, and some NESB families. It was considered that the collection of comparative information across different income groupings was the best way of describing and exploring the nature of relative poverty and its long-term impact.

The composition of the final sample of children in the study reflected the general population trends for these two areas. There was a sharp contrast between family income levels. Approximately one-quarter of the families were in private rental housing with one-quarter in public housing, and the remaining 50 per cent being home owners or home purchasers. A little less than one-third of the children had NESB mothers.

Interview questions

Mothers were asked a number of questions about their situation and needs. They were also asked which services they used during pregnancy; whether they found any services particularly helpful (which ones, and why); whether they found any services to be unhelpful (which ones and why); and whether they had needed help at any stage but hadn't been able to get it. The mothers were also asked the same questions about their use of services at the child's birth and also in the early months following the birth. Questions were also asked about mothers' informal support networks and the amount of support provided by their partners.

Strengths and limitations of the research

This research provides a consumer view of services during a period of intensive use. Consumer studies provide essential feedback to both service providers and to governments making policy decisions about services. Consumer studies are also important as an advocacy tool to represent the

interests of powerless people, whose view is usually not heard elsewhere. As an addition to the poverty research literature the strength of this report is in providing a comparative view of experiences of services across different levels of family income.

The major limitation of this research is that it does not provide any systematic evaluation of the impact of the services on people's health and well-being. This includes the fact that the research is based on a limited number of self reported measures of mothers' own health and well-being, their own children's health and well-being, and their use of services; it lacks the views of service providers; and it does not include an analysis of the impact of organisational arrangements on the delivery of services.

Structure of the report

Chapter 2 introduces the families and discusses their characteristics on a range of measures including income level, family size, and housing tenure. This provides a context for the research material presented in the following three chapters. Chapter 3 presents an analysis of the needs of mothers and babies. Chapter 4 provides information on the mothers' informal support networks from partners, relatives, and friends as an extension of the definition of family needs. Chapter 5 examines the use of services. In the final chapter (Chapter 6) conclusions are drawn on the adequacy of services from a consumer perspective and on directions for change.

INTRODUCING THE CHILDREN AND THEIR FAMILIES

CHAPTER 2

This chapter presents a brief description of the sample of families in the study, including details of family size, mothers' age, mothers' country of birth, and housing tenure.

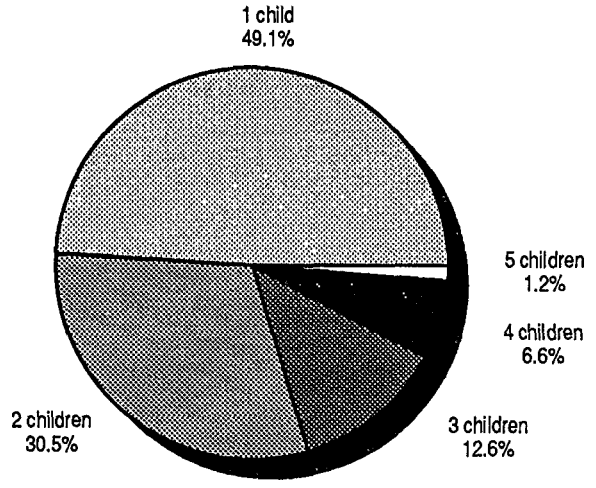
Number of children

The 167 children were born between March 1990 and December 1990.

The 167 children were born between March 1990 and December 1990. At the time of interview, most children were living with both parents. The exceptions were 20 children living in 19 sole parent households. In all sole parent households the child was living with his or her mother. There were three sets of twins. Just under half the children were first children. Figure 1 summarises this information.

Larger families were much more likely to be in the low-income category. For example, 34 per cent of families on low incomes had three or more children, compared with 17 per cent of families on medium incomes and only 9 per cent of families on higher incomes. This does not necessarily mean that actual family income is lower for larger families, as the income categories include an adjustment for the number of dependants that the income has to support.

Figure 1 **Number of children in the family**



Age of mothers

The age of mothers ranged from 18 years to 44 years with a small number of mothers under 22 years of age and over 40 years of age (Figure 2). Almost half the women (45 per cent) had their first child when they were over 30 years of age. This reflects Australia wide trends for some women (usually from more middle class backgrounds) to delay having children to early middle age. Seven of the 10 mothers under 22 years of age were on a low income.

Figure 2 **Mothers' age**

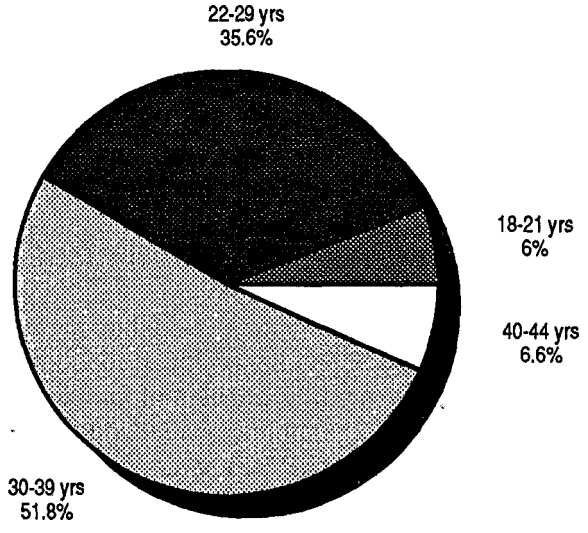
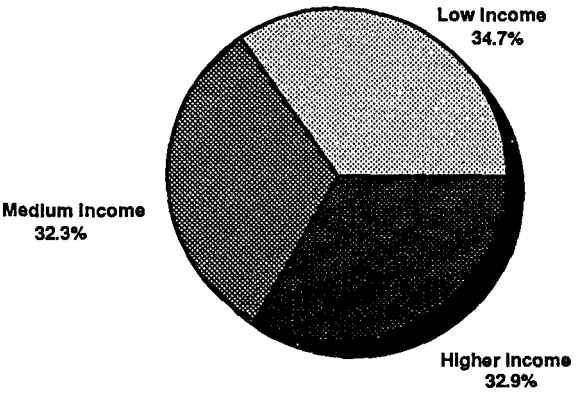


Figure 3 **Income of families**



Income levels

The incomes of families were categorised into low, medium or higher. About one-third of the families in this study were on a low income, about one-third had a medium income, and the remaining third were in the higher income category. This is illustrated in Figure 3.

Housing tenure

About one-quarter of the families were in public rental housing, one-quarter were in private rental housing, and one-half of the families were home owners or home purchasers (Figure 4).

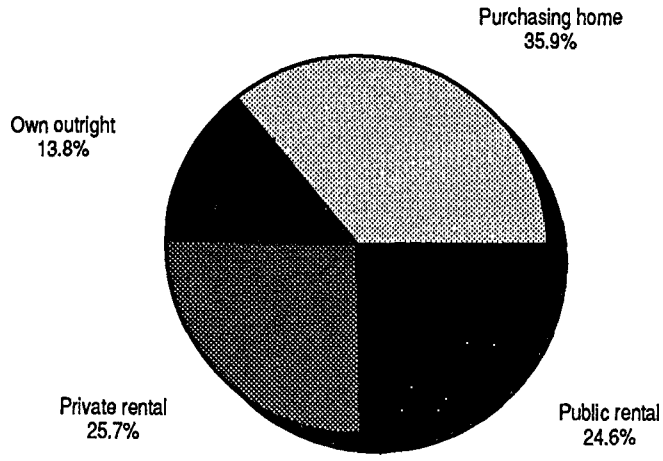
There was a strong association between housing tenure and family income.

Families in this study had a slightly higher proportion of private rental housing (26 per cent compared with 20 per cent Australia-wide); a much higher percentage of public rental housing (25 per cent compared with 6 per cent in publicly owned dwellings Australia-wide); and a lower proportion of owner-occupiers (50 per cent compared with 70 per cent Australia-wide (Commonwealth of Australia 1991, p.4). Most of the families in public rental housing were living in high rise estates or (to a lesser extent) three and four storey walk-up flats.

There was a strong association between housing tenure and family income. Most (83 per cent) of the public tenants were on a low income, while nearly half (47 per cent) of the private tenants were on a low income. In contrast, only 7 per cent of the home purchasers/owners were on a low income.

The average weekly rental for families on low income in private rental housing was $92, with the highest rent being $150 per week, while the average public rental figure for families on low income (usually calculated at 20 per cent of income) was considerably lower at $55 per week, with the highest rent paid being $89 per week.

Figure 4 **Housing tenure**



Ethnic background

Just under one-third of the children (31 per cent) were born to NESB families (Figure 5). Most of these were in Vietnamese families, some of whom were Vietnamese-speaking and some of whom were Chinese-speaking.

Many of the NESB families were recent arrivals to this country, within the last five years, and many had little or no English. Sixty four per cent of the low income group in this study were from NES backgrounds.

Figure 5 **Mother's country of birth**

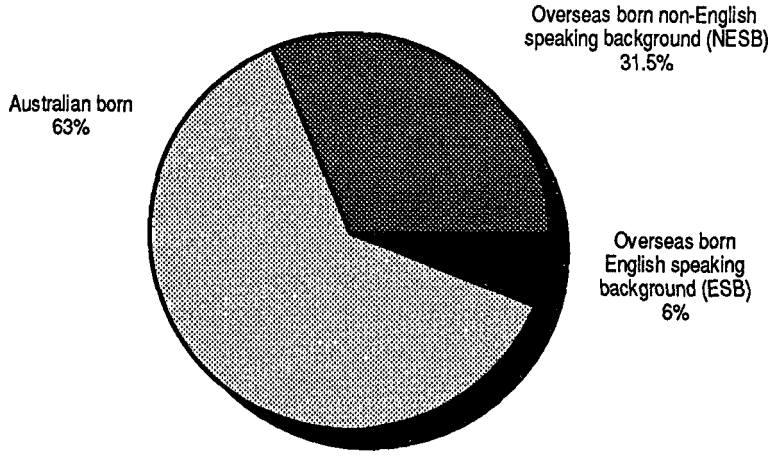


Illustration of family circumstances

Three families are described below to illustrate the range of family situations and the resources and supports available to them.

- Tom and Anne are an Australian born couple in their early 30s, with two children, Helen – the baby, and their elder daughter, Nancy. They own their own terrace house outright. They run a family business with an annual income in excess of $60,000 per annum and Anne said they were able to save money. Both parents completed their secondary education. Anne has completed part of a tertiary degree, and Tom has a trade qualification. Anne rated her own and Helen's health as 'good', and saw Tom as 'fairly involved' with Helen. She was happy with her life overall. The family receives good support from their own parents, especially Anne's parents whom they see every day.
- Van and Bich are a Vietnamese couple in their late 20s with three children. The family arrived in Australia in 1987. They speak very little English and neither completed secondary school. Van and Bich have both been unemployed since arriving in Australia. Their source of income is unemployment benefit, and their income is about $16,500 per annum. Bich felt she had just enough to live on. She rated her own health as average, and the health of her youngest child (Allan) as good. She has mixed feelings about her life overall. They live in a high rise public rental housing flat in inner urban Melbourne. Their own parents live in Vietnam.
- Linda is a sole parent in her early 20s living with her own mother who rents a house (public rental housing) from the Department of Planning and Housing. The baby Hilary is Linda's only child. Linda left high school after completing Year 8. Her only source of income is the Sole Parent's Pension with an income of just under $11,550 per annum. Because she pays a low rent to her mother, she feels that she has enough to get by with a few extras. Linda rates her own health and Hilary's health as 'good'. She has mixed feelings about her life overall. She gets good support from her own mother.

Their source of income is unemployment benefit, and their income is about $16,500 per annum. Bich felt she had just enough to live on.

Summary

About half the women in the study were first-time mothers. Their ages ranged from 18 to 44 years, with a small number of very young mothers (under 22 years of age) and a small number of mothers over 40 years.

The families were divided by income levels with about one-third on low income, one-third on medium income and one-third on high income.

Approximately one-quarter of the families were in public rental housing, one-quarter in private rental housing, and one-half were home owners or home purchasers. Most of the families in public rental housing lived in flats in high rise estates. About one-third of the families were from NES backgrounds, often recent immigrants to this country with little or no English ability. Over 60 per cent of these families had a low income.

Mothers in families on low income were also more likely to be younger, to have more children, and to live in public or private rental accommodation than those in the medium and higher income groups.

THE NEEDS OF MOTHERS AND BABIES

CHAPTER 3

Pregnancy, birth, and the first months of a child's life are times of adjustment for all families. This chapter sets out to discover whether mothers and babies in families on low income in this study had greater or lesser needs than those in more affluent families. It explores the needs of mothers and babies by analysing mothers' reports of some of the stresses they faced and their feelings of well-being, such as depression and happiness.

Pressures on mothers are explored below in terms of their experience of a series of common stressful life events (including mothers' health problems), their children's health and behaviour, and their experiences of depression and overall happiness.

