The establishment of a health promoting case management service: A policy process case study

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References
The purpose of this case study is to demonstrate the potential contribution that analysis based on established public policy theories can make to understanding the complex processes integral to the development and implementation of health promoting policies and programs. To date very little of the policy-related health promotion literature makes any reference to public policy theorists or research. To help fill this gap two well established streams of policy analysis are used in this micro-level case study: agenda setting and interorganisational dependencies. These two approaches are used to describe and analyse the development and establishment of a health promoting case management service for people with acquired brain injuries. What emerges is not an account of a rational, linear and inevitable sequence of events. Rather, it reveals an amalgam of policy processes that include elements of rationality, conflict, cooperation, opportunities, constraints and the exercise of power in a complex and changing network of actors.
1 Introduction

There is a considerable body of research on public policy processes which can make a substantial contribution to understanding the development, implementation and evaluation of health promotion programs, but it appears to have rarely been utilised. As an initial step in filling this void, this paper utilises two streams of policy literature - agenda setting and policy networks - in examining the policy processes related to the establishment of a case management program for people with acquired brain injuries in Victoria, Australia.

In early June 1996 the Victorian Minister for Community Services, made a decision to provide interim funding to the Melbourne City Mission to continue to provide state-wide case management services for people with non-compensable acquired brain injuries. In effect this was a 12 month continuation of a service which Melbourne City Mission (MCM) has been providing for almost 3 years. Before June 1997 a number of organisations will be invited to tender for funding to provide a similar service, perhaps for a period of 3 years. To develop a micro-level analysis of the development and establishment of a health promotion program this paper will examine the policy processes preceding the Minister’s decision in June 1996.

The principles underpinning the MCM case management service for people with non-compensable (not work or traffic accident related) acquired brain injuries (ABI), and the service’s activities can be described as health promoting within the context of the Ottawa Charter for Health Promotion. The Ottawa Charter defines health promotion as “the process of enabling people to increase control over, and to improve, their health” (WHO 1986:1). The case management service’s primary role is to assist people with head injuries live healthier lives in the community by helping them to access appropriate services; providing information and support; and assisting them to gain greater control over their lives. The starting point for the case management service’s activities is “What does the client want”, based on the view that control over their own lives is essential to a good quality of life. From this starting point come a range of activities which can be divided into two interrelated areas: work done with and for specific clients, and work to make other services and public policies more responsive to client’s needs.
1.1 Methods

Information used to construct this case study was obtained from several sources. Prior to writing this study, Leonie Segal and I spent almost three years undertaking an evaluation of the pilot case management service that is at the centre of this study (see Summers & Segal 1996). As a by-product of the evaluation considerable information was collected regarding relevant policy processes and participants, particularly through the 50 interviews undertaken with service providers and policy makers, and numerous meeting and discussions that were part of the evaluation. Additionally, for this case study a number of relevant documents, reports, and journal articles were reviewed, and extensive in-depth interviews were conducted with five of the key policy participants.

1.2 Policy Analysis and Health Promotion

Most of the existing policy-related health promotion literature can be divided into three areas:

- healthy public policy, considers macro issues and focuses primarily on describing the characteristics and contents of healthy public policies;

- how-to descriptions/prescriptions for developing and implementing health promotion programs. These are of value for program advocates looking for a “map” of how they should proceed, but are essentially simplistic in their accounts of policy processes and emphasise rationality and linearity; and

- descriptions about the structure, content and (sometimes) outcomes of health promotion programs.

However, in each of these areas it is rare to see any reference made to public policy theorists or policy research. Stevenson and Burke (1992: s49-s50) make a number of observations about this, including: “the field of health promotion shows a serious lack of familiarity with significant developments in political and social theory”; in reference to health promotion’s emphasis on community and individual empowerment, the “health promotion literature...largely ignores the politics of competition and struggle”; and that the policy context, including “fiscal crisis”, the “contradictions of the welfare state”, and government shifts to a neo-conservative agenda, are not systematically addressed in the health promotion discourse.

This case study applies some of the policy analysis literature to a health promoting program. In particular, it is based on two well established and widely used approaches to policy analysis, Kingdon’s agenda-setting theory and Benson’s inter-organisational dependencies (or networking) theory. A single, micro-level case study such as this one cannot fully address or resolve the issues raised by Stevenson and Burke. It can however provide a concrete example and indication of the potential contribution of different policy theories to understanding the development and implementation of health promotion policies and programs.

1.3 Summary of Key Events

One possible view of policy processes is that they are relatively straightforward and rational . This account would go something like this:

1. In 1991 the Head Injury Impact Project (a joint initiative of the Health Department Victoria, Community Services Victoria and the Transport Accident Commission) made over 40 recommendations, including the establishment of a statewide case management service for people with non-compensable ABI.

