

# NURSES ON THE MARKET: THE IMPACT OF NEO-LIBERALISM ON THE VICTORIAN MATERNAL AND CHILD HEALTH SERVICE

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## ABSTRACT

### **Objective:**

To examine maternal and child health (MCH) nurses' experiences of the implementation of the rationalisation processes and compulsory competitive tendering (CCT) associated with neo-liberalism.

### **Design:**

Policy analysis, survey of all Victorian MCH nurses, interviews and focus groups with MCH coordinators and some managers of MCH services.

### **Setting:**

Primary health care in maternal and child health services.

### **Participants:**

Sixty MCH coordinators, 300 MCH nurses, six managers (95% female overall).

### **Results:**

The Victorian MCH workforce is overwhelmingly female, with 30% over 50 years of age, and 53.5% working part-time. CCT processes in the mid-1990s effectively put maternal and child health services 'on the market', threatening jobs, and creating highly stressful work environments. Tenders for about 17% of MCH services were won by organisations other than local government, the traditional provider of MCH services. This created new challenges for MCH nurses. In spite of the enormous stress and confusion occasioned by the restructuring, improvements in strategic focus, skill development, teamwork and flexibility were also reported.

### **Conclusions:**

CCT processes provided MCH nurses with greater transparency about management and budgets. Restructuring gave MCH nurses greater responsibility than they had earlier and they became more aware of the need to 'sell' their service and to understand management contexts. Major hurdles still to be overcome related to wage parity, workload discrepancies and a restrictive, policy legacy about the practice of MCH nurses.

## INTRODUCTION AND BACKGROUND

Since the 1920s, the Australian state of Victoria has provided a highly regarded primary health care nursing service for childbearing women. The Maternal and Child Health (MCH) Service, as it is now known, has traditionally been available through local centres, universally available free of charge on a needs basis, with funding jointly provided by local and state governments. Although the practice of MCH nurses was able to be adapted to the particular character of an area, their professional identity was based on a sense of belonging to a state-wide health service. Whilst employed by local municipal councils, most MCH nurses felt a proprietorial attitude to 'their' centres, and it was common for nurses to remain in an area for many years. MCH nurses attained a high degree of independence and autonomy, often having little contact even with council staff and limited accountability to the State Department of Health. During the 1990s, however, significant change in administrative arrangements and neo-liberal policy directions in the public sector transformed MCH services by introducing a market model.

Managerialist strategies were introduced into the Victorian public service by 1980s governments to 'squeeze more from existing resources' (Considine 1992, p.199). In order to stimulate competition and raise productivity, the emphasis on outputs, goals and targets increased. Program budgeting and new corporate images were introduced. Senior staff, once secure in their employment, were put onto fixed term contracts. In Victoria from 1992, the neo-liberalist Kennett government introduced a more extreme version of new public sector management, unreservedly embracing the ethos of the private business world (Hancock 1999). Within government departments, funding of services was restyled to reflect a 'purchasing' rather than a 'providing' role for the state. The principles of neo-liberalism underpinned moves to sell off, or contract out, facilities and services to the private sector. As in 1980s Britain, this commercialisation process involved a whole range of services being 'packaged and marketed as commodities' (Whitfield 1992, p.72), even when they

remained under state control. Public service units and community services were restructured to make them more autonomous and accountable, oriented to cost-cutting efficiencies, technical rationality and values of competitiveness (Hancock 1999).

MCH services were not immune from these developments. Indeed, a need for 'reform' of the MCH service was argued consistently in public service documents (Australia: Department of Health and Community Services 1993; 1994). Through the late 1980s to early 1990s, health policy focused on tighter targeting of service goals, establishment of measurable standards and more efficient data gathering. Surveillance of infants and young children was increasingly seen as the 'core business' of MCH services (Australia: Department of Health and Community Services 1993). Service users were redefined as clients or consumers.