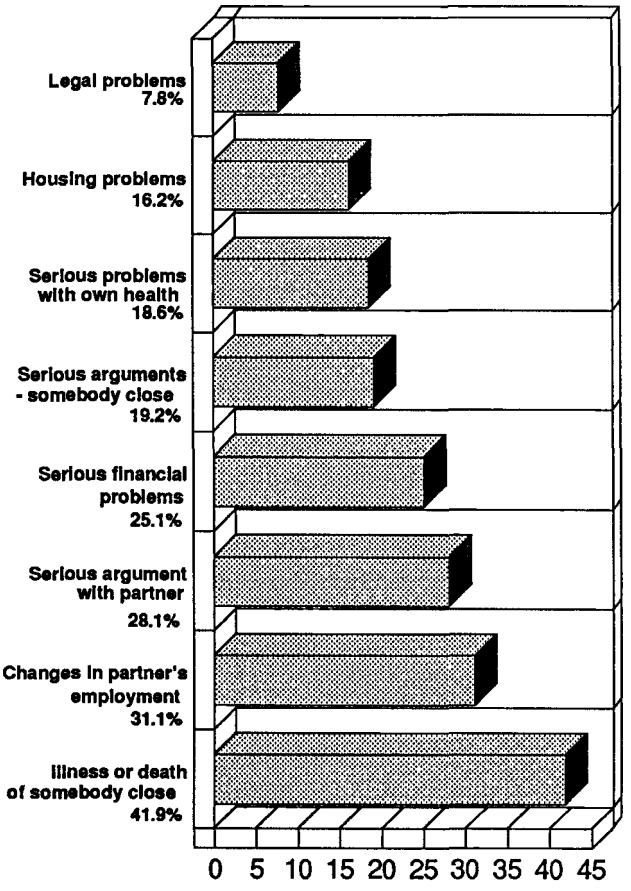
Stressful life events

Women in the study were asked whether they had suffered from eight common stressful life events over the past year. They were asked how these events affected them and whether they felt that these experiences had an impact on their caring for their child.

The stressful life events that mothers were asked about were the illness or death of somebody close to them; changes in partner's job situation; disagreements with partner; financial problems; disagreement with somebody close (other than partner); problems with their own health; housing problems; and legal problems. The mothers were asked to identify these problems when they were of a serious nature.

Just under three-quarters of the mothers in this study (74 per cent) had experienced one or more stressful life events in the previous year. The four most commonly experienced were the illness of somebody close to them, changes in partner's job situation, serious disagreements with their partner and serious financial problems. The results are summarised in Figure 6.

Figure 6 **Stressful life events**



Twenty-three mothers (14 per cent) felt that external stresses affected their ability to care for their child.

Women's comments on these life events suggested that their impact varied from severe emotional upheaval and depression, to minor problems that they were well able to cope with. Most of the mothers who said they had experienced one or more of these stressful life events also said that they had no effect on their caring for their baby. It is of particular concern that 23 mothers (14 per cent) felt that these external stresses affected their ability to care for their child. The fact that some mothers felt they had been unable to insulate their babies from external stress appeared to be a strong indicator of its severity.

Seven mothers talked about the impact of marital conflict. These situations varied from very severe problems of physical violence from the partner (two families) where the children were described as 'very frightened', and imminent separation of the parents (one family), to less severe problems such as ongoing arguments and disagreements (three families). Comments such as 'it affects the kids a lot', 'leaves me with little energy for the baby' and 'I was losing milk and impatient with the children' were made.

My husband's never there for me, to give support. This also affects [the] kids. We fight a lot. We talk about separating. [It] makes me anxious, stressed. (Woman in her early 30s with four children)

Four women said that financial problems directly affected their caring for their infant. One mother said she was worried about unpaid bills and felt that she wasn't able to care for her child 100 per cent because of this. Another mother was concerned that she wasn't able to spend as much money on the children as she needed to. A third mother (with a sick partner) tried to save money by 'not buying enough nappies and milk formula'; while a fourth woman commented that she spent less time with her baby because she had to help out in her own father's business, which was going into liquidation.

Three women talked about how their own health problems affected their ability to care for their babies. One woman had a back problem that made it difficult to pick up her baby and enjoy her time with her; another woman had a knee injury that placed considerable extra responsibility on an older child (cooking, washing, etc.); while a third woman had four weeks in hospital (with baby) because of her own illness.

Two women talked about their feelings of anxiety following their child's birth. Another child of one of these mothers had died and because of this she tended to 'keep the baby up during the day' and 'worry about small irregularities'. Another mother talked about the stress caused by police coming into the backyard area of her house (see quote *).

Two women mentioned housing problems. One family had to move, which meant that the baby spent more time being cared for by other people, and it was a demanding time overall for her children. Another family were having their house renovated, which meant less living space for mother and baby.

Two women experienced stress from relatives which affected their caring for their babies. One woman had the stress of the death of a mother-in-law and the separation of her own parents. A second woman had a sick father, and felt that her distress about this was transferred to her baby and made her 'less settled'.

One woman talked about having to return to work earlier than planned which meant having to put her child into creche, and switching to bottle-feeding. Another woman found it difficult to cope when her partner was working and unable to offer support. Another who said she had been affected by seven of the eight

** Police came into the yard without identification. I don't feel as secure in my own house any more. We don't know why they came into our garden... I'm nervous about the window nearly in the baby's room. I worry for the safety of the baby.*(Couple in their 30s with three children)

stressful life events, commented that 'all of them distract me', and if 'there are demands upon me, the baby has to wait'.

Stressful life events and low income

Mothers in families on low incomes were much more likely to report suffering from the following stressful life events than those on medium and higher incomes: health problems, serious disagreements with their partner, and financial problems (Table 2). They were slightly less likely to experience the illness of somebody close, and disagreements with somebody close (other than partner), though these results may also be more a reflection of a lack of close friends and relatives (see later discussion). The information on partner's job change is difficult to interpret as it includes both positive changes, such as promotion, and negative changes, such as unemployment. The table below summarises this information.

Table 2 **Stressful life events by income level**

	Low income	Medium income	High income
Illness of somebody close	29%	33%	39%
Problems with own health	33%	7%	15%
Disagreements with partner	44%	24%	18%
Disagreements with someone close	14%	24%	20%
Financial problems	43%	19%	13%
Partner's job change	45%	31%	26%
Housing problem	22%	15%	2%
Legal problem	14%	8%	2%

Experiences of birth

Just over half the mothers reported that there had been problems with the birth, with 17 per cent identifying more than one problem. The most commonly reported complications were: caesarian delivery (16 per cent), forceps delivery (14 per cent) and long labour (14 per cent). Mothers in families on low income were not more likely to report these problems. Four women's comments on birth illustrate the range of responses:

> It was long and drawn out and it was a bit disappointing [emergency caesarian]. You feel everyone else can pop them out. When she was just born I was really groggy [from pethidine] and I couldn't hold her ... my husband thought I'd rejected the baby, he was really worried, but it wasn't until the next day I pepped up. *(Couple with their first child)*

> [Baby presented in] posterior [position] and wouldn't come out. Second stage of labour [lasted] for five hours. Used vacuum

extraction and epidural. In labour for 24 hours [eventually] transferred out of Birthing Centre. *(Sole parent in mid-20s with her first child)*

It was actually for me fantastic, I was really pleased that we opted to have [baby] in the hospital - no difference from Birthing Centre or at home. I wanted to stay in hospital this time. They weren't interventionist. *(Couple with two children)*

[Birth experience] was different [here] than in Turkey. Nurses helpful here. [They] didn't push down on [mother's] body to 'help' the baby out. *(Couple with three children)*

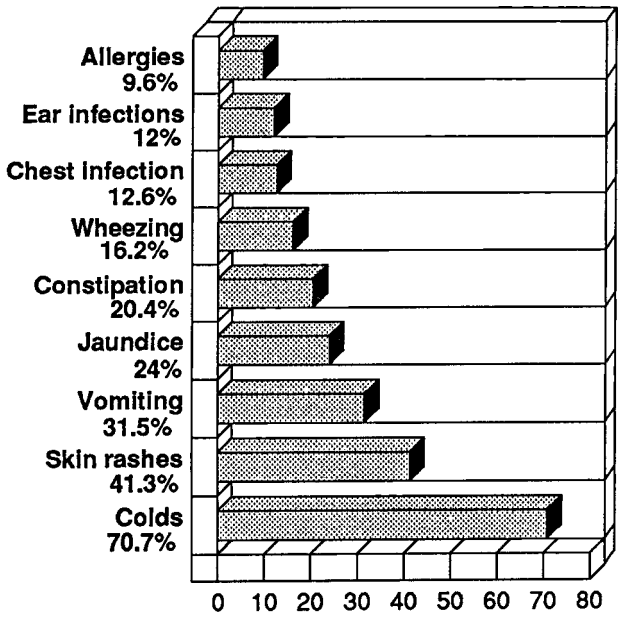
Children's health

Another common pressure on mothers is caused by poor health in their children. Mothers were asked whether their children suffered from a standard list of 16 common health problems and whether these were of a mild, moderate or serious nature. The major forms of health problems reported by mothers were: colds, skin rashes, vomiting, jaundice, wheezing, chest infections, ear infections, and allergies (Figure 7).

When asked to rate these health problems as mild, moderate, or severe, mothers reported 32 children (19 per cent) as having severe health problems, and 10 children (6 per cent) as having more than one severe health problem. The health problems rated as severe were: colds (11 children), vomiting (six children), skin rashes (five children), allergies (three children), viruses (three children), jaundice (two children) and severe accidents (one child).

He's certainly been problematic, [the] result of stomach problems. At times I've felt incredibly desperate because of his difficulties. [It's] made me incredibly stressed out at times, and incredibly fatigued, so there have been physical as well as psychological effects. I think the emotional drain was the worst. I said to my husband it's like being tortured. (Couple in their early to mid 30s, with two children)

Figure 7 **Children's most common health problems**



Low birth weight (<2500 grams) and very low birth weight (<1500 grams) have been associated with poorer health and developmental outcomes for children (Jolly 1990, p.20). Fifteen babies in this study had a low birth weight and two babies (prematurely born twins) had a very low birth weight.

Children's health and low income

Mothers in families on low income were more likely to identify their children as having problems with wheezing, chest infection, vomiting, constipation, and feeding, as indicated in Table 3.

Table 3 **Children's health problems by income level**

	Low income	Medium income	High income
Colds	69%	78%	66%
Ear infections	14%	9%	13%
Chest infections	29%	6%	6%
Wheezing	29%	15%	4%
Vomiting	46%	24%	22%
Constipation	29%	15%	16%
Skin rashes	41%	44%	38%
Allergies	10%	7%	11%
Viruses	5%	6%	6%
Convulsions	5%	0%	0%
Jaundice	22%	19%	31%
Feeding problems	24%	11%	13%

N.B. Percentages refer to the proportion in each income group and therefore do not total 100 per cent, either across or down the columns.

Children in families on low income were not more likely to have a low or very low birth weight.

Breastfeeding

Mothers in families on low income were less likely to breastfeed their children.

As breastfeeding has been positively associated with children's health (Health Dept Victoria 1990, p.18; Jolly 1990, p.12), women in this study were asked if they breastfed their child.

At birth, over three-quarters of the mothers (78 per cent) used breastfeeding as the only feeding method, 10 mothers (6 per cent) used a combination of breastfeeding and bottle-feeding, 25 mothers (15 per cent) used bottle-feeding only, and one child was fed from a bottle and tube. Some four to seven months later there was a major change, with just over half the mothers (58 per cent) still breastfeeding their children. Because of the age of the children, it was also quite common (43 per cent) for mothers to have introduced solids into their child's diet, and 11 women (7 per cent) were using a combination of bottle and breastfeeding.

Mothers in families on low income were less likely to breastfeed their children. About two-thirds of mothers (66 per

cent) on low income initially breastfed their children, compared to over 90 per cent of those on medium income and higher incomes.

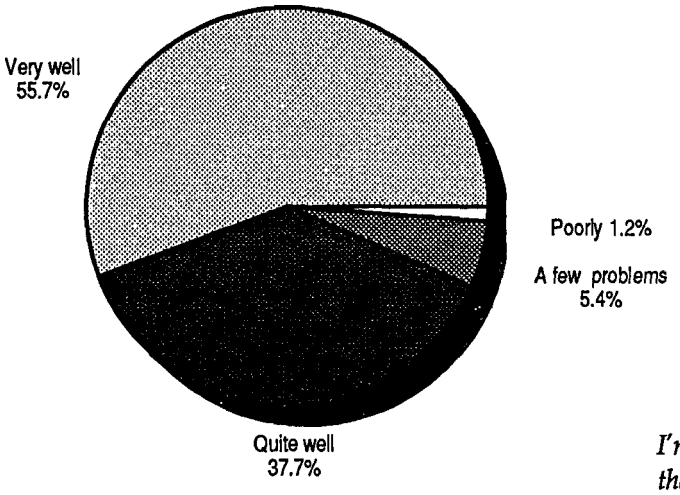
Children's behaviour

About two-fifths (41 per cent) of the mothers reported that their babies' behaviour caused them problems, and one-fifth of these mothers mentioned more than one difficulty. The most common ones were problems with sleeping (16 per cent), crying (15 per cent) and feeding (10 per cent).

When mothers were asked how their infants' behaviour affected them, the two most common responses were feeling tired or fatigued (22 per cent of all mothers), and feeling anxious or tense (20 per cent of all mothers). Other effects were extra pressures on the relationship with their partners, feelings of indecision and feelings of low self-esteem.

Mothers in families on low income were more likely to identify that they were experiencing problems with managing their children.

Figure 8 **Mothers' rating of managing with child**



When asked to rate how they were managing overall with their child, most women said they were managing very well or quite well (Figure 8). A small percentage of women said they were having quite a few problems in managing, and two mothers said they were managing poorly.

Children's behaviour in families on low income

There was little difference between the three income groups in mothers' reports of children's behaviour causing problems. However, mothers in families on low income were more likely to identify that they were experiencing problems with managing their children, as indicated in Table 4.

