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**Following the policy pathway: the impact of policy processes on children's access to
healthcare in rural Australia**

Running head: Policy pathway - children

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Abstract

Children are deserving targets of healthcare policy. However, to make a difference to children's lives, health and welfare policy goals have to be translated into services. For children and families living in small Australian rural communities, access to assistance and support from health services is dependent on the administrative and technical detail of health policy. This paper reports the findings of a case study investigating health care in two small rural towns in New South Wales. The study takes a pragmatic and practical approach to identifying the impact of policy intent on improving the health of rural children. The study identified the way policy goals are translated into practice by interviewing three distinct groups; policy makers, policy implementers and policy recipients. The research found that health policy was not well costed, implemented or available to children who lived outside regional or metropolitan areas. There were limited avenues for children, parents or health workers to influence the policy development or implementation process.

Following the policy pathway: the impact of policy processes on children's access to healthcare in rural Australia

Introduction

Healthcare is an important issue on political agendas. Problems in health care access and availability will reliably cause controversy and attention resulting in rapid responses from politicians. When ill or needy children are the focus of attention the level of controversy is heightened. A common political response to topical concerns is calling for, or promising action. This paper reports the findings of a project that aimed to follow the call to improve the health of rural children. The sociological action research project used community development processes to follow the policy pathway through the stages of development and implementation. The path's end is in health and welfare services provided to children and families in two small towns in rural NSW. Following an overview of health policy processes, the project method and findings are presented and the implications discussed.

Children comprise one fifth of the Australian population and are frequently the object of policy processes. Early childhood in particular is a priority area for Australian governments [1]. Policy action examples include programs to develop literacy skills, support families and engage in exercise for example. Many of these programs are a direct result of changing morbidity data that demonstrates Australian children are affected by social and environmental changes occurring globally. Increasing mental health problems and rises in chronic diseases such as asthma and obesity are highlighted[2].

Chronic poor health affected 41% of children in 2004-2005 [2]. Disability affected 8% of children under 15 and 15% of all children under 15 had a mental or behavioural problem. In both these categories boys were more likely to be affected than girls. Social conditions also played a part in the health of children. Sawyer et al found that children in poor, non-traditional families had high rates of mental health problems and behavioural disorders [3]. In rural areas where

incomes are lower and health care access is more difficult, improving children's health is a complex problem [4].

Once a problem is on the political agenda, action becomes the responsibility of policy makers. Identifying the problem, in rural health care for example, is just the beginning of a lengthy process influenced by the electoral cycle and other competing issues [5]. Policy makers must decide, within the confines of approved approaches and funding constraints, what solution(s) will quieten public debate.

Once a policy goal is developed a number of policies will follow targeting different sectors of the system it comes from. In healthcare this might include types of services provided, groups served, strategies used and locations prioritised. Jamrozik notes that policy intent must be translated into administrative and technical detail that makes the policy do something to the problem [6].

Health policy has to consider the needs of the entire population shaping for example, minimum standards of care, promoting new treatments and prevention strategies, specifying workforce numbers, skill-mix and so on. Policy from Australian state and Federal health departments tends to be generic, that is health care focussed, in a whole-of-population approach. However, health outcomes are increasingly recognised as being the result of a combination of health services, welfare services, public policies and support strategies in times of stress. A whole-of-government approach is suggested to foster the necessary inter-sectorial action required to implement public policy [7]. Partnership and collaboration between government and non-government agencies are the strategies proposed to meet the policy objectives.

The field of collaborative service provision is complicated by funding processes that impose competition policy on the non-government community service agencies designed to support people at a local level [8]. This sector has a key role in providing formal services that have been identified as promoting the population's health status by raising education levels and work force participation rates, both factors in health status [9]. For example, support for families with young children, education retention programs and job seeking and training services for the most disadvantaged community members are provided by community agencies.