Despite professional and consumer activism to reverse what were seen as alarming trends (Reiger 2001), the reform agenda took a different turn in 1993 when the Kennett government began a radical restructuring of local government. The number of Victorian local government areas (LGAs) was reduced from 210 to 78 through a process of rationalisation that was overseen by commissioners who were appointed to replace elected councillors. Within 12 months of the amalgamations, a whole raft of local government services were restructured into business units to meet a requirement that by 1996, 50% of all services were to be put on the market via compulsory competitive tendering (CCT).

Amid lively debate about the lack of democratic process, the period of local government amalgamations under the Kennett government was both tumultuous and chaotic. MCH services were directly implicated. First, quite different MCH services with distinctive cultures and histories were suddenly thrown together in new and rapidly changing structures. In the former municipalities, MCH services had been mostly based on 'baby health' centres staffed by a single nurse who often had little to do with other nurses, let alone with those in neighbouring municipalities. Second, in the majority of local government areas, MCH services were among the first to be put out to test their 'market' potential via a tendering process. MCH nurses found themselves formed into business units, with some required to prepare the specifications to permit the tendering to occur, while other nurses responded to the call for tenders by writing proposals to try to win the MCH service back for local government. For some MCH services, the whole process was repeated two years later through a second round of CCT, but this was at the discretion of the local council.

The new administrative arrangements took place in a changing industrial relations environment heightened by the election of a neo-liberalist Federal Government in 1996. Uncertainty and organisational restructuring continued during the later 1990s, although the worst of

the pressure associated with new administrative regimes was over by the time the Bracks Labor government abandoned CCT shortly after its election in late 1999. The decade of change presented a period of extraordinary challenge for Victorian MCH nurses. This paper examines the impact of these changes on MCH nurses who were in effect, 'put on the market' along with their services, and reports our research into the impact these significant changes had on MCH nurses' work environment.

## METHOD

Both qualitative and quantitative research approaches were used. Policy analysis was based on background documents and reports related to maternal and child health policy, planning and services. A database was constructed with all local government contacts included. Ethics approval was obtained from the Human Research Ethics Committee of La Trobe University (Bendigo Campus) in 1998 and later extended to cover follow-up data collection in 2001. A small grant from La Trobe University's Intercampus Research Grants Scheme supported the project.

The research benefited enormously from the involvement of MCH staff as stakeholders in the study. We were able to brief nurses at a Saturday in-service meeting, while individual coordinators provided invaluable feedback on draft materials. MCH coordinators from metropolitan, regional and rural services were approached for one-to-one interviews or small focus groups, with participation by a total of 60 coordinators (from 78 LGAs). With participants' consent, all focus groups and interviews were tape-recorded and transcribed. As maintenance of confidentiality was very important in view of the climate of apprehension and anxiety engendered by the competitive tendering environment, all raw data was coded using identifiers known only to the researchers. MCH staff were very cooperative and we were confident that good representation of the state's services was achieved. In addition to the coordinators, a sample of six local government middle managers was drawn from metropolitan and rural areas. The enormous amount of qualitative data was managed using QSR NVivo software (Qualitative Solutions and Research 1999), which allows full transcripts of interviews to be coded in multiple ways, with themes established and explored. A detailed coding frame was developed according to the project's conceptual concerns with organisational change and professional issues. The coding scheme was modified as new categories emerged from the data analysis.

The early qualitative data collection informed the development of a survey of 58 items which was distributed in late 1998 via their coordinators to most of the 550 full-time, part-time and casual nurses MCH nurses employed in Victoria at the time. Each respondent was able to return the survey anonymously

by prepaid mail to the researchers. Only one follow-up call for return of surveys was made, and the 55% response rate doubtless reflected data collection in the busy period of December. A mix of pre-coded and open-ended questions was used with a high level of consistency in the quality of the completed questionnaires indicating clarity in the framing of the questions. Shorter open-ended question responses were coded and entered along with pre-coded data into SPSSx (Statistical Package for the Social Sciences). Frequencies and cross tabulations were used to draw out key findings. Longer open-ended answers were entered into a database for integration with the qualitative data. The triangulation of methods provided a very thorough picture of the nurses' experience of changes in the Victorian MCH service. Although change continues, and only a small amount of policy research and 'updating' of organisational data was possible during 2000-2001, we are confident the issues raised here remain pertinent. Given the richness and complexity of the data, only selected results can be reported but a full report is available (Reiger and Keleher 2002).