I'm staying home all the time – not going to work – stuck with the baby, tired. About once a month, I have a good cry and feel better afterwards. My sister comes over on those occasions. It usually lasts one day a month. I still wish that I was working. (Sole parent in early 30s, with two children)

I felt like 'I' my ego, didn't exist basically ... it was a loss of self, especially having been a career women for a very long time now, feeling cut off and house-bound and particularly fatigued. I'd hoped for a malleable baby. I'd expected a passive docile baby who sleeps – and he wasn't. At times I've felt like murdering him. It didn't impair any bonding but if I had not had the support systems I would say it could have affected the bonding. (Couple in their 30s, with two children)

Days in succession, now, not as severe as they were. Tiredness – can't get out of it. Easily depressed, don't cope with things. I'm tired. Inability to cope. (Couple in their 30s, with three children)

Table 4 **Managing with children by income level**

	Low income	Medium income	Higher income
Very well	47%	52%	69%
Quite well	38%	46%	29%
Quite a few problems	12%	2%	2%
Poorly	3%	0%	0%

Depression

Post-natal depression is a commonly experienced health problem suffered by women. The usual research method for measuring depression is to ask women a standard set of questions such as those used in the DSM – IIIR scale, which estimates that between 20 to 40 per cent of women suffer from post-natal depression (Williams & Carmichael 1991, p.76). A more simplified scale, the Edinburgh Postnatal Depression Scale, reports a lower incidence of postnatal depression, with between 10 to 20 per cent of all mothers affected (Health Department Victoria 1990, p.130).

Both the DSM – IIIR and Edinburgh scales exclude more minor experiences of post-natal depression. However in this study women were simply asked whether they had felt low or depressed since the birth. This difference in research method probably explains why a majority of women (65 per cent) in this study reported having such feelings. Their reports varied from short periods of intense depression in the first month following the birth, to periods of episodic depression over a longer period of time, to ongoing depression, with 16 per cent of the women still suffering from it at the time of the interview. In describing their feelings mothers talked about tiredness and exhaustion, of crying and of feelings of tension. In explaining their feelings mothers talked about the baby being hard work, their anxiety about their baby's health, a loss of former identity, of being unable to meet the needs of others (usually their partner), of lack of preparation for the birth and lack of experience (first-time mothers), of specific health problems, and of insufficient support.

Most of the mothers who said they had felt low or depressed since the birth also identified things that helped with this depression, such as having someone sympathetic to talk to.

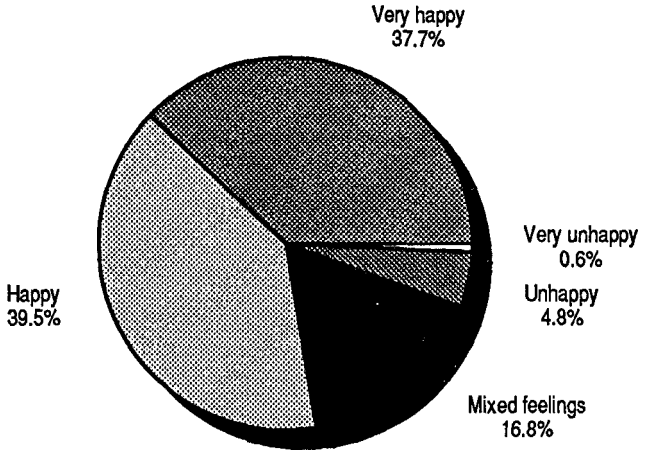
Mothers and families on low income were not more likely to report feelings of maternal depression, nor were they more likely to report still being depressed at the time of the interview. However, they were less likely to have access to supports that mothers identified as helping them with their feelings – such as a sympathetic partner or friend.

Overall happiness

Mothers were also asked to rate their overall happiness on a five point scale from very happy to very unhappy. Over three-quarters of mothers rated their lives as being happy (78 per cent). However the remaining 22 per cent said they had mixed feelings about life or were unhappy (Figure 9).

Women in families on low income were much more likely to report being unhappy or having mixed feelings about their lives overall.

Figure 9 **Mothers' rating of happiness**



Women in families on low income were much more likely to report being unhappy or having mixed feelings about their lives overall, as Table 5 illustrates. About half the mothers (49 per cent) in families in the low income group rated their lives as somewhere in the range between 'mixed feelings' and very 'unhappy' compared to 11 per cent of mothers in families on medium income, and 6 per cent on a high income.

Table 5: **Mothers' rating of happiness by income level**

	Low income	Medium income	Higher income
Very happy	11%	35%	69%
Happy	40%	54%	26%
Mixed feelings	35%	11%	4%
Unhappy	12%	-	2%
Very unhappy	2%	-	-

The difference between mothers' reports of depression and happiness may partly reflect the short-term nature of feelings of depression for many mothers in this study; and also the 'levelling' experience of giving birth and caring for a new life, when there is a risk of depression for all mothers.

Summary

... the very families who have the least financial resources were more likely to experience the worst problems.

This chapter began with the question of whether mothers and babies in families on low income had greater or lesser needs than those in financially better off families.

Women on low income reported suffering from a greater range of pressures than their medium and higher income counterparts. They were more likely to report experiencing a number of stressful life events (including their own health problems, marital conflict and financial problems), having children in poor health, and identifying problems in managing their children. They were also more likely to rate their lives overall as less happy.

On the mothers' own assessment, the very families who have the least financial resources were more likely to experience the worst problems. The next chapter will explore the range of informal supports available to these women.

INFORMAL SUPPORT NETWORKS

CHAPTER 4

This chapter analyses the patterns of informal support identified by all mothers in this study, and whether mothers in families on low incomes have greater or lesser informal supports than mothers in more affluent families. Mothers were asked to describe the support from their partners, relatives and friends. Mothers were asked about overall support they enjoyed in the few weeks after birth, and what support was received at the time of interview.

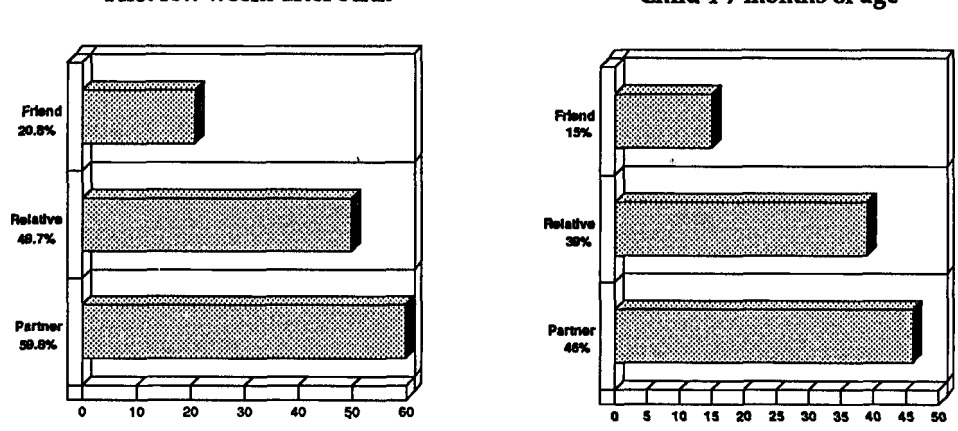
My parents come weekly and look after the baby and help with the housework. My partner helps around the house and spends more time at home out of work hours and he is available [Friends] – it is good knowing they are there, having a network of support. (Couple in 30s with one child)

Overall support

In the first few weeks after birth most women (92 per cent) said they were receiving some form of assistance with the baby. At the time of the interview, when the children were somewhere between four and seven months old, most (81 per cent) of the mothers were still receiving some assistance. However the proportion who had no support increased from eight to 19 per cent (Figure 10).

Just over a quarter of mothers (27 per cent) said they were receiving assistance from services, such as the MCH service and home help services in the first few weeks after birth. This

Figure 10 HELP FOR MOTHERS



proportion dropped to 13 per cent some four to seven months later. The mothers of nine children (5 per cent) said they were receiving assistance from services only in the first few weeks after the birth, with no assistance from their partner, relatives or friends.

It was most common (59 per cent) for mothers to have support from more than one source (including services) in the first few weeks after the birth, and for this percentage to be unchanged four to seven months later.

Support from partner

Over half of the mothers (56 per cent) said they relied on their partners a lot, while over a quarter (29 per cent) relied upon their partners a fair amount (excluding sole parents). At the less helpful end of the scale, 10 per cent said they relied only a small amount on their partners and 5 per cent of mothers said they didn't rely on them at all.

Understandably, sole parents (all women) received the least assistance from the children's fathers. Of the 19 single parents, only five said they received any practical or financial help from the child's father.

The importance of support from partners is illustrated by two quotations, one from a mother whose partner provided good support, and one from a sole parent who did not have this help.

> [He] was at the birth, participates in daily events. [The] baby, she recognises him, they play together... [He will be] a guiding influence. He is strong [about] being honest with yourself, and following it through. He will encourage [her] making her own decisions. *(Couple in their 20s with one child)*

> The hardest thing is the strain of having to do everything yourself, ... Having a little one, I can't go here and there with the older one like I used to; [the] difficulty financially, and not having an adult to talk to ... you can't save for holidays or have things you need or things you'd like to have. They [kids] would like to go to the cinema, [and] shops, [and buy] clothes. It's hard being a single parent. *(Sole parent in late 20s with two children)*

Support from partners in low income families

Considerably fewer women on low income said they received support from their partner. For example, only 37 per cent of the low income mothers said they relied a lot on their partners for assistance, compared with 55 per cent of those on medium income and 72 per cent of those on higher incomes. At the other extreme, there were seven mothers who said they did not rely on any assistance from their partners. Six of these mothers were in families on low incomes.

Lack of assistance from partners was a particularly strong theme amongst NESB women. Only 29 per cent of women in this group said they relied upon their partner a lot, while 18 per cent said they did not rely on any assistance at all.

Another indication of the relative lack of support from partners in the low income group can be seen in responses to questions about whether they helped in the first few weeks after birth, and at the time of interview. Half the mothers in low income families said they were assisted by their partner in the first few weeks after birth, compared with 63 per cent of those on medium income, and 67 per cent of those on higher incomes. Some four to six months later, 36 per cent of mothers on low income said they were being assisted by their partners, compared with 63 per cent of those on medium incomes and 69 per cent of those on higher incomes.

Support from grandparents

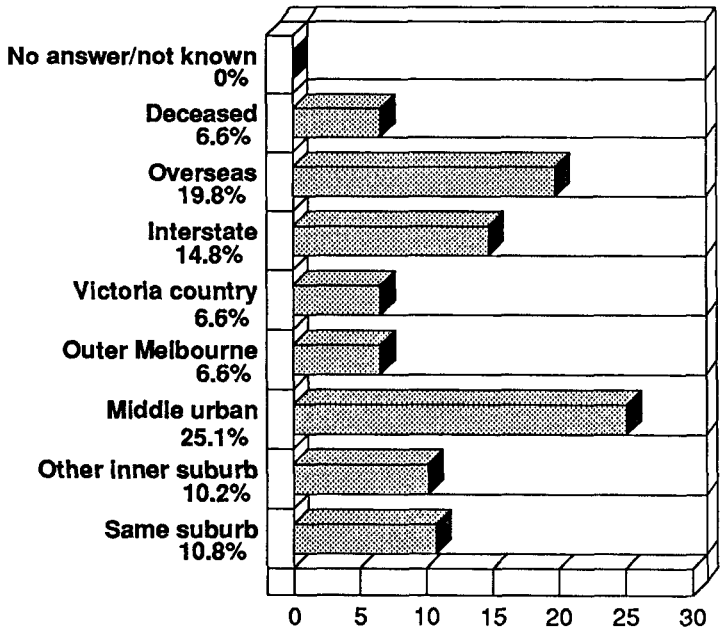
Mention has already been made of the importance of support from close relatives. Because the issue of support from the children's grandparents is of such importance, a series of more detailed questions were asked. They include whether the grandparents were still alive, where they lived, whether they were a support (and what kinds of support they provided), or whether they caused stress (and what these stresses were).

Mum took over, helped out. Mum knows a lot about babies.
(Sole parent in early 20s, with one child, living with her own mother)

Most grandparents, on both sides of the family were still alive. The lowest mortality rate was for maternal grandmothers (6 per cent), and the highest mortality rate was for paternal grandfathers (34 per cent).

The location of maternal grandmothers (Figure 11) varied from very accessible, (within the same suburb and sometimes in the same dwelling); to fairly accessible (living within the inner urban area of Melbourne); to increasingly less accessible (living in middle urban Melbourne, outer Melbourne, Victorian country, interstate, or overseas). The location of paternal grandmothers was similar.

Figure 11 **Residence of grandmother (mother's mother)**



The degree of contact with maternal grandparents varied from no contact at all (four families) to seeing them every day (30 families). Just over two-thirds of families (67 per cent), with maternal grandparent(s) still living, had contact with them at least once per week. The frequency of contact with paternal grandparents tended to be lower, with only 47 per cent of families seeing them at least once per week.

Overwhelmingly, the mothers in this study saw their own parents (78 per cent) as being helpful, and only 14 per cent said they were not helpful. The spouse's parents were less likely to be seen as helpful, with just under half (48 per cent) seen as helpful and one-quarter seen as not helpful.

What mothers valued from their own parents were emotional support, practical assistance, child-care, direct financial assistance, and gift giving as a symbolic act. The most common comment about emotional support was that their parents were there when they needed them, while practical assistance included the purchase and preparation of food, and housework.

In addition, mothers were also asked if their parents or parents-in-law had been a source of stress. Nineteen per cent of mothers said they found their own parents to be a stress in their lives, and 16 per cent found their partners' parents to be a cause of stress.