2. In 1992 the Ministerial Implementation Committee on Head Injury (MICHI) was formed to implement the HIIP recommendations.
Two million dollars was provided by a one-off grant from the Transport Accident Commission to implement the recommendations.

Approximately one million dollars from this grant was used to fund a statewide three year pilot case management service.

Melbourne City Mission successfully tendered to provide the case management service, which began in August 1993 and accepted its first clients in October 1993. The funding for this pilot ran out in August 1996.

In February 1996 an evaluation of the first two years of the case management service was completed. The evaluation was overwhelmingly positive, and concluded that there was clearly a need for such a service and the pilot service was performing quite well (Summers & Segal 1996).

In early June 1996 the Minister for Community Services decided to fund the case management service for a further 12 months, during which time selected service providers would be invited to tender for providing case management services in the future.

When policy accounts are described in the health promotion literature they are usually presented in a similarly linear and implicitly rational manner. The problem with this example, and likewise the problems with similar accounts elsewhere, is that while they may be factually correct and provide a summary of some key events, they are misleading and leave many questions unanswered. Such accounts are misleading because they suggest that policy processes are rational, uncontested and value free. Some of the unanswered questions include: how and why did ABI become such a prominent problem; why was case management seen as such a major part of the solution; why and how was money made available to fund a new service in the midst of overall government spending cuts. Other questions also need to be answered regarding who the stakeholders and other interested participants are, and the extent to which they have been interested in and able to shape the recent decision.

To answer these and other key questions, theoretical approaches concerned with policy agenda setting and interorganisational behaviour/policy networks provide useful frameworks. These two approaches are used below to gradually build a more complete and complex discussion of some of the most relevant policy processes leading up to and shaping the recent decision.
2 Agenda Setting

In policy analysis the concern with agenda setting is an attempt to go beyond the stock phrase of “An idea whose time has come” and finding out how such situations occur. Kingdon (1984) proposed a useful approach to understanding how particular problems come to be prominent on the policy agenda; why particular solutions come to be favoured; and why other significant problems and possible solutions are never seriously considered. Although Kingdon (1984: 16-17) considers the roles of different participants in “agenda setting and alternative specification”, most of his focus is on three processes: problem recognition; policy proposals (solutions); and political events. In his research, Kingdon (1984: 21-22) observed that:

While governmental agendas are set in the problems or political streams, the chances of items rising on a decision agenda... are enhanced if all three streams are coupled together...The separate streams of problems, policies and politics come together at certain critical times. Solutions become joined to problems, and both of them are joined to favourable political forces.

2.1 Recognising and Defining the Problem

Victorian Government departments and other policy actors have been aware of problems in relation to people with non-compensable ABI for some time, but two major barriers prevented any significant action on the part of the Victorian Government: “firstly, there were no figures, secondly, the political football - no one wanted to take us [people with ABI] on...they knew it would be expensive” (Gallent 1991:12).

The Head Injury Impact Project Report in 1991, funded by the Victorian Government, was a major attempt to solve the problem of “no figures”. Because extensive and reliable data on ABI was not (and is not currently) routinely collected, valid and reliable statistics regarding the number of people in the community living with moderate to severe ABI, and their need for services could not be generated. There were however, many significant problems and issues identified in the Report, including some limited but helpful statistics on the incidence of traumatic ABI. These were generally seen as important and conclusive enough to warrant action, even though in an absolute sense the problem of “no figures” had not be adequately resolved. Of particular relevance to the establishment of a pilot case management service for people with ABI was the finding in the Head Injury Impact Project that there was considerable disparity in regards to access to services between people who receive substantial compensation for their injuries and those who do not. The disparity between people with compensation and without , whose needs for services are the same, was seen as unjust and unacceptable and not in accordance with the then Government’s Social Justice Policy. The Ottawa Charter also emphasises equity issues: “Health promoting action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential” (WHO 1986:4).

The problem of expense was partly overcome when a number of stakeholders developed a definition of the problem in such a way that it was seen as more expensive not to do something about people being inappropriately placed in hospitals and nursing homes, and by settling on an apparently inexpensive solution - case management. It is also important to note that this particular problem (equity of access) and solution (case management) were developed within the context of many other problems and solutions related to people with ABI (and other health and community service users). It was also part of a broader context which involved a major restructure of the service system.