## RESULTS AND DISCUSSION

### Profile of respondents and services

The survey indicated that the MCH nursing workforce in Victoria is ageing, with over 30% of the workforce aged over 50 years. A high proportion (53.5% of the sample) is in part-time work, mostly by choice. The workforce is overwhelmingly female, with more than half also responsible for caring for their own children. The data also points to a high rate of geographical stability amongst MCH staff, with only 10% having worked interstate and 33% working in their current location for over ten years.

Two years after the first round of CCT, the overwhelming majority of MCH nurses (83%) were still working for local government units which had successfully won tenders. As well as a few rural municipalities that continued to run MCH services 'in-house' without formal tendering processes, there was a small but significant group of 11.4% who worked for community health services. A further 2% worked for hospitals and there were some 'other' outsourced arrangements also in place. Of the sample, 65% were employed in services in Melbourne, 19% in rural cities and 14% in rural shires. Few were spared the tumultuous changes associated with first amalgamations, then CCT.

### The impact of service amalgamations on MCH nurses

Local government rationalisation also amalgamated MCH services that were often quite disparate in workloads and pay rates, organisational cultures and relationships with council management. Peer relations and styles of leadership also varied. The result was escalating levels of personal and professional stress, uncertainty and confusion about organisational

processes and working conditions, as well as tensions around workload management. The role of coordinators generally became more formalised with consequences for their relationships with both nursing colleagues in their teams and with others in the organisation.

In some areas, personal and professional differences between nurses produced a distressing process of readjustment. Several coordinators reported frustration at how long it took to build new cohesive teams in the face of different expectations and experience. As one coordinator commented about meeting one year after amalgamation:

*It was just incredible. I mean, all this stuff came up. Money issues, because a lot of the nursing staff were on much higher awards, and of course, I mean, that sort of really hurt them. It was them and us, and oh, it was dreadful.*

Others also found the 'them and us' mentality often produced personal animosity:

*Little things... like [such and such]... we did it this way. And that would rub the other girls. The hostilities would come, you could see it. So we had to be really honest with each other... we're all together now... we had to air that.*

Conflicts over procedures and ways of organising their practice were further complicated by differences in council management structures and how well integrated the MCH service was into these. At one (not uncommon) extreme, in a rural shire, the acting team leader commented that, mostly, they had only ever gone to the council office to collect their mail and had very little contact with other staff. Geographical distance could work both to exacerbate differences on occasions but mitigate it in others when nursing staff did not have to work closely together. The merger of MCH services was accompanied, in many cases, by a process of integration into other larger council organisations, with new systems of accountability and resource allocation to be negotiated and new networks established which further complicated nurses' peer relationships. Resistance to change presented many coordinators with the dilemma of managing nurses who clung to what they termed a 'fortress maternal and child health' philosophy in the face of changed realities.

In some LGAs, up to six municipalities were amalgamated, but regardless of size and across the state, budget constraints meant work rationalisation and often reduction in staff levels. In the redrawing of borders for newly amalgamated services, socio-economic and class differences also made for conflict especially over different workloads. One metropolitan coordinator discussed the problems which resulted when her service, in a 'fairly poor area which ran on the smell of an oily rag' in which nurses carried high workloads, amalgamated with the neighbouring 'fairly middle class' area that had quite moderate workloads. In rural areas, MCH tensions were worsened by geographic distance and considerable local hostility to the whole

amalgamation process, impacting as it did on local jobs and the identities of entire communities. No sooner had the amalgamations been partially bedded down, than the wave of reform associated with CCT was imposed during 1996-97.