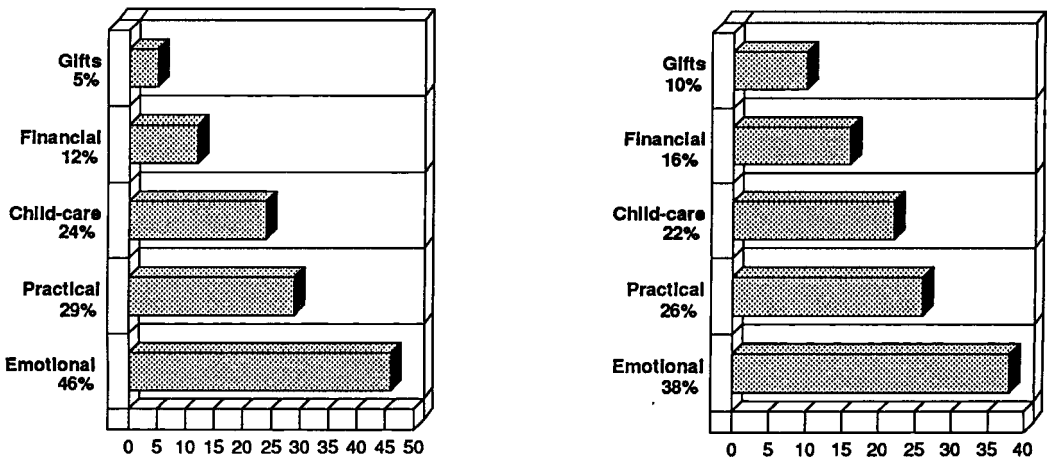
The stresses on mothers from their own parents arose from different ideas on child rearing (eight women), the fact that their parents were too far away to be of assistance (seven women), the poor health of one or both of their parents (five women), having to help out their own parents financially (three women), and being concerned about her parents' lack of interest in the child (one woman). The mothers' explanations of the stresses from their spouses' parents were similar, except that they were more likely to talk about paternal grandparents' lack of interest in their baby (five women).

Support from grandparents – families on low income

While the support of close relatives was as common for women in families on low income as for those on medium and higher incomes in the few weeks after the birth, it was less common a few months later; with the main contrast being between women on low income who were receiving this help (38 per cent) and women in the higher income group (58 per cent).

Mothers in families on low income were also considerably less likely to say that their parents and their spouse's parents had been

Figure 12 TYPE OF SUPPORT FROM GRANDPARENTS



helpful. However they were *no* more likely to identify that their own or their spouse's parents were a stress on them.

Table 6: **Assistance from grandparents by income level**

	Low income	Medium income	Higher income
Mother's parents helpful	69%	92%	93%
Spouse's parents helpful	50%	61%	81%

Some mothers on low income did receive strong support from close relatives, as the introductory quotation from a sole parent indicates. Non-English speaking born mothers were less likely to receive assistance since their parents were often living overseas. In a small number of cases the families were sending money overseas to support their own parents.

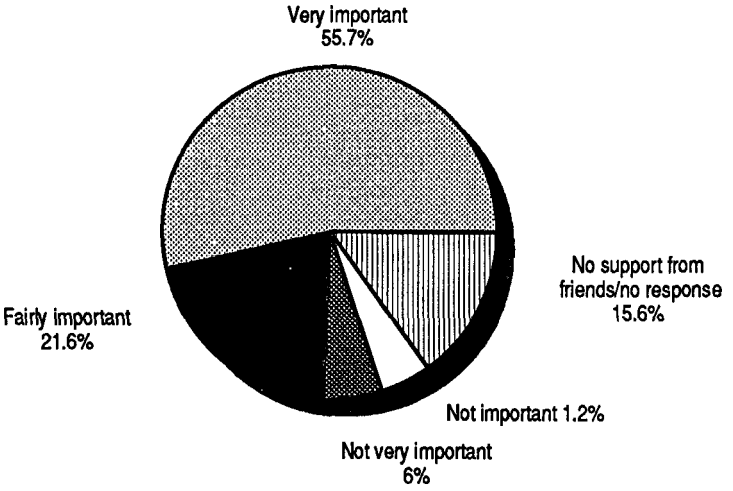
Support from friends

It gives you peace of mind if you can discuss problems and friends can help you solve them. (Couple in their 30s, with one child)

Mothers were asked whether they had a friend they could go to when they were upset or needed advice, and then asked to rate how important this assistance was. Mothers who said they did not get this support were asked whether there were times when they felt they needed it.

Most women (86 per cent) had a friend or friends who they could talk to when they were upset, or wanted advice. Women rated this assistance highly (Figure 13), with over three-quarters of women (77 per cent) saying that this help was very or fairly important. Of the 22 women who didn't have this support from friends, all but four said that there had been times when they needed it.

Figure 13 **Importance of support from friend(s)**



Mothers on low income were less likely to receive this help. Around the period of birth, some 13 per cent of mothers on low income said they had friends around to help compared with 22 per cent of those on medium income and 29 per cent and of those on higher incomes. These figures remained very similar at the time of the research interview.

Summary

This chapter began with the question of whether mothers in families on low income in this study had greater or lesser informal supports than families that were better off financially.

Mothers in families on low income generally received less support than those on medium and higher income.

Mothers in families on low income generally received less support than those on medium and higher income. This included less assistance from partners, grandparents, and friends. Their informal support networks did not compensate for the greater needs they faced.

The majority of mothers received considerable support with their new babies, especially from relatives, and valued this support greatly.

The majority of mothers received considerable support with their new babies, especially from relatives, and valued this support greatly. A small number of mothers found that partners and their own parents and parents-in-law were also a source of stress.

The very strong value that many women placed on these supports highlights the extra pressures that women who lacked this assistance had to face. The lack of someone with whom to share the workload, the freedom to have 'time out' by leaving the child in the safe care of somebody the mother could trust, the lack of emotional and practical support in times of depression or stress, the feeling of having to take all the responsibility, the lack of a sense of others celebrating or sharing the experience of a new life were the types of pressures that women without support of kith and kin faced in their day to day lives.

USE OF SERVICES

CHAPTER 5

The previous two chapters discussed mothers' and babies' needs and their informal supports. The mothers in families in this study with the least financial resources were more often than not those who identified the greater needs but also had less informal support. This chapter extends the analysis by examining the question of whether mothers and babies in families on low income had better or worse access to birthing and early childhood services.

Patterns of service use

In a series of questions about services used by mothers for their own health and well-being it was found that the most commonly used services were hospitals, general practitioners, chemists, classes to prepare for the birth, and obstetricians (Figure 14).

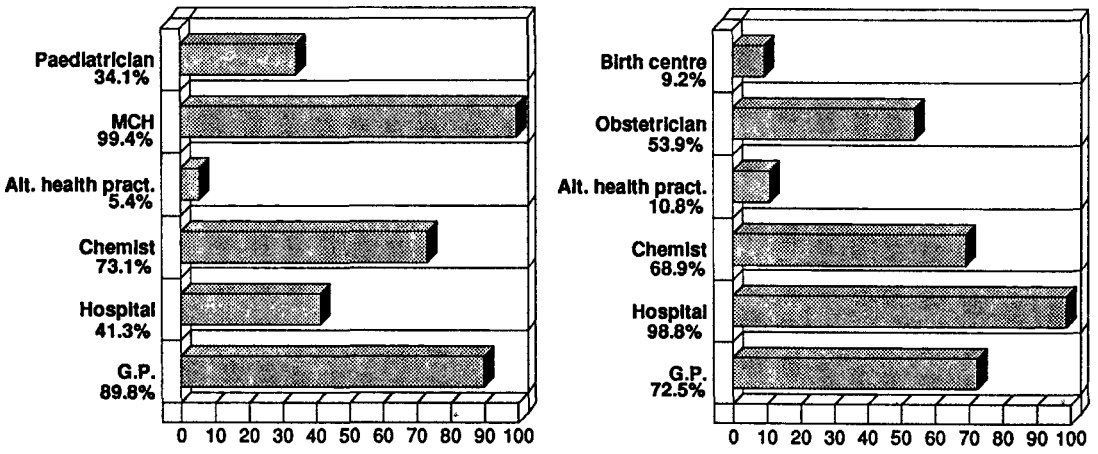
In responding to questions about services used for their children, all but one mother (a recently arrived NESB mother who had moved and could not find the local centre) said they used the MCH service. The other major services used included general practitioners, hospital services, obstetricians and paediatricians (Figure 14). The use of general practitioners ranged from one visit to more than 13 visits, while 18 children had at some stage been in-patients in a hospital.

The use of hospital services during pregnancy and at birth reflect the main models of birthing services available to women

in Victoria (Health Department Victoria 1990). These are the use of standard hospital care in the public health system, and the use of private hospitals – usually in conjunction with a specialist obstetrician.

The use of child-care services in relation to employment patterns is discussed as a separate issue later in this chapter.

Figure 14 MOST COMMONLY USED SERVICES



Mothers were asked about the services they used for themselves (especially during pregnancy) and for their children. As Figure 14 indicates the most commonly used services for mothers were hospitals, general practitioners, chemists and obstetricians. For children the mosy commonly used services were MCH centres, general practitioners, chemists, hospitals and paediatricians. All birthing took place in hospitals except for two home births, with 9 per cent of births in birth centres (within hospitals).

There was a range of other services used by mothers, including the Nursing Mothers' Association, Community Health Centres, alternative health practitioners, welfare and social work services, and self-exercise programs. While the use of these services was much less common, they were often of great importance to those who used them.

The infant welfare centre [MCH] I found very helpful. They are a great asset to the community in terms of your own support, the baby's health and meeting other women. (Couple with one child)

Use of services by low income families

Mothers on low income were much less likely to make use of specialist medical services, such as obstetricians and paediatricians than mothers in medium and higher income families (Tables 7 and 8), and they were less likely to use private hospitals for the birth (Table 9). They were also much less likely

to attend classes to prepare for the birth, have the birth of their child in a birthing centre, or make use of the Nursing Mothers' Association, or alternative health practitioners such as naturopaths or homeopaths. They were slightly more likely to make use of hospital services for their children. This information is summarised in the two tables below, under the headings of use of services for mothers and use of services for children.

Young mothers (under 22 years of age) were unlikely to attend antenatal classes (only three out of 10 young mothers attended) or use the Nursing Mothers' Association (one out of 10). Most of these young mothers (seven out of 10) were on a low income.

The distinction between services for mothers and children reflects the structure of the interview schedule and is a somewhat arbitrary one, as most of the services can be viewed as important to both mothers' and babies' health and well-being.

Table 7 **Use of services for mothers by income level**

	Low income	Medium income	Higher income
General practitioner	76%	74%	67%
Hospital services	100%	98%	98%
Birth centres	2%	23%	35%
Alternative health practitioner	3%	17%	13%
Obstetrician	16%	67%	82%
Chemist	64%	65%	78%
Birth classes	21%	61%	84%

Table 8 **Use of services for children by income level**

	Low income	Medium income	High income
General practitioner	35%	32%	33%
Maternal and Child Health	98%	100%	100%
Alternative health practitioner	0%	13%	4%
Paediatrician	23%	30%	51%
Hospitals	50%	33%	40%
Nursing Mothers' Association	5%	32%	40%
Chemist	64%	69%	87%

Antenatal (birth) classes and use of Nursing Mothers' Association

Mothers having their first child were twice as likely as mothers with older children to attend birth classes, and they were also more likely to seek advice from the Nursing Mothers' Association. However, the majority of women in families on low

The majority of women in families on low income having their first child did not attend birth classes.

income having their first child did not attend birth classes (14 out of 23 did not attend), or seek advice from the Nursing Mothers' Association (21 out of 23 did not seek advice). In addition, a number of NESB women in this study (with older children) were having their first experience of child birth in Australia. Mothers were not asked why they did not use these services.

Since women in families on low income were much less likely to attend birth classes, it is worthwhile looking in detail at responses to interview questions to understand what women who did not attend these classes potentially missed out on.

Most women who attended the classes said they were valuable and helped them to prepare for the birth.

Most birth (or antenatal) classes attended by women in this study were held in hospitals, with the major agencies being the Royal Women's Hospital (38 women), the Mercy Maternity Hospital (18 women), St Vincent's Hospital (eight women), St Andrew's Hospital (seven women), and the Collingwood Community Health Centre (three women). Mothers also attended classes in the Monash Medical Centre, St George's Hospital, Cabrini Private Hospital, Vaucluse Hospital, the Diamond Valley Council (Adult Education), and a private physiotherapist. Seven women combined these classes with additional classes, including an obstetric clinic, an Active Birth Workshop, yoga classes (two women) a Royal Women's Hospital film, and antenatal classes and aerobics in Oakleigh. Ten of the women who attended birth classes at the Royal Women's Hospital said that these classes were held within the birth centre.

The number of sessions for these classes ranged from two to 14. The most common number of sessions offered was two, three or four. Some women with older children elected to go to only one or two sessions as a refresher even though more were offered. At least one set of classes was provided on a 'fee for service' basis, with seven classes costing $100.

Most women who attended the classes said they were valuable and helped them to prepare for the birth. The most common comment was that it was good preparation for what to expect (20 women). Ten mothers said that the classes made them feel relaxed (which included the two women who attended yoga classes), while one mother said the classes made her feel more anxious. Twelve women said the exercises were valuable, 11 commented favourably on the breathing exercises, and two women said they had learnt 'how to push' during labour.