Privatisation of all services including healthcare, is promoted and enabled by current government policies. Government rebates for taking out private health insurance are one example of

encouraging support for business approaches to healthcare. However, health remains a core government function [9]. While there is support for business approaches in many arenas, the legacy of the welfare state means there is an expectation of free and accessible health services in Australia [6]. What the core health functions consist of, and the way they are distributed, are important questions for Australia that are echoed around the world [10].

Inland Australia is sparsely populated. Only eighteen per cent of the population live in towns and villages outside metropolitan centres and coastline [11]. Many of the smaller towns have experienced population drift to regional centres or coastal areas subsequently suffering a decline in industry, employment and withdrawal of services [12,8]. Limited access to general practitioners (GPs), diminishing hospital services, allied health workforce shortages, centralised support services and diminishing resource allocations have all been identified as both the cause and the result of a crisis in rural health care [13]. Recognition of the crisis has resulted in political and policy attention but little concern about the impact of any action.

This project had two pragmatic and impact-focussed, policy-related objectives. The first was to clarify the policy pathway that aims to make rural Australians healthier; beginning with a policy goal and ending with the technical services delivered. The second objective was to identify the impact of the rural setting on health service policy intended to improve the health of children. The following sections of the report describe the project methodology, outline the findings relevant to the project objectives and discuss the implications of these.

Methodology

The project received approval from the Charles Sturt University Ethics in Human Research Committee (2007/140).

The research project was conceived as a community development project consistent with a sociological action research approach [14]. The initial research phase was a needs analysis that identified felt, expressed, normative and comparative needs for health care in rural areas [15]. Within the sociological action research approach there is an aim to engage with the case study towns and implement the research findings over a period of time. Chronicling and analysing the much larger bureaucratic and government processes is a vital but under-researched part of community development and action [14].

The policy analysis was part of a case study of two rural communities in NSW. A case study approach entails an in-depth investigation of an area of interest. In this case, people and services bounded by a geographical location. The project is an instrumental case study of a bounded system [16]. The aim was to identify what was similar about each case and also what was unique. Each case site was instrumental to understanding the issue of rural health and community service provision not simply the intrinsic conditions of the site [17].

The case study towns were selected because they appeared demographically similar and unremarkable in rural districts across Australia. That is, they had experienced the effects of the current long term drought, had no significant industry other than agriculture, were within one hundred kilometres of a large regional centre and had no special populations such as immigrants or Indigenous people, likely to attract specific policy attention.

Both case study towns of approximately 1500 residents had similar profiles in the 2001 census. For example they had similar income levels, employment rates, and educational achievement. Both towns were the responsibility of the same local government and Area Health Service. Both towns had hospitals, two general practitioners, community health services and schools up to year 12. Both towns were subject to the same state and Federal health and welfare policies and service provisions. In each town children under the age of 15 were approximately 20% of the population, consistent with the national average.

Qualitative and quantitative data was collected to build a picture of each case. As well as health and community service policy analysis, the methodology included collection of available statistical data about each town and focus groups with community members including health and community workers.

Data collection

The policy data collection involved two stages. The first stage was a desk audit that identified the available sources of support and service provision from government and non-government agencies with a clearly stated interest in the health of rural communities. Five key agencies stated in marketing material that they provided services with health related outcomes (18). One of these state agencies takes a whole-of-government approach delivering early intervention and support services to families with young children by coordinating five state government agencies (19).

Policy and funding documents from these health focussed state and commonwealth departments mapped the parameters of health and health related service provision available to the community.

The second stage of the policy analysis phase included interviews with representatives of the policy development arms of these agencies, regional managers responsible for implementing policy and local residents of the case study towns including health and welfare workers. This is set out in table one.

Table one: sample and data collection

Participants	Policy goals	Policy methods	Policy input mechanisms
Policy makers 3 participants	How are policy goals identified?	How are goals put into action?	How is policy directed and changed?
Policy implementers 7 participants	What is the role of policy in allocating services?	How do you decide what needs are and where services should go?	What ways do you influence new policy or change policy?
Policy recipients 16 focus groups – 128 participants	What services are provided and how?	What service problems have you experienced? What unmet needs do you have? What is good about local services?	How do you get new or different services?