### Surviving tender processes

Councils varied in how they managed tendering processes so nurses received varying levels and forms of support. Nurses were, in general, philosophically opposed to tendering, and 76% of the survey sample either disagreed or strongly disagreed with CCT. In open-ended comments they noted that CCT was not appropriate for a primary health service caring for families as it was not a commercial proposition. A recurring theme in accounts of the impact of tendering processes on MCH nurses was that they were 'all at sea' with absolutely no idea about how to write specifications, tender briefs or tender proposals - but neither did council staff. There was turmoil as the rules kept changing and very high levels of distress among MCH nurses. In a field in which nurses' tenure had been commonplace, in many cases it was clear that their jobs were on the line. Only after the first round of tenders, did many existing or in-house teams, and their managers, realise what an advantage they had in already running the service, and in the cost that would have been involved in paying out the nurses if the service had not been won in-house. Nevertheless, they felt vulnerable to external competition, not knowing where it might come from. 'All this', said one coordinator, 'sent anxiety levels up to the ceiling'. In this highly stressful environment, nurses had to maintain their clinical practice and administer the Service but deal also with the demands occasioned by the tendering process.

### Selling the service

In the new competitive climate, while the outcomes of tendering were uncertain, there was little doubt that MCH services had to continue, but now be promoted and redefined as 'business units'. The extent to which councils supported their existing Service directly shaped outcomes. In many councils, consultants were brought in to help either the contract team developing the specifications or the team developing the proposal, but the respective teams were kept away from each other as a requirement of CCT. Some councils, but not all, provided adequate relieving staff to backfill positions to allow permanent staff to work on tenders. One coordinator told of the nurses being given space to work at council offices and help from human resources staff, and commented that the nurses gained 'quite a presence... there were lots of jokes about the nurses moving in'. In other cases, negativity and bitterness were long lasting legacies, requiring good leadership in the ensuing years to enable the service to move on.

Many of the external consultants or other council staff assisting had little understanding of the MCH service. The nurses had to explain the complex nature of their work to people who tended to see nurses as mere 'baby weighers'. Asked about the value of assistance provided, one coordinator commented:

*They were trying to help us and we were getting nowhere. That probably went on for five or six weeks... so then they brought in a consultant. He was an engineer... they know a lot about crushed rock but not much about mothers and babies!*

Another coordinator explained that they had put in a lot of groundwork to ensure the role of MCH was understood, 'a lot of marketing with the staff and the council in terms of what we are responsible for, especially the child protection issues.'

### Going it alone: Perceptions of the Department of Human Services and the Australian Nursing Federation

As MCH nurses and leadership dealt with 'marketing themselves', little policy direction was available from the Victorian Department of Human Services (DHS). Having laid down the program standards governing nurses' practice and the minimal requirements for their contribution to funding the MCH service, DHS otherwise largely vacated the field. Although the survey showed continued expectations that DHS had an important role to play in shaping the direction of the MCHS across the state, it was clear that nurses felt largely left on their own in a period of tumultuous change. Numerous stories emerged of DHS representatives not being able to answer questions, of nurses' frustration with lack of information and confused messages. Many felt that the central department was no longer interested in them. The cut-backs and turnover of staff at both central and regional level presented ongoing problems: 'There's no-one in there now... They tell you to ring the regional office, but there's nobody, no nursing adviser there now'. In rural areas, the loss of clear lines of contact was strongly felt:

*There was always someone who would know what you were on about in the department, you did feel safeguarded by that person, but now I wouldn't have a clue who is in there.*

Another said:

*They change their names that often down there, you wouldn't know [who to contact].*

Asked about the relationship with DHS, more than one coordinator responded with derisory laughter. A rural coordinator responded with:

*What relationship? We don't have one. Who are they? We don't have anything to do with 555 Collins Street and at the regional office. I think they are more stretched than we are. If ever you want to speak to somebody, they are not around and they never get back to you either.*

Others from the metropolitan area described 'the city' as 'a dead loss' and 'hopeless'. Organisational restructuring and the neo-liberal policy shift to 'steering not rowing' human services imposed an unacknowledged burden on nurses in the community.