Eleven women commented on the value of the general information provided, with the most common comment being that the staff running the classes 'answered my questions'. In addition, two women said they were given useful information on diet/nutrition, and four women commented favourably on the information provided on what might go wrong at the birth. Conversely, five women criticised the classes for not preparing

them for what went wrong in their own labour and delivery. Three of these women gave birth by caesarian section, one woman had an induced birth and an epidural, and the fifth woman commented that nobody told her that she might bleed for eight weeks after the birth. One of the women who had the birth by caesarian said that if she had been told how common this method of giving birth was she could have prepared for it.

Six women commented favourably on being shown over the hospital and becoming familiar with the wards and the equipment, with one Vietnamese women saying that she knew where to go if her husband was not there to help her. Five women said it was useful having other mothers to talk to, while one mother felt that this was unnecessary. Six women with older children said that going to classes was useful as a 'refresher'.

Eleven women said that the classes were valuable for getting their partners involved, with one woman commenting that the classes 'made it real for him', while another woman with midwifery training said that getting her partner involved was the only reason she attended classes. One woman withdrew from the classes because she was unable to involve her partner. Two women criticised the classes because they were not helpful for their partners, with one woman saying that the staff were not supportive of him, while another commented that her husband felt 'foolish' when asked to join in 'panting' sessions!

Three women commented on the caring nature of staff running the classes, while one woman criticised them as 'uncaring'. Four women also criticised how the classes they attended were run. One comment was that the classes were too large (50 people), two said that there were too many sessions, and one woman criticised the classes on the basis that it prepared her for labour and the birth only. In contrast to this last point, two women commented that the classes were helpful for pregnancy but not for the birth, while three women said they helped with parenting, including preparing them for breastfeeding and how to deal with sibling rivalry.

The birth

Women on lower incomes in this study made greater use of standard hospital care in the public health system while women on medium and higher incomes were more likely to make use of private hospital care in conjunction with a specialist obstetrician. The table below shows the different use of public and private hospital care for the birth by income level.

Table 9 **Use of hospital services for birth by income level**

	Low income	Medium income	Higher income
Public patient	93%	56%	36%
Private patient	7%	43%	62%
Home birth	-	2%	2%

A small number of women in this study also referred to less commonly used models of care. These were a shared care program involving a maternity hospital and a community health centre (or general practitioner), a birth centre, and home birth.

Helpful services

They [Caroline Chisholm Society] were supportive of my situation. [They] gave the baby some clothes ... and found this flat for the baby and me. (Sole parent in her early 20s with one child)

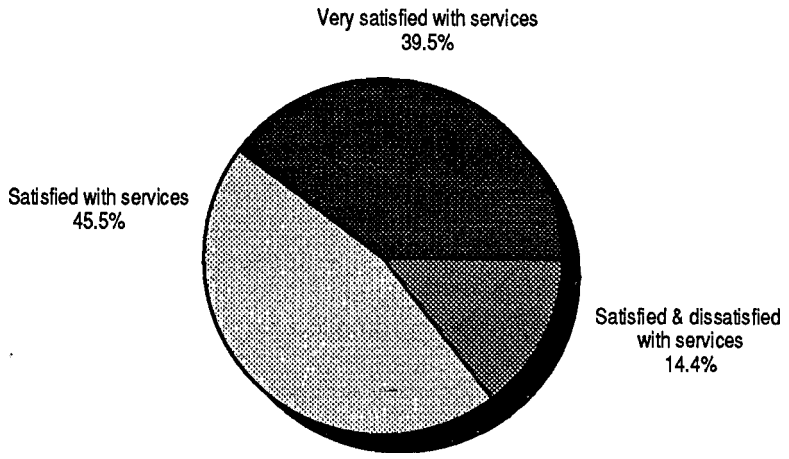
Mothers were asked to rate their overall satisfaction with services, whether there were services that were particularly helpful, and what they valued about these helpful services.

Again an attempt was made to distinguish between services that were for the mothers' well-being and the children's well-being, and again the distinction was often blurred. The most notable example was the MCH service where over two-fifths of mothers (42 per cent) identified it as a particularly helpful service (in a series of questions about their own use of services) and over half (59 per cent) again identified it as being a particularly helpful service in a series of questions about their use of services for their children's health and well-being.

I could ask them [G.P. and hospital staff] about anything and they would tell me. Hospital staff were very supportive, excellent. (Sole parent in early 40s, with two children)

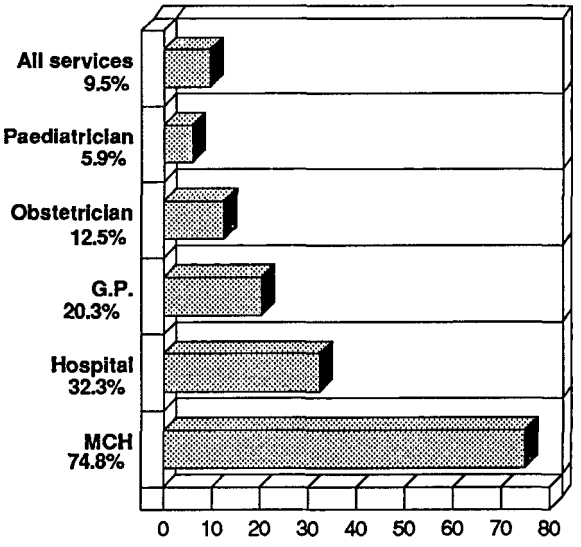
The overall level of satisfaction with services was high (Figure 15) though there was a group of mothers (14 per cent) who were both dissatisfied with some aspect of services as well as satisfied with other aspects.

Figure 15 **Overall satisfaction with services**



Most mothers (93 per cent) identified one or more services as being particularly helpful, with over half the mothers (52 per cent) identifying only one service as being particularly helpful. The services most commonly reported as being particularly helpful (Figure 16) were: the MCH Service, hospital services, general practitioners, obstetricians and paediatricians. Ten per cent of mothers said that all the services were particularly good.

Figure 16 **Particularly helpful services**



Mothers in families on low income were as likely to be satisfied overall with services as those in the medium and higher income groups, and to identify particularly helpful services.

Some examples of women's comments on particularly helpful services, covered services which in some form were universally available (the MCH service and hospital and general practitioner services), and some more targeted services (the Caroline Chisholm Society, an outreach youth work service and a Community Health Centre).

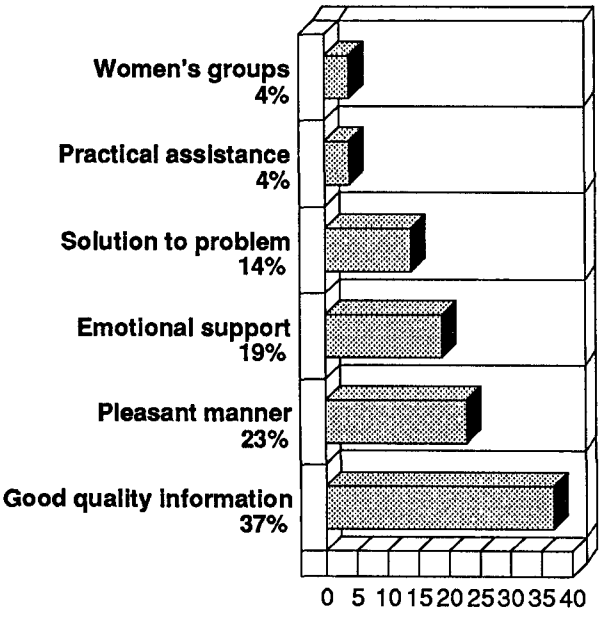
What women particularly valued about these services were the provision of good quality information, a pleasant manner and approach from the worker, the emotional support provided, a solution to the problem they came in with, accessibility, the practical help provided, and the opportunity to meet other women through mothers' groups organised through MCH centres (Figure 17).

The health [MCH] sister is a very calm woman, so just her presence is helpful. She is extraordinarily positive. There is no notion of right or wrong ways to do things and its been 11 years since I had my other child and you forget really. If I had any anxieties she'd alleviate them. Her information was very useful and very practical and very affirming of the feminine role – more so than you could get from a doctor, so I tended to want to see her first, and there were other mothers and babies there – I found it quite fun to be there. (Couple in their 30s with two children)

They are all very good at the Community Health Centre. There are workers there who speak my language. They are kind and caring. They tried to help me overcome the language difficulty, introducing me to a home tutor, encouraging me to join the 'women's club'. (Vietnamese couple in their early 20s, with one child)

Yes, [she's] a member of the God Squad, a motor cycle Christian. She'd help and pick him [the baby] up. Makes a lot of difference. She works with street kids. I've known her five and a half years... I met her at Flinders Street. There's been five babies born in last two weeks of people she knows and helps ... she's great and always there to talk to ... my best friend. (Couple with three children)

Figure 17 **What mothers valued about services**



Mothers' groups

Mothers of babies of same age met weekly ... someone else to talk to, made me think of things which I didn't usually think of.

It's been really helpful to women in the area who don't have a network of friends... I would have really depended on it if I'd been less established in the area and had different neighbours. (Mother's group participants.)

Mothers' groups provide one way of establishing informal networks for those who lack this support. The use of these groups by women in families on low income is of particular interest, given that a lack of informal support networks has been identified as a problem for these women.

One of the MCH nurses in the study area provided the following comment on the difficulties of involving women in families on low income in these groups:

> Most MCH nurses arrange new mothers' groups and playgroups. These are always well attended by articulate, educated and socially skilled mothers. They gain enormously by meeting new friends and benefit from discussions around parenting.
>
> The dilemma for MCH nurses is how do we involve the less confident, less articulate, frequently isolated mother. These mothers are particularly represented in the low income and more disadvantaged groups. It takes a lot of courage to walk into a room of strangers and sometimes these groups can be even more alienating when some families are identifiable as 'better off'. I would argue that the MCH nurse frequently needs to be present to nurture some of these disadvantaged mothers into the group environment, and where that support is not there, they will often drop out. Once at playgroups the financial differences often do not appear as obvious and there can be lots of benefits of providing NESB mothers who are

wanting to practice their English skills with the opportunity to mix in. Children have a wonderful ability to break down barriers, but experience tells me that it takes a little longer for some mothers to feel confident enough to become active participants.

Unhelpful services

The major criticisms of services concerned professional standards and staff motivation

Women were also asked whether there were services that were not of much assistance, and whether there were times when they felt they had needed assistance, but were not able to get it.

Thirty nine per cent of women identified one or more services that they felt were not of much assistance for either themselves or their children. The main services identified were general practitioners (10 per cent), hospitals (10 per cent), MCH services (8 per cent), obstetricians (6 per cent), and paediatricians (3 per cent). Other services criticised were Community Health Centres, the Nursing Mothers' Association, and lactation support advice.

Themes in mothers' criticisms of the particular services included criticisms of professional standards and motivation, problems with service availability, lack of a service-user orientation (not helping with the problems that mothers identified), the manner and approach of workers, a lack of continuity of care, unnecessary services, and cost of services.

The major criticisms of services concerned professional standards and staff motivation (25 responses). This was not an anti-professional theme, but a criticism of particular services and sometimes individual staff. Some examples of comments were: 'conflicting views from doctors on daughter's health'; 'didn't understand my queries' (general practitioner); 'antenatal classes inadequate – attitudes haven't changed in 20 years'; 'the intensive care area was like something out of the dark ages' (hospital); 'come back in three days, didn't give enough info.' (hospital); and incorrect filling in of a doctor's script (chemist).

Comments on the lack of service availability (six responses) were: 'not there when you need them', 'long waiting times', 'not open after hours'. An example of a lack of orientation to the needs of service users was: 'the nurse didn't come and look after my baby when I was sick and tired on the second day'. Criticisms of the manner and approach of workers included 'found her [MCH nurse] really unfriendly', 'you are terribly vulnerable after you have a baby', and 'she didn't ask how I was'. Two mothers talked about a lack of continuity of care with changes in staff (hospital, MCH service). Other responses included not being told about a charge for a service and the worker not calling at the arranged time.

Three comments are provided below because they illustrate some important themes. The first comment is a poignant example

of access to services being refused because of the inability of a mother to pay. The approach of most women in this study who could not afford certain services was to not use them rather than risk being refused access to them.

> I went to an obstetrician at six months [pregnant]. Then he said as I couldn't afford it I shouldn't come any more. He said it wouldn't be fair to him! I realised he didn't care about me. (Sole parent in early 40s, with two children)

In contrast to this mother who was denied a choice in access to services, another mother used the services of a private obstetrician but did not find it useful. She did point out that she was trained as a midwife and that her considerable knowledge of pregnancy and birth influenced her feelings about this. She comments:

> It was such a straight forward pregnancy. You spend so much time waiting, two or three hours. It seems ironic to me it costs so much money. Everything was fine. It was such a waste. (Couple with one child)

From this example it is easy to understand the bias that a 'user pay' approach builds into services; with one woman complaining about what she saw as an unnecessary service, while another woman is denied access to the same type of service. The next comment illustrates that some services that mothers were generally happy with still had their critics.

> The hospital wasn't of much help. She [baby] was very sick with bronchitis. They said bring her back home, she's not sick enough ... and then took back in hospital for 10 days. When [we] came home, [she] still hadn't used her bowels. They've done nothing for her ... She's still crook and she's got to depend on these [drugs] and is an outpatient now. [You have to] wait there for hours, when you get in there. I could have told them over the phone what's happening. (Couple in early 20s, with two children)

A quarter of the mothers also said there had been times when they needed help but were not able to get it. The major theme in women's comments here was again a criticism of existing services (16 per cent). Minor themes were that additional services were needed (7 per cent), and a small number of women (3 per cent) described particular health problems for which they did not get help.

The additional services that mothers said were needed included: special accommodation for mother and baby to stay after birth (when they didn't want to go home); better access to home help; and a support group for women suffering from anxiety disorders (two women).