Interviews with policy makers and implementers were conducted by phone or at the participant's office. Focus groups were held with existing community groups including Rotary, CWA, mother's groups and school teachers, at their usual meeting place and time. This included local

health and community service workers. Interviews and focus groups were recorded as minutes and on a digital voice recorder. Minutes and files were transcribed into word documents. The findings of the needs analysis are reported elsewhere. This paper examines the policy processes specifically targeting children's health care.

Data analysis

The sociological action research approach shaped the data analysis and fitted well with the pragmatic view of policy analysis [14]. Strauss, notes that a pragmatist views the present situation as different from the past from which it has developed [20]. This is consistent with the concept that the intent of policy could be altered during its implementation. In data analysis the approach results in exploration of the process and actions that result from ideals or concepts rather than elaboration of theory. However, discourse in the form of explanation of processes and actions, is central to the analysis.

Interview transcripts were examined and a deductive analysis was applied to the top-down approach. The intent of policy was identified from the policy maker interviews and compared with descriptions of the technical and administrative detail of implementation and subsequent impact at a regional and local level. An inductive analysis sought any participant statements that indicated the way policy mechanisms could be influenced at all levels of the process.

The findings are reported for each participant group under the subheadings of goals, methods, problems encountered and policy input processes.

Findings

Policy maker's goals

There is no clear and streamlined way of identifying the policy development process. Participant interviews emphasised information and support for particular action coming in from a wide variety of sources often with competing opinions.

Interest groups lobby and politicians have ideas that influence policy that are not necessarily the needs of the population.

One participant noted that the current emphasis was on evidence that a particular strategy made a difference rather than developing broad policy goals;

Health in Australia is generally good. We have a good approach. Budget and workforce are the problems not policy development. We need new models not new policy.

When asking about the way rural conditions were considered in policy development, one participant stated;

You can't just go with what you think, or someone else thinks, should happen. Rural people are not special, they're just an interest group. They're no different to the homeless or people with a mental illness. The problems are the same.

Similarly, another participant noted competition between policy areas and systems that influenced the priority given to particular interest groups or issues;

Policy mechanisms exist within the system to prioritise different aspects of health like rural health. Consumer, clinical and government perspectives all have to be taken into account.

The way the multiple perspectives were considered could not be identified. Policy writing moved back and forward between setting goals and implementation strategies including costing. For example;

We can't say what should happen [in health services] without thinking about how it's going to happen.

Allocation of funding for any policy action is the end result of lobbying and consultation. For example;

It has to go to Treasury for the dollars to be allocated. That's when we know something can happen.

Policy maker's methods

A policy statement or directive has to be ‘*signed off*’ by political and government leaders before implementation can begin. Who signs off depends on the various department or agency and the amount of money involved. Once funding is available to implement a policy the money is given to whoever is responsible at a regional level. For example NSW Health provides funding to Area Health Services to implement policies and services as they see fit. For example;

The money goes to the Areas and then it’s up to them

Other agencies are more prescriptive with their funding, specifying the types of services that will be provided. However, where the services operate remains a regional decision.

The funding system is complicated with the Federal government allocating money to the states for health services but also allocating money to Federal programs that operate in the same locations as state programs. For example in NSW the Department of Aging, Disability and Health Care (DADHC) provides a range of services for children. The Federal department of Health and Aging also provides services for children and provides funding to DADHC for their services. This project could not clarify what coordination existed about what services each agency provides or where they are provided.

Problems encountered by policy makers

The most significant problem encountered by policy makers was financial. This included obtaining funding and also costing the implementation of policy, particularly if it was new or there were special conditions to be considered. For example;

Our biggest problem is economic analysis. We don’t get proper costings. At best it’s an estimate, at worst a guess.

Policy input mechanisms

A number of policy input mechanisms were identified by policy makers when they discussed lobby groups, research findings and systems mechanisms such as COAG and similar bodies. However, funding is currently tied strongly to evidence and outcomes and this limits ‘*soft*’ evaluations of community perceptions of health services that are not considered as valuable as scientific measures. For example;

The outcome measures have to be measurable. One of ours is the size of babies' heads at birth. An increase in head circumference will indicate healthier babies through healthier pregnancies.