For many, the feeling of being virtually 'abandoned' applied also to their industrial representation by the Australian Nursing Federation (ANF). The context of the 1990s 'industrial relations reforms', in which negotiations over contracts took place, was largely antipathetic to

unions. Clearly, managements varied in political complexion, but the ANF's role also varied. The survey included specific questions concerning ANF support in the tendering process and negotiation of enterprise bargaining agreements and local area work agreements. Just over half those who answered with regard to tendering (54%, n=119) said the ANF had given assistance with information and phone advice, but 46% had found it inadequate. Those dissatisfied claimed that the union, which was strongly opposed to CCT, had been hard to get hold of, had not turned up to meetings and was of little or no help in scrutinising contracts. Others reported however, that the ANF had been much better in dealing with industrial issues since tendering, giving examples of significant help to individuals. There were still many critical comments:

*Who or what is the ANF!! - We were asking for their help with our LAWA (Local Area Work Agreement). It (the ANF) only came in at the very last minute.*

Another said they had felt 'little support' and increasing 'sense of abandonment'. The feeling of being let down by their union, which like everyone else had few rules to go by, contributed further to the experience of being abandoned in the market environment in which all the old rules of authority, leadership and policy direction had changed.

### Working under contract

Although the most intense period of stress was over by the time the research was carried out, nurses reported a variety of ways in which altered organisational arrangements impacted on their practice. For many, there was pressure to acquire new skills such as computer usage, increased monitoring of client 'throughput', and for those who now worked within new organisations such as community health, often new expectations of their work. While far fewer services were eventually outsourced than nurses had feared, MCH systems that operated across all municipalities had been taken for granted and had to be renegotiated and re-established when the MCH service moved out of the local government system. In some cases, the transfer of MCH worked well, organisationally and professionally. In other areas, mutually respectful relationships developed over time but required considerable effort to establish. One nurse in a rural community health/hospital-based service said she found it difficult to know who to liaise with and often felt quite isolated. She had trouble getting resources as no one was quite sure whose responsibility it was to provide even minor items. Others reported being expected to undertake 'welfare' work with non-MCH clients such as handling requests about anything from bus timetables to welfare payments as well as a variety of other health concerns. While in some cases, the increased contact with other health professionals was welcomed, many felt there was little understanding of their role.

The most appropriate organisational location for the operation of the MCH services has never been addressed state-wide. It has been an ad hoc, localised, sometimes

quite idiosyncratic process as to whether MCH Services have remained council-based, or ended up in other settings - either community health, a hospital (usually rural) or even a private provider. Respondents to the survey indicated strong support for having team leaders or coordinators who were themselves MCH nurses because of their knowledge of the service. In services led by dynamic coordinators, new initiatives were seized and effective relationships established with management. The survey responses indicate that nurses' relationships with line management and coordinators had deteriorated between 1994 and 1999. They reached a low ebb before recovering somewhat but not usually to their previous level. For example the proportion who reported having had excellent or good relationships with senior management five years before was 43%, but it dropped to 27% for three years before the survey and only then recovered to 31%. Comparable patterns emerged even with coordinators. The contracting process was not only highly contentious and stressful but had long-term consequences. Negotiating their working conditions within the constraints of contracts involved complex interactions within teams and with management. Some of the 'in-house' teams found that their contracts were more apparent than real and likely to be varied in the council's favour. Those 'tendered out' faced new challenges of integrating into organisations with which they had formerly had little contact. For some, especially for those with good leadership, this worked effectively, but poor management of contracting process generated significant conflict for a few services.

In spite of the administrative reorganising and confusion over central policy direction, at the level of everyday practice, the service continued to provide the traditional care for mothers and babies, along with widening responsibilities for families in the community. Direct service was affected more in some services than others, but did not suffer the severe cut backs which the neo-liberal regime imposed across many other health and welfare services, particularly hospitals. The MCH's long history and levels of community support provided significant protection, although the nurses experienced something akin to an earthquake across the MCH service. While its intensity varied, the impact of first amalgamation and then tendering processes produced immediate distress and a good deal of fear and resistance to change.