Mothers' reports of health problems, where they needed help but did not get it, included feelings of depression during

pregnancy that led to overeating, incontinence, sore nipples, lack of iron, morning sickness, stress and a drug addiction. One woman talked about missing the support of her own parents because they were living interstate.

Mothers on low income were slightly less likely to identify services that were unhelpful for their own and their children's use. However, they were slightly more likely to identify that they needed assistance but did not get it, with just under a third of mothers in families on low income (32 per cent), compared with 19 per cent of mothers on moderate incomes, and just over a quarter (26 per cent) of those on higher incomes.

Child-care

Child-care is discussed as a separate services' issue because of its close relationship to employment. Mothers were asked about their current use of child-care, and their proposed future use in relation to plans to undertake paid employment.

Mothers were asked about their current use of child-care, and their proposed future use in relation to plans to undertake paid employment.

For the 49 mothers (29 per cent) who were working at the time of interview, the most common forms of child minding used the resources of the immediate and extended family (Figure 18). The major sources of child minding were: child's father, relative, child-care centres, family day care, and paid baby-sitters/nannies. A number of mothers also indicated that they looked after their own children while in paid employment. The use of the father as the child minder was usually associated with the father having flexible work hours, or the mothers working regular shift work or weekend work. Mothers who looked after

Figure 18 Child-care
Mothers in paid work force

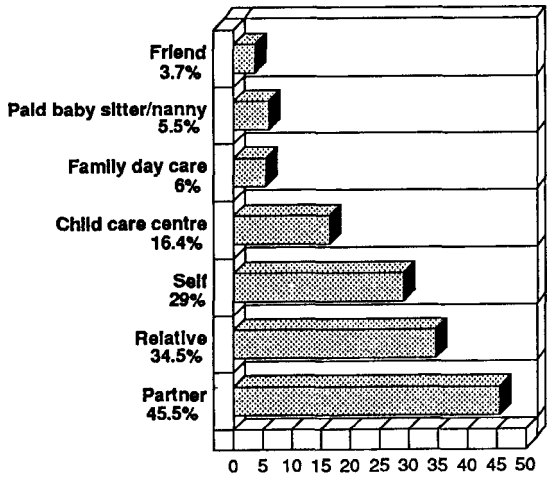
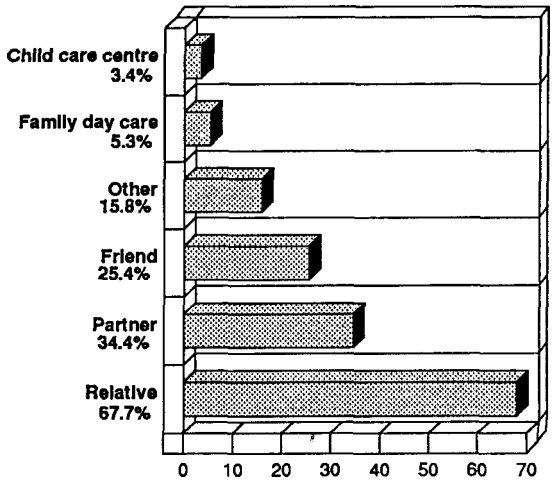


Figure 19 Child-care
Mothers not in paid work force



their own child while they worked were usually self-employed, either working from home or in a family business.

For the majority of mothers (65 per cent) who were not working at the time of interview about half had some form of child minding. For these mothers the most common form of child-care was again family and friends; with a close relative, child's father, and friends figuring most prominently (Figure 19), and with only a small amount of paid child-care through a child-care centre or family day care. Satisfaction was again high, with only five mothers expressing any dissatisfaction.

Twenty-nine mothers (17 per cent) who did not have child minding wanted access to it.

Eighty per cent of these women who were not in paid work at the time of the interview were planning to return to work at some stage, and just under one-half of these mothers were planning to do so before their child's second birthday.

Eighty per cent of these women who were not in paid work at the time of the interview were planning to return to work at some stage, and just under one-half of these mothers were planning to do so before their child's second birthday. When asked what form of child-care they proposed to use, a number of women identified more than one source of child-care, as did women who had child-care. The forms of child-care most commonly identified were fee-paying services, with over three-quarters of the mothers saying they would use a child-care centre or family day care.

The proposed use of resources within the extended family was still important here, sometimes in conjunction with child-care centres and family day care, with 26 per cent of the mothers planning to use a relative, 12 per cent to use the child's father and 6 per cent to use a friend. These informal arrangements were sometimes planned in conjunction with fee-paying child-care services. There were also mothers who intended to continue to mind their own children or use baby-sitters. Twelve per cent planned to delay employment until their child attended primary school, while 8 per cent had no plans to enter the work force.

The extent to which these women are able to find employment in a period of recession and what form of child-care they use will be followed-up in stage 2 of this study.

Use of child-care by families on low income

When I want to go out to buy things, I want someone to look after her for me. I have to take her wherever I go. That means I cannot go out very often. Almost every day of the week I am at home. (Couple with one child and no child-care)

Women in families on low income were considerably less likely to be working at the time of interview (12 per cent) compared with their medium income (29 per cent) and higher income (59 per cent) counterparts. This was only to be expected as women's employment was an important source of family income.

Women in families on low income were also far less likely to have some form of child-care/child minding. Forty per cent of this group of mothers had no form of child-care compared to 47 per cent of those on medium income and 70 per cent of those on higher income.

This lack of use of child-care by women in families on low income was not simply a matter of choice, but a reflection of the lack of informal supports and inability to gain access to paid child-care. Thus 12 women in families on low income who had no form of child-care said they wanted access to it, compared with nine women in families on medium incomes and seven on higher incomes.

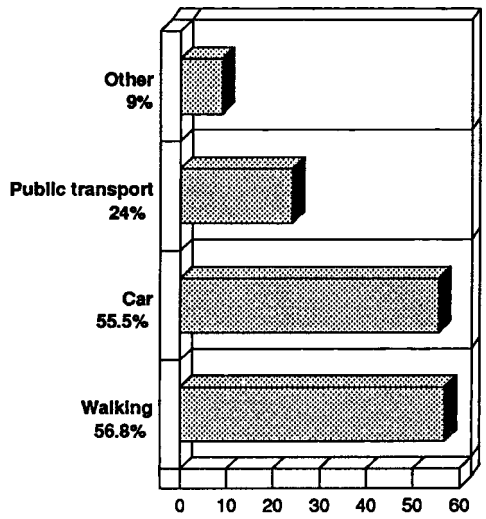
Physical access to services

In inner urban Melbourne, mothers usually have easier physical access to a range of services than mothers living in outer urban or rural environments where there are fewer services, greater distances, and considerably less public transport.

Nearly all the families on medium and higher incomes had a car, while over two-fifths of families on low incomes did not.

The ease of physical access to services in inner urban Melbourne is indicated in the range of means by which mothers got to services (Figure 20). Access by walking, by car and by public transport was reported and two-fifths of mothers used more than one option.

Figure 20 **Transport to services**



Nevertheless, 22 per cent of mothers still found that there were places that they found difficult to get to. Not surprisingly, the 16 per cent of mothers in families without a private motor vehicle (usually on a low income) were much more likely to say that they had problems with access. Seventy per cent of those without a motor car reported problems in getting to some places, while only 24 per cent of those with motor cars said they experienced problems (often with parking).

Only two of these mothers' comments related directly to services. One woman found it difficult to get to the Royal Children's Hospital, and another with five children found it too difficult to walk to the MCH centre.

Nine women in families on low income talked about the problems of using a pram on trams. There were difficulties in folding the pram or in getting help to lift it on or off. One woman had not travelled to the city since her child's birth because of her concern about this.

There were a number of other critical comments of the public transport system by women in families on low income, including that it was 'too clumsy to use for long distances', that 'it was very inconvenient to have to rely on it', and that there were long waits for buses and trams. Other comments related to experiences by women who did not have the use of a car – one woman felt that she was stranded in her own local area.

The experiences of two women in this study point to the additional problems of access faced by families on low income with cars. In one family, the car was not reliable enough to drive to the mother's parents' home in the country, while another family could not afford petrol to drive their car out of Melbourne.

While a small number of women on medium and higher income also made some criticisms of public transport or found it difficult to park their car in some locations, it could be said that their plight was less severe given that they usually had the choice of private or public transport.

Summary

The most disturbing findings were the less frequent use of a range of mainstream services, particularly those providing advice and support during pregnancy, and access to child-care support.

Women in this study used a wide variety of services during the period of pregnancy, birth and in the first months of the baby's life. The most commonly used, during pregnancy, were hospitals and general practitioners, while the MCH service was the most commonly used after birth. Child-care included a mixture of paid child-care and informal arrangements within immediate and extended families. The major gap in child-care was for women who were not working and who had no access to child-care, though the number here was small.

Women were generally well satisfied with the services, though they expressed some disturbing criticisms, and there were some expressions of unmet need. These included existing services which should have been of more assistance and the need for provision of new services.

On a positive note, women in families on low income used a variety of services, and there were no families that seemed to fall outside part of a services 'net'. They were also no more likely to be dissatisfied with services overall, or to feel that particular

services had been unhelpful. Major services, such as the MCH and hospital services, were seen as helpful by those on low income. In addition, women on low income also talked very positively about health and community services particularly targeted to their needs, such as social and youth work services and community health centres (which provide an important avenue for improving access to services for NESB mothers).

Given the earlier findings of the greater pressures on families on low incomes, and their poorer informal support networks, the most disturbing findings were the less frequent use of a range of mainstream services, particularly those providing advice and support during pregnancy, and access to child-care support. Other concerns were a higher reporting of unmet needs, and problems with using public transport, despite the highly developed system that exists within the study area.

There are problems of access to services beyond simply a question of individual choice. Barriers appear to be lack of access to services provided on a 'fee for service' basis, lack of information about what services are available, and lack of self confidence to become involved in some services (such as new mothers' groups).

CONCLUSIONS

CHAPTER 6

Introduction

This research paper has presented a consumer view of birthing and early childhood services, collated from the experiences of 164 mothers (and their 167 children) living in inner urban Melbourne at the time of their child's birth in 1990. Its purpose was to explore the different experiences in use of services of mothers in families on low income compared with mothers in families with medium and higher incomes, in what can be described as a 'services rich' area.

This concluding chapter summarises the research findings, discusses what can be learnt from them to improve services for people on low income, and emphasises the importance of maintaining current service levels.

Three research questions

The three research questions posed in the introductory chapter of this report concerned the extent to which mothers in families on low income reported greater needs, less informal support, and poorer access to services, than families on medium and higher incomes. The main research findings on these three questions are briefly summarised below.

Greater needs

The issue of family needs can be closely equated to one of the equity goals of health and community services identified in the introductory chapter, equality of health and well-being outcomes.

On a number of measures mothers in families on low income were in a worse situation than those in more affluent circumstances. These included being more likely to rate their lives as less happy overall, to more commonly

identify poorer health for themselves and their children, to report they had greater problems in managing their own children, and to identify themselves as being more subject to a greater range of stressful life events, including serious marital and financial problems.

Informal supports

Mothers in families on low income had substantially less informal support. The 19 sole parents (all women) received little financial, practical or emotional support from the child's father. Other mothers in families on low income in two-parent families were more likely to report serious marital conflict and less assistance from their partners in the first few weeks after the birth, when the children were four months or older, and gave a lower overall rating of support from partners. Mothers in families on low income were also less likely to have the support and assistance of their own parents, their partners' parents, and to have supportive friends.

Access to services

Equalising access to services on the basis of need was identified in the introductory chapter as a goal of health and community services. The fact that mothers in families on low income reported greater problems and stresses in their lives than mothers in more affluent families indicated that overall their need for services was potentially greater, and this was further reinforced by the fact that these women had less informal support.

Mothers in families on low income were less likely to use a number of services, including antenatal classes, obstetricians, paediatricians, the Nursing Mothers' Association, and child-care services. They were however more likely to use some welfare services particularly targeted to their needs, such as provided by youth and social work services and community health centres. Women in families on low income were much more likely to be public hospital patients, while mothers in medium and higher income groups were more likely to be private patients.

Improving what we have

The findings of the study have implications for our understanding of the importance of health and community services to people's well-being, for our recognition of the barriers to access confronting low-income groups in particular, and for policies designed to overcome barriers and improve services.

Importance of health and community services

It might be argued that poorer access to services by people on low incomes is not necessarily a problem because there is no proof that the services would have made a difference to their health and well-being, and because it can be demonstrated that the problems faced by people on low income are often outside the scope of health and community services to remedy. This research certainly supports the viewpoint that some of the problems faced by low-income families (such as those caused by inadequate income) lie outside the influence of health and community services. However, while the study is not in any sense a systematic evaluation of the contribution of services to the well-being of mothers and babies, it is clear that the mothers involved perceived a number of services to be of great value. Mothers in families on low income in particular indicated the importance of some services, such as MCH centres, to their health and well-being. From their perspective, the services certainly did make an important difference, even if they did not provide solutions to all the problems identified.

Barriers to use of services

A number of barriers to the use of services were identified in the introductory chapter. They included barriers arising from financial differences, geographic isolation, socio-cultural and language differences, and asymmetric power relationships.

A number of these barriers were evident in the study. The clearest example of those related to financial differences was the tension between the use of public and private hospital care on the basis of family income, where private care was also associated with the use of a private obstetrician. While mothers' comments suggest general satisfaction with use of the public hospital services for the birth, other mothers who could afford private hospital care commented favourably on having some additional choices – for example, seeing the same obstetrician on each visit and for the birth. There were fewer choices available to public patients in the hospital system, and some mothers commented unfavourably on what they saw as a lack of continuity of care.