We've done a lot of community consultation in the past to identify needs but you don't necessarily get good information, you don't create evidence.

Policy implementers

Goals

Policy implementers were individuals with the responsibility of distributing their funding allocation across a region and/or a range of services. Their goals were uniformly stated in participant interviews. For example;

We have to do the best we can with the money and within the guidelines given to us by the funding body.

We have a big area to cover. I have to make best use of the resources I have, that includes funding and people on the ground to do the work.

Policy implementer's methods

Methods used by policy implementers to effectively use their funding allocations included identifying where supports for new services or strategies could come from to bolster what was already provided as well as minimising establishment costs. Any available funding opportunities were applied for to increase available resources. Policy implementers were concerned with ways of networking and sharing of resources to make use of minimal staff and services. These were often limited to certain areas and/or days of the week to stretch funding out for as long as possible.

Problems encountered

The problems encountered by policy implementers were numerous. However, they were frequently linked to trying to apply limited resources to a large area with a dispersed population. The following participant statements are two of many examples;

Competitive tendering means one service will run something for a whole region, sometimes half the state, on the smell of an oily rag. The most cost efficient places will get the best services and that's likely to be closest to the auspice body.

We're funded to service western NSW and we can't do it. We limit most of our work to [town] because that's all we can respond to.

Service duplications and lack of coordination or communication between state and Federal funding bodies was also a problem for policy implementers. There was a concern that effort spent planning and establishing a service in an area would then be duplicated by another agency in the same area while other places would receive nothing. For example;

In one town it's a state funded service, in another town it's a federal funded service. They will be called different names but essentially have the same goals, client group – always families- and outcomes expected to be delivered over a huge area with one part time worker. It's pretty hit and miss.

Collaboration across sectors was often prevented by other agencies policies. For example;

We organised meetings with them [other agency employees] to share information and resources but they won't budge on the referral criteria.

Frequently, working in partnership across agencies resulted in additional meetings with no perceptible impact. For example;

We share information all the time but we're locked into service contracts set by Cabinet. There's not much room to move.

If they [worker] went to all the possible meetings, they'd be serial meeting goers.

Policy input mechanisms

Policy input mechanisms noted by policy implementers included regular reporting back to funding bodies including details about budgets, community needs, service problems and outcomes and suggested changes. However the capacity to change the services or the budget was described as limited. For example;

We have to meet our outcomes or they will take our funding.

One participant stated that active lobbying for more resources or drawing attention to poor or inadequate services was a difficult thing to do because ‘*you can’t bite the hand that feeds you or they won’t feed you.*’

Policy recipients

Goals

Policy recipients were community members in the two case study towns. The health and welfare workers living in these towns were also policy recipients. However, when talking about the delivery of services in the towns they usually referred to examples from the clients’ experiences rather than their own. The main goal of policy recipients was to get a service when they needed it. Most of the time they did not know about the range of services that existed if they had not needed them and they did not know about the way services were distributed or supplied by policy guidelines. For example;

They’ve been told in Sydney their child is autistic but they haven’t been told where the help might be or what it is.

Policy recipient’s methods

Policy recipient’s methods of adapting services for their own use seemed to vary according to their ability to advocate for themselves or have someone support them. For example;

We needed early intervention services so because I was on the committee I could arrange the service from [town] to come over every Monday to the pre-school and see several children. Otherwise I would have had to take time off work to take my son there every week.

Problems encountered

Many of the problems encountered by policy recipients were related to lack of services or limited services. However, many participants stated they were lucky to have the services they could access and were unlikely to demand more. However, health and community service workers could clearly identify ongoing policy problems that they believed disadvantaged community members. For example;

The parents here take what they can get. If there wasn't a rule that DADHC deals with children under 5 and Health after that, some kids could have had early intervention three years ago. It's case load management not case management.