However, there were also new professional opportunities. On the whole it appears that many MCH nurses successfully negotiated the move from being sole practitioners to becoming team players in multidisciplinary organisations and developed new skills to deal with the emerging entrepreneurial environment. Several coordinators undertook further training in business administration but found some of their nurses quite resistant to taking responsibility for balancing workloads and planning developments. The position of coordinators which had been very variable and often informal in the earlier regime, now became more clearly

managerial. This occasioned considerable resentment in some services and intense personal anguish for those responsible for leading them. However, many coordinators demonstrated impressive leadership and strong commitment to adjusting the service to the changed administrative circumstances as well as to families' needs in their local area. New initiatives such as outreach programs, developing a computerised data base, more effective workload measures, multi-nurse centres and closer relationships with other local family services reflected the enterprise of the MCH nurses who rose to the challenge presented by the CCT processes.

## CONCLUSION: THE POST-CCT ENVIRONMENT

With the election of the Bracks government and the removal of the compulsory aspects of tendering, many pressures were relieved. The 'client/provider' separation and the general climate of fear created by the inherent competitiveness of CCT diminished. Communication between service coordinators increased further and, as a rural coordinator noted, 'the end of CCT has improved security for staff and done away with pointless paperwork to meet contract requirements'. Yet the changes implemented in preceding years have continued to have a profound impact. Uncertainty about the legal status of contracts after the Bracks government abolition of CCT was exacerbated by high levels of council staff turnover and internal restructuring resulting in further loss of continuity and institutional memory. In 2001 coordinators gave mixed responses to questions about satisfaction with their current organisational structures and the likely impact of 'best value' policy development under the Labor government. Overall however, both those responsible for council and non-council teams reported good support for MCH programs, improvements in strategic focus, teamwork and flexibility, and enhanced working relationships with other professional colleagues.

There is no doubt that promoting an internal market was divisive and something of a distraction. Nevertheless, some MCH nurses used the upheaval to create opportunities for empowerment, growth and personal development. Of real significance is that the processes of CCT gave MCH nurses, particularly coordinators, access to information about the structure of their budgets and increased control over expenditure. In the past, surpluses disappeared and professional development allowances and maintenance budgets lacked transparency. However, through CCT processes, MCH nurses became much more knowledgeable. One coordinator made the point that, post-CCT, 'no-one touches one line of my budget!!' Many nurses, coordinators especially, have developed the capacity and confidence to access and apply relevant information to the management of the services, learnt new skills and how to utilise them effectively. Restructuring has given MCH nurses greater responsibility than they had under the earlier administrative regime and they have had to become much more aware of the need to 'sell' their service and to understand the new management context.

Although it seems that many continue to prefer the traditional modes of service delivery and resist collaboration in teams, they are increasingly out of step with their profession and organisational realities.

Further research is needed in specific areas. MCH nursing may well be asked in the future to justify its existence in still more stringent terms than CCT demanded. The diverse experiences of the service users require ongoing research through more detailed evaluation frameworks than customer satisfaction surveys. Most importantly, a common process across individual municipalities is needed to ascertain clients' views across the state. As governments are debating the nature of universalism, studies about the community role of MCH nursing would be valuable. These should incorporate analysis of what are legitimate expectations of mothers from all strata for access to the advice and support that they need. We suggest that cost-effectiveness studies of MCH services pay particular attention to maternal health as well as that of infants and children. The shift to community health auspicing of MCH services also warrants further research, as it is not yet clear what effect this new location will have on overall policy approaches and service delivery. The role of private providers also requires attention. The risks of fragmenting the consistency and quality of MCH services through maintaining contractual arrangements that vary across municipalities should be examined and means of ensuring effective support for the nurses in coordination roles explored.

Major hurdles still need to be overcome, including wage parity and workload discrepancies, along with a policy legacy of that sought to restrict the practice of MCH nurses to agendas driven by medically defined surveillance. In our view, this orientation is at odds with the developing interest, globally and nationally, in social support in the early years of life as one of the most influential social determinants of health (Marmot and Wilkinson 1999). This requires a broad primary health care driven response to the health and welfare of mothers and their children and an important role for well-supported and directed MCH services.

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