There were no financial barriers to the use of general practitioners or the MCH service. Presumably cost would be an issue in using child-care, alternative health practitioners, and specialist medical services, though mothers made few explicit comments about this.

Geographic isolation was not a problem for the 164 families in inner urban Melbourne who reported that they had good physical access to a broad range of health and community services. However, it might be noted that even in this 'resource rich' environment, there were differences in access reported by mothers in the different income groups.

Lack of English ability in families from NES backgrounds as a barrier to their knowledge of and use of services (and the need for skilled interpreters) was discussed in detail in an earlier report from this study (Taylor & MacDonald 1992). It is of particular concern that mothers in families on low income, especially first-time mothers and NESB women having their first baby in Australia, often did not have access to the information provided in antenatal classes and from the Nursing Mothers' Association. It is not surprising that mothers in families on low income were considerably less likely to breastfeed their children.

The importance of socio-cultural barriers to use of the Nursing Mothers' Association was a theme in that organisation's development of an innovative project in which two teenage mothers who had breastfed their babies were trained to be peer counsellors for teenage mothers in hospitals (Victorian Health Promotion Foundation 1991). At a public forum held at the Victorian Health Promotion Foundation in 1991 there was an explicit recognition from the Nursing Mothers' Association that this project was needed because some older women counsellors with 'middle class values' were unable to communicate effectively with very young mothers. A similar point was made about the need to find and train voluntary counsellors from non-English speaking backgrounds.

Mothers from all three income groups made criticisms of professional standards and motivation that they appeared to be powerless to do anything about. This lends support for the view that differences in power between users and providers of services may partly at least be seen as a broader problem of professionalism itself.

The fact that MCH service was the one most commonly identified as being particularly helpful, and the range of explanations provided by mothers for this, may well reflect on the relatively easy access to a free local service and the low key informal nature of the advice and support provided.

It was a limitation of this study that the use of services by families on low income was not explored in sufficient depth to determine how the quality of care in health and community services varied according to income, despite other Brotherhood of St Laurence research that suggests that this is an important issue (Gilley 1990; Taylor 1990). A major study is needed on this issue.

Improving services

In the introductory chapter the notion of 'progressive universality' was suggested as a broad strategy to overcome barriers to access to services by people on low income. The findings of this study are consistent with and support a number of the elements of 'progressive universality' proposed by Harris (1990). These include:

- adequate and guaranteed income and secure housing,
- a universal framework of services, and

- positive and counter-discrimination measures on behalf of disadvantaged groups.

In distinguishing between the experience of families by their income level, the study has shown that on measures of family need, informal supports and access to services, families on low income are in a worse situation than families that are better off financially. The study's findings reinforce the importance of family income for health and well-being and so support the case for an adequate and guaranteed income.

Questions on the housing tenure of families revealed that about one-half of the families were home purchasers or home owners, one-quarter were public tenants and one-quarter were private tenants. Families on low income were usually public or private tenants. Rent levels were also examined. The relatively low housing costs for families on low income in public rental housing (averaging $55 per week) contrasted with the higher costs of private rental arrangements (averaging $92 per week). This demonstrates the significance of public rental housing for low-income families if the requirement of secure housing is to be achieved.

The range of birthing and early childhood services available to all mothers in this study qualifies in terms of providing a universal framework of services. Certainly mothers' comments on the range and quality of the services they used confirm other reports (e.g. Health Department Victoria 1990) that, within the inner urban Melbourne area, there is an extremely valuable network of services available to women during the critical periods of pregnancy, at birth, and for mothers and babies in the months following birth. However, further action needs to be taken to make these services available on the basis of need without the financial constraints that impact on access to a number of services, particularly some hospital and medical services and child-care.

A small number of mothers reported benefiting from positive discrimination measures that allocated additional resources for those in need, such as interpreter services and bilingual staff in community health services, and a range of social work and youth work services.

The extended comment from one of the MCH nurses, quoted earlier in this report, outlined the difficulties and extra resources required to involve NESB families and low-income families generally in the MCH service. The experience of this service provider over a number of years in the study area emphasises the importance of counter-discrimination measures to combat social and cultural barriers to the use of mainstream service.

The major criticisms of services concerned poor professional standards, lack of availability, poor manner and approach from workers and lack of continuity of care. Many of these comments relate to the attitudes and understanding of professional staff, and include the kind of information that needs to be used by service providers and training institutions as a professional development issue. It perhaps also points to the need for services

to have accountability mechanisms through which service users can provide direct critical feedback.

Other comments include the need for additional resources to enable reduction in waiting times in hospitals, making services (such as the MCH centres) available in the evenings, or introduction of additional services. The challenge raised by mothers who said they needed help but did not get it is how to make that help available and accessible.

New approaches

Services also have an important role in further reducing the impact of disadvantage on mothers and babies by identifying needs and developing appropriate responses.

Innovative child-care services, for example, have the potential to be an important form of family support, through their use as an entry point for isolated mothers into local support networks. Together with kindergartens, they also have the potential for giving children a 'head start' through exposure to a range of opportunities and resources not available in the home environment.

The experience of a small scale innovative child-care service organised by the Brotherhood of St Laurence in the study area illustrates both the potential benefits for child-care services for families of low income, and the barriers to the provision of this care. The philosophy of this particular service is to focus on the needs of children, rather than to function purely as an activity program. It also provides a source of both family support and referral to other services.

It does not give priority to parents in the work force and is flexible enough to provide sessional child-care. The service is also provided at a very low cost to the families, and has a higher ratio of qualified to unqualified staff than is required by legislation. Because of these policies the Brotherhood of St Laurence has to meet some 75 per cent of the cost of the service. The very attributes that make it a potentially valuable service to families on low income mean that the bulk of funding is not available through government sources.

The two critical barriers to the provision of these kinds of child-care services are financial (level of fees) and the emphasis in funding policies on the child-care needs of employed people to the exclusion of non-working parents.

A problem identified by this research is that there is no system through which pregnant women can automatically gain access to the best information, advice and support available, especially important for first-time mothers and NESB women having their first Australian-born child. The stage of pregnancy at which women contact a general practitioner varies considerably. The diversity in what is provided in antenatal classes and lack of use of these classes by women on low income has already been discussed.

One answer might be the provision of a universal contact point in early pregnancy such as the MCH service, combined with high quality information (in different languages) available to women at their first point of contact with services.

Retaining our strength

This research is being published in a period of economic recession, with historically very high unemployment (currently in excess of 11 per cent) and a new Victorian government (1992) which gives high priority to fiscal restraint and the reduction of government debt.

In these circumstances there is both an increase in needs due to increased rates of unemployment and a reduction in funding for health and community services as a result of changed government policy. Both have significance for the provision of health and community services and are likely to increase the barriers and disparities reported in the study.

One threat arises from a reduction in the level of resources to services so that they have to attempt to do the same (or more) with less. This occurred recently when the Victorian State Government reduced funding to local councils for the MCH service and it was left to individual councils to decide whether they would meet the cost of relieving staff (when staff were on annual recreation leave) or reduce the hours the service was open. A reduction in funding levels to the MCH services in the study area would have obvious negative implications for current efforts to improve access to the service for families on low income.

Another potential threat to existing levels of service provision is to extend existing user-pay systems to services currently provided free, or to increase the cost of services already provided on a fee-for-service basis. For example, mothers in this study had good access to general practitioners, many of whom direct billed. The $2.50 co-payment charge for doctor's fees introduced in the federal 1991-92 budget (since abolished) increased the cost of medical services for people without a Health Care Card. A recently published paper suggested that co-payments of 25-30 per cent could reduce demand for medical services by as much as 25-28 per cent, but that it would reduce the use of medically 'necessary' and 'unnecessary' services by about the same amount (Richardson 1991, p.30). Another report (McClelland 1991b) found that co-payments have greater impact on service use by people on low incomes.

Critics of the health policies of the Federal Opposition have argued that they will increase the cost of medical services by up to $15 per visit for people on low incomes without a Health Care Card, by reducing the Medicare rebate from 85 per cent to 75 per cent of the scheduled fee, and removing restraints on increases in the scheduled fee level (ACOSS 1992). It would be expected that people on low incomes who were not Health Care Card holders would

be most likely to reduce their use of services despite their need for such services.

During 1991 there was a shortage of funds for interpreting services through the Ethnic Affairs Commission, which meant that the availability of services to NESB women was reduced in the study area. If continued, this will exacerbate the difficulties reported in this study.

In a period of economic recession, discussion of the need for additional services in outer urban growth areas and poorly serviced rural areas can easily become a debate about the re-allocation of resources from 'services rich' to 'services poor' areas. This research suggests caution in assuming that the inner urban Melbourne is over-resourced in terms of birthing and early childhood services. At the very least it suggests that resources should not be re-allocated out of the area without a thorough examination of its likely impact on people on low income.

There are then a range of threats to the continued provision of services at current levels. The point has been made elsewhere that during periods in Australian history when there has been no public universal health care provision, 'the anecdotal evidence is that low income families were deterred from using health services – particularly G.P. and dental services' and that 'the introduction of Medicare and the wider availability appears to have improved the accessibility of G.P. services' (McClelland 1991b, p.45). This study has indicated similar results.

The likely political expression of economic pressures during a period of recession threatens the continued provision of good quality birthing and early childhood services through funding cuts. On the evidence of this study, any reduction of services needs to be resisted.

Final comment

This research on the use of birthing and early childhood services was collected as part of the first stage of the longitudinal study on the life chances of children. The purpose of this first stage was to better understand the early advantages and disadvantages experienced by a group of children from a diverse range of socio-economic backgrounds. In answer to the question 'what kind of a start have these children had in life?', the research evidence shows that in the first months of life children in families on low incomes are differentiated by greater needs, but have less access to resources, both in terms of informal supports and access to services. These children are already worse off than children in more affluent families.

The policy implications of this research for the provision of health and community services may be expressed in terms of trends which need to be resisted, and reforms which are most critical.

Trends which need to be resisted include:

- any reduction in funding to birthing and early childhood services;
- extension of a 'fee for service' payment for service use in health and welfare;
- further reductions in service levels in inner urban Melbourne to pay for the extension of services in rural Victoria and in outer urban and fringe growth areas, without a thorough assessment of their likely impact on people on low income.

Reforms which are critical to the improvement of services involve:

- a concentration on the provision of antenatal care to women on low incomes (including women from NES background), to include the extension of their choices within the public hospital system and the further development of community alternatives. The Ministerial Review of Birthing Services in Victoria provides a range of excellent recommendations on how to do this (Health Department Victoria 1990, pp.180-190).
- The extension of the MCH service to the provision of good quality information, advice and support to pregnant women, especially first-time mothers or overseas-born women having their first child in Australia.
- A review of federal child-care funding policies, to extend affordable child-care for non-working mothers and families on low income, and the expansion of innovative child-care programs to provide a 'head start' to children in families on low income.
- The provision of adequate resources to enable services to be truly accessible to women on low incomes through positive and counter-discrimination measures.
- The need for research on the quality and effectiveness of services, in order to identify what is critical to improving the health and well-being of mothers and babies, particularly those on low income.

To do less would mean neglecting the opportunity to improve the quality of services and by this means developing a better future for all our children.

METHODOLOGY

APPENDIX 1

Introduction

This study was planned as a longitudinal study of children. The first stage (stage 1) involved an interview with the mothers of 167 children born in two local council areas in inner urban Melbourne, in the 10-month period March 1990 to December 1990. Future follow-ups are planned as stage 2, stage 3 and so on.

The initial identification of the children and contact with the families was through the MCH service. This service is auspiced through local councils in Victoria, and is partly funded by state government. Each MCH centre receives all birth notifications of babies born to mothers resident in the local catchment area of the service.

Development of the research

The steps leading to the development of the research design included:

1 A review of Australian and overseas literature on children's studies and longitudinal studies.
2 A review of Brotherhood of St Laurence research on children and families.
3 Discussions with a series of local 'experts' to gauge their views.
4 Three group discussions with mothers, two from low-income backgrounds and one from middle/higher-income backgrounds, all living within the Melbourne inner urban area, on the subject matter of the research.
5 Formation of a Research Advisory Group including both Brotherhood of St Laurence research staff and external experts, which would meet regularly to provide research advice.
6 Development of an interview schedule.

7 Pilot testing of the interview schedule with five people – from both low and medium/higher-income backgrounds.

Sample loss

The sample loss from refusals or being unable to contact mothers was 34.5 per cent overall. It was much lower for the initial area of the study (21 per cent) than for the second area (47 per cent). Information provided by MCH nurses for the initial study area indicated there was no bias in the sample loss on criteria such as income level (using a broad estimate), housing tenure, marital status, and NESB status. Incomplete information from the second study area indicates a particularly high loss of NESB families, most of whom could have been expected to be on low income and living in a Ministry of Housing high-rise estate. An additional six children with NESB parents were therefore added from the first study area. These births took place in November-December 1990.

Sample loss		
No. of children born in two inner urban areas	246*	(100%)
No. of children (mothers interviewed)	161*	(65.5%)
No. of children (mothers not interviewed)	85	(34.5%)

*Excludes the additional six children included from the first study area with Nov-Dec 1990 birth dates.

Age of children at time of interview

The decision to interview mothers with children aged four to seven months was based on the following factors:

1 Interviewing mothers with children at exactly the same age (e.g. four months) would have extended the fieldwork stage by as much as three months, depending on what age was set.
2 The range of ages allowed for greater flexibility between interviewer/interviewee in organising a suitable interview time, and meant that in a number of cases that mothers who were difficult to contact could still be included in the study.
3 The age range of four to seven months should not have a major impact on the research results, given the kinds of variables for which data was being collected.