Policy input mechanisms

There were few examples of policy input mechanisms amongst policy recipients. One woman had lobbied successfully at a local level to have wheelchair ramps installed in a number of places in the town to improve her wheelchair bound son's mobility. However, other examples of policy input involved trying to identify the best policy to fit the needs of the population not vice versa. For example, a pre-school struggling with limited resources and increasingly disadvantaged parents wanted to become a long-day care centre. The change in title also came with different funding rules and allocations, staffing requirements and accreditation procedures. However, it required a substantial amount of work from the volunteer management committee and a degree of risk;

If we do it parents will get fee subsidies and we will get the gap so overall there will be more money in our kitty for staff and other things. But we might do the work and then a couple of families move out of town and we haven't got the numbers anyway.

Discussion

The policy pathway is difficult to follow. There was no trail from government policy documents through to services provided in the case study communities. In all of the agencies examined in this project there was no standardised number of services or type of services allocated per head

of population or by identified needs of any particular population. Instead the picture developed is that the whole-of-population approach to service delivery is so badly under resourced that rural community members are wise to think they are lucky if they can readily access any service.

Competition policy drives the funding of non-government community agencies and the impact of limited resources and regional or urban auspice bodies is clearly patchy, limiting service access. However, competition is apparent throughout the policy process not just in funding allocations. Without a lobby group with evidence and a politician on-side any particular health needs are likely to be invisible. Most parents describe a lack of time and energy for high level advocacy instead relying on service providers to do what they can or restricting their lobbying to get regional service providers to come to their town rather than some other location.

The whole-of-government approach that is intended to address the structural problems linked to poor health status is also under resourced and difficult to implement. Consequently policies support short-term government funded programs with a specific population target and easily measurable outcome not related to any change in health status or life expectancy. Policy guidelines about services provided and age ranges of clients make local services inflexible. For example one state agency provides services to children under five years old and another provides services to school age children. Currently (in 2007) government funding focus is on early intervention services for children under five. However, the service that delivered this in the case study towns had staff vacancies and could not provide a service at all. The school aged service could provide some support to families in speech pathology and occupational therapy but policy regulations prevented this. While health and welfare workers talk about bending the rules when they can see a family in need, they do it surreptitiously. This strategy does not address the cause of policy problems.

The rural setting has a significant impact on policy implementation. While the policy intent is well meaning, the resources allocated to a vast area with a small population means that the intended recipients may never see the service meant for them. Without an effective adult to lobby, provide transport and come to terms with policy guidelines, children needing healthcare, other than emergency treatment, are unlikely to get it. Evidence based best practice is in the realm of fantasy for over stretched rural health and welfare workers struggling with the administrative and technical detail of policy.

Conclusion

This project's first objective; to clarify the policy pathway from goal to service delivery that aims to make rural Australians healthier was not fulfilled because the pathway was not clarified. Our documentation of this, however, demonstrates serious problems in policy implementation processes and provides an important avenue for change. Clearly the political imperative of responding to publicised need does not translate into the technical detail required for children's support such as early intervention services. Greater flexibility in funding rules, work practices and guidelines could enable collaboration between service providers and improve service delivery. However, this has to be enshrined in policy development processes rather than the current emphasis on competition.

The second objective was to identify the impact of the rural setting on health service policy intended to improve the health of children. The rural setting, with workforce shortages, small and dispersed populations and under resourced health and welfare services magnifies the effect of complex policy processes. The popular construction of children as valuable and in need of protection has limited impact on the way health care is provided, particularly to children in small rural communities.

The findings of this study indicate that political and policy attention needs to follow on through to the evaluation phase of the policy cycle rather than the development phase. A whole of government approach should begin with policy makers and be reflected in policy guidelines.

Accordingly we believe the lessons for international audiences from our rural Australian study are that political imperatives and policy intent are only the beginning of the policy pathway. Policy is affected by context and process and may not achieve the intended aim because of local conditions. Popular policy does not always equate with good outcomes particularly for vulnerable populations disengaged from the policy process such as children.

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