The table below shows the age of child at time of interview.

Age of child	Per cent	Age of child	Per cent
4 months	15	7 months	11.4
5 months	36.5	8 months	3
6 months	31.7	9 months	2.4

Fieldwork

The fieldwork comprised the following:

- The MCH nurses approached the mothers personally and asked them to take part in the study. At the same time they gave each mother a letter which explained the purpose of the study and what it would involve them in. When the mothers were from a non-English speaking background the letter was provided in their own language.
- For the main language groups (Vietnamese, Chinese and Hmong), bilingual interviews were used. Interpreters were used for interviews with three Turkish women and one interview with a woman of Yugoslavian background. A training day was held for interviewers.
- Interviewers made an initial contact with mothers to explain the study again, to answer any questions they might have, to organise a suitable time and place for interview, and to seek permission to tape the interview.
- Interviewees were offered $30 for taking part in the study to show that their participation was valued.

Method of analysis

The interview schedule provided a mix of open and closed questions – for both quantitative and qualitative data. Quantitative data was analysed using SPSS Statistical Package for Social Sciences.

Maintaining contact with families

Contact with families has been maintained by:

1 Asking mothers in the interview to advise the researchers of any change in address.
2 Sending letters to explain progress in the study to mothers, and following up any letters returned 'address unknown'.
3 Asking the study's participants for the name/address/phone number of two close relatives/friends who the researcher could contact, if contact was lost with participants.

LIST OF SUMMARY DATA TABLES

APPENDIX 2

Income levels used in these tables are defined in Chapter 1 of this report. Percentages have been rounded to first decimal place.

Table 1 **Number of children in family by income level**

Number of children	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
1 child	23	(39.7)	17	(31.5)	42	(76.4)	82	(49.1)
2 children	15	(25.9)	28	(51.9)	8	(14.5)	51	(30.5)
3 or more children	20	(34.5)	9	(16.7)	5	(9.1)	34	(20.4)
Total	58	(100)	54	(100)	55	(100)	167	(100)

Chi-Square= 35.32213 D.F = 35.32213 P=0.0001

Table 2 **Mothers' age by income level**

Mothers' age	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
18-21	7	(12.3)	1	(1.9)	2	(3.6)	10	(6.0)
22-29	26	(45.6)	20	(37.0)	13	(23.6)	59	(35.5)
30-44	24	(42.1)	33	(61.1)	40	(72.7)	97	(58.4)
Total	57	(100)	54	(100)	55	(100)	166	(100)

Chi-Square is not appropriate because numbers are too small

Table 3 **Mothers' country of birth by income level**

Country of Birth	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Overseas born	38	(65.5)	18	(33.3)	6	(10.9)	62	(37.1)
Australian born	20	(34.5)	36	(66.7)	49	(89.1)	105	(62.9)
Total	58	(100)	54	(100)	55	(100)	167	(100)

Chi-Square=36.55 D.F=2 P=0.0001

NB: Overseas born category includes 10 children born to English speaking background mothers while the remaining 28 children were born to mothers from non-English speaking backgrounds.

Table 4 **Housing tenure by income level**

Housing tenure	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Home purchase/ ownership	4	(6.9)	33	(61.1)	46	(83.6)	83	(49.7)
Public rental	34	(58.6)	7	(13.0)	0	(0)	41	(24.6)
Private rental	20	(34.5)	14	(25.9)	9	(16.4)	43	(25.7)
Total	58	(100)	54	(100)	55	(100)	167	(100)

Chi-Square=83.01928 D.F = 4 P=0.0001

Table 5 **Stressful life events by income level**

Type of stress	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Illness or death of somebody close	20	(34.5)	23	(42.6)	27	(49.1)	70	(41.9)
Major problem with own health	19	(32.8)	4	(7.4)	8	(14.5)	31	(18.6) *
Serious disagreement with partner	24	(43.6)	13	(24.1)	10	(18.2)	47	(28.7) *
Serious disagreement with someone else close	8	(13.8)	13	(24.1)	11	(20.0)	32	(19.2)
Serious financial problems	25	(43.1)	10	(18.5)	7	(12.7)	42	(25.1) *
Major change in partner's job situation	22	(44.9)	16	(30.8)	14	(25.9)	52	(33.5)
Serious housing problem	13	(22.4)	8	(14.8)	6	(10.9)	27	(16.2)
Legal problems	8	(14.8)	4	(7.5)	1	(1.8)	13	(7.8)
Stressful life event(s) affecting mother caring for child	10	(20.8)	6	(15.8)	9	(23.7)	25	(20.2)

* Denotes a significant association at the P 0.05 level (Chi-Square)

Table 6 **Children's health problems by income level**

Health problem	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Colds	40	(69)	42	(77.8)	36	(65.5)	118	(70.7)
Ear infections	8	(13.8)	5	(9.3)	7	(12.7)	20	(12)
Hearing problems	0	(0)	1	(1.9)	0	(0)	1	(0.66)
Chest infections	15	(25.9)	3	(5.6)	3	(5.5)	21	(12.6) *
Wheezing	17	(29.3)	8	(14.8)	2	(7.4)	27	(16.2) *
Vomiting	26	(44.8)	13	(24.1)	12	(21.8)	51	(30.5) *
Constipation	17	(29.3)	8	(14.8)	9	(16.4)	34	(20.4) *
Skin rashes	24	(41.4)	24	(44.4)	21	(38.2)	69	(41.3)
Allergies	6	(10.3)	4	(7.4)	6	(10.9)	16	(19.6)
Viruses	3	(5.2)	3	(5.6)	3	(5.5)	9	(5.4)
Convulsions	3	(5.2)	0	(0)	0	(0)	3	(1.8)
Accidents	2	(3.4)	4	(7.4)	1	(1.18)	7	(4.2)
Sleeping problems	16	(27.6)	9	(16.7)	6	(10.9)	31	(18.6)
Jaundice	13	(22.4)	10	(18.5)	17	(30.9)	40	(24)
Birth injury	3	(5.2)	1	(1.9)	2	(3.6)	6	(3.6)
Feeding problem	14	(24.1)	6	(11.1)	7	(12.7)	27	(16.2)

* Although there is a greater incidence of these conditions amongst children and families on low income, use of Chi-Square is not appropriate because of the small numbers involved.

Table 7 **Mothers' rating of managing with child by income level**

Rating of management	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Managing very well	27	(46.6)	28	(51.9)	38	(69.1)	93	(55.7)
Managing quite well	22	(37.9)	25	(46.3)	16	(29.1)	63	(37.7)
Having problems in managing	9	(15.5)	1	(1.9)	1	(1.8)	11	(6.6)
Total	58	(100)	54	(100)	55	(100)	166*	(100)

NB: The third category 'Having problems in managing' combines the following three ratings: Having a few problems, Managing poorly and Managing very poorly.
NB: Use of Chi-Square not appropriate because the numbers are too small.
* One no answer.

Table 8 **Help received by mother at time of interview by income level**

Help received	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	42	(72.4)	44	(81.5)	50	(90.9)	136	(81.4)
No	16	(27.6)	10	(18.5)	5	(9.1)	37	(18.6)
Total	58	(100)	54	(100)	55	(100)	167	(100)

Chi square=6.38814 D.F=2 P=0.0410

Table 9 **Mothers' rating of happiness by income level**

Happiness rating	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Very happy	6	(10.5)	19	(35.2)	38	(69.1)	63	(38.0)
Happy	23	(40.4)	29	(53.7)	14	(25.5)	66	(39.8)
Mixed feeling	20	(35.1)	6	(11.1)	2	(3.6)	28	(16.9)
Unhappy	7	(12.3)	0	(0)	1	(1.8)	8	(4.8)
Very unhappy	1	(1.8)	0	(0)	0	(0)	1	(0.6)
Total	57	(100)	54	(100)	55	(100)	166	(100)

Chi-Square not appropriate because the number of cells are too small

Table 10 **Mortality rates of grandparents by income level**

Mortality	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Mother's mother deceased	3	(5.2)	4	(7.4)	4	(7.3)	11	(6.6) *
Mother's father deceased	13	(22.4)	18	(33.3)	12	(21.8)	43	(25.7) *
Father's mother deceased	9	(19.6)	6	(11.3)	11	(20.46)	26	(17) *
Father's father deceased	19	(41.3)	16	(30.8)	17	(31.5)	52	(34.2)

* Not significant at P level

Table 11 **Residence of maternal grandmothers by income level**

Residence	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Same suburb	10	(18.2)	6	(12.0)	2	(3.9)	18	(11.5)
Inner urban Melbourne	8	(14.5)	7	(14.0)	2	(3.9)	17	(10.9)
Middle urban Melbourne	5	(9.1)	14	(28.0)	23	(45.1)	42	(26.9)
Outer urban Melbourne	1	(1.8)	5	(10.0)	5	(9.8)	11	(7.1)
Victoria country	3	(5.5)	3	(6.0)	5	(9.8)	11	(7.1)
Interstate	5	(9.1)	7	(14.0)	12	(23.5)	24	(15.4)
Overseas	23	(41.8)	8	(16.0)	2	(3.9)	33	(21.2)
Total	55	(100)	50	(100)	51	(100)	156	(100)

Chi-Square value significant at P level

Table 12 **Mothers' parents helpful by income level**

Help received	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	35	(68.6)	46	(93.9)	49	(92.5)	130	(85.0)
No	16	(31.4)	3	(6.1)	4	(7.5)	23	(15.0)
Total	51	(100)	49	(100)	53	(100)	153	(100)

Chi-Square=18.16833 D.F=4 P=0.001

Table 13 **Help for mothers from friends by income level**

Help received	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	43	(74.1)	48	(90.6)	52	(96.3)	143	(86.7)
No	15	(25.9)	5	(9.4)	2	(3.7)	22	(13.3)
Total	58	(100)	53	(100)	54	(100)	165	(100)

Chi-Square=14.05041 D.F=4 P=0.0071

Table 14 **Satisfaction with services by income level**

Level of satisfaction	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Very satisfied	10	(17.5)	23	(42.6)	33	(60.0)	66	(39.8)
Satisfied	38	(66.7)	22	(40.7)	16	(29.1)	76	(45.8)
Both satisfied and dissatisfied	9	(15.8)	9	(16.7	6	(10.9)	24	(14.5)
Total	57	(100)	54	(100)	55	(100)	166	(100)

Chi-Square=22.65977 D.F=4 P=0.0001

NB: No mothers used the lower two ratings: 'dissastisfied' and 'very dissatisfied'

Table 15 **Services used by mothers by income levels**

Services	Low income		Medium income		High income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
G.P.	44	(75.9)	40	(74.1)	37	(67.3)	121	(72.5)
Alternative health practitioner	2	(3.4)	9	(16.7)	7	(12.7)	18	(10.8)
Obstetrician	9	(15.5)	36	(66.7)	45	(81.8)	90	(53.9) *
Birthing centre	1	(1.7)	12	(22.6)	19	(34.5)	32	(19.3) *
Nursing Mothers' Association	4	(7.0)	20	(37.0)	24	(43.6)	48	(28.9) *
Public hospital for birth	54	(93.1)	30	(55.6)	20	(36.4)	104	(62.3) *
Private hospital for birth	4	(6.9)	23	(42.6)	34	(61.8)	61	(36.5) *
Chemist	37	(63.8)	35	(64.8)	43	(78.2)	115	(68.9)

* Chi-Square value significant at P level

Table 16 **Services used for children by income level**

Service	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
G.P.	51	(87.9)	49	(90.7)	39	(70.9)	139	(83.2) *
MCH service	57	(98.3)	54	(100)	54	(100)	166	(99.4)
Alternative health practitioner	(0)	(0)	7	(13)	2	(3.6)	9	(5.4)
Paediatrician	13	(23.2)	16	(29.6)	28	(50.9)	57	(34.5) *
Hospital	29	(50)	18	(33.3)	22	(40)	69	(41.3)
Chemist	37	(63.8)	37	(68.5)	48	(87.3)	122	(73.1)

Table 17 **Helpful services for children by income level**

Whether services are particularly helpful	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	41	(74.5)	43	(82.7)	47	(85.5)	131	(80.9)
No	14	(25.5)	9	(17.3)	8	(14.5)	31	(19.1)
Total	55	(100)	52	(100)	55	(100)	162	(100)

Chi-Square = 1.18608 D.F. = 2 P = 0.5526

Table 18 **Services not helpful by income level**

Whether services are not helpful	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	12	(22.2)	13	(24.1)	20	(36.4)	45	(27.6)
No	42	(77.8)	41	(75.9)	35	(63.6)	118	(72.4)
Total	54	(100)	54	(100)	55	(100)	163	(100)

Chi-Square = 3.23086 D.F = 2 p = 0.1988

Table 19 **Car ownership by income level**

Own a car	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	33	(56.9)	53	(98.1)	54	(98.2)	140	(83.8)
No	25	(43.1)	1	(1.9)	1	(1.8)	27	(16.2)
Total	58	(100)	54	(100)	55	(100)	167	(100)

Chi-Square = 47.56840 D.F = 2 p = 0.0001

Table 20 **Difficulty in getting to places by income level**

Difficulty	Low income		Medium income		Higher income		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Yes	26	(46.4)	15	(27.8)	12	(21.8)	53	(32.1)
No	30	(53.6)	39	(72.2)	43	(78.2)	112	(67.9)
Total	56	(100)	54	(100)	55	(100)	165	(100)

Chi-Square = 47.56840 D.F = 2 p = 0.0001

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