In 1991 the general definition of the problem - difficulty of people with non-compensable head injuries in accessing services - was widely accepted and supported by the stakeholders. However, it is important to realise that different stakeholders had different reasons for supporting this particular definition of the problem:
people with ABI and their families/friends consistently identified their inability to access appropriate services as major barriers to achieving a better quality of life, and observed that consequently many people with ABI were inappropriately placed in nursing homes;

Headway, the major Victorian advocacy organisation for people with ABI, while supporting the perspective held by consumers and families, also saw this broad definition of the problem as appropriate because it closely reflected their experience that ABI affected the whole of the person's life and no single service such as accommodation would be sufficient;

for hospitals trying to discharge people with non-compensable ABI the difficulties in accessing appropriate community-based services often meant that discharges were delayed, and with the implementation of case-mix based funding this was perceived by hospital managers as an expensive problem;

nursing homes, where many people with non-compensable severe ABI lived, often found these very difficult people to look after properly, and with the advent of new public funding arrangements (CAM/SAM) nursing home operators argued that the remuneration for looking after people with ABI was inadequate;

the state-level bureaucrats in health and community services departments were under pressure by people with ABI and their families, Headway, hospitals, and nursing homes (through direct lobbying and news media coverage) to do something about shifting people with non-compensable ABI into the community; and

the inadequacies of the service system for people with non-compensable ABI resulted in the relevant state government ministers being constantly harassed by disgruntled people with ABI, their families and Headway.

One of the main reasons the problem of access to services became so prominent on the agenda (and stayed on the agenda) was that, although there were a wide range of perspectives on the problem, all key stakeholders had something significant to gain if the problem could be solved. Earlier attempts to improve the situation for people with non-compensable ABI were focused more narrowly (see for example Head Injury Accommodation Secretariat 1990; Head Injury Accommodation Committee 1990; Health Department Victoria & State Trust Corporation of Victoria 1988) and did not gain such widespread support, particularly across state government departments. Other reasons included a general movement to shift people out of institutions into the community. Additionally, in 1991-1992 there were a number of high profile cases in which people with ABI were not being adequately or appropriately provided for under the current arrangements. These were featured in the news media and were widely discussed within the bureaucracy. Bureaucrats found that they were often unable to resolve the problems related to these cases satisfactorily, often after considerable time and effort was expended. This worked to keep the pressure on and give the issue a sense of urgency within the health and community services bureaucracy and at a political level.

2.2 The Solution

In many ways case management was a solution that was "sitting there" looking for another problem to attach itself to. Case management was a well established and accepted approach which the Victorian Government was already either providing or funding for people with intellectual disabilities, and clients of Children's Protective Services and Mental Health Services. Kingdon (1984) observed that a policy option that is successful "in one area contributes to success in adjacent areas". Two of the main reasons case management was seen by Government as a successful solution in these areas was its capacity to act as a cost control mechanism, and its symbolic importance in demonstrating that the Government was actively addressing problems. Kingdon also
noted that problems and solutions are not necessarily developed one after the other, but that existing solutions often help to determine how the problem is defined. This seems to have occurred in this instance. It is also important to note that while there was general support for case management as a solution, this was not uncontested.

The value of case management was contested within the bureaucracy, and was labelled as a superficial and inadequate solution by some. This was based on the view that if the service system functioned properly, case management would not be necessary. Their preference was to fix the service system. However, these people found that they could support a case management service if it was clearly seen as only a pilot, and if the pilot had a major role in establishing pathways and structures within the service system that would obviate the need for case management after the pilot was completed. The brief for the establishment of the case management service emphasised two major streams of activity - working with clients and generating systemic change (MICHI 1992).

The few existing community based service providers (such as ARBIAS) and Headway who had extensive experience and knowledge of working with people with ABI believed that a case management model could provide the individualised service essential to meeting the widely varying and often changing needs of this client group. It is also important to note however that some of the key people and organisations at this level see case management as only a limited reform measure, and believe that more radical changes are required. In particular there is considerable interest in the creation of a national compensation scheme that would do away with the differences between people who have compensation for their injuries and those who do not. Typically people with compensation have funds to purchase necessary services, while those without compensation must rely on gaining access to publicly funded services which are frequently not available, have extensive waiting lists, or lack the necessary skills to work with people with ABI. In the 1970’s during the Whitlam Government a national compensation scheme was considered and was generally believed to be too expensive to be implemented. There is still interest in this idea, but because it may never be achieved and in any event a long way off, case management is seen as a good way to improve the situation (and would probably be a significant element in any future national compensation scheme).

Other service providers, including acute and rehabilitation hospitals, varied in their support for case management. Some were mildly hopeful and others were openly sceptical.

At a strategic level, the proposal for a pilot case management service helped to minimise any strong objections. If it proved unsuccessful or unworkable, there was no ongoing commitment to it. Additionally, case management can mean many different things. What it meant in this context was not clearly defined until after substantial support had been generated. Just prior to funding a case management service, MICHI developed a detailed brief. A case management service was also seen by bureaucrats as a way of helping people with ABI to gain access to mainstream services and thus helping to avoid or minimise the need to create ABI specific services. This emphasis on mainstream services rather than specialised services was (and continues to be) a major determinant of health and community service provision policy.

It should also be noted that case management was never seen as “the” solution in isolation from other activities, but rather was part of a broad strategy to improve access to appropriate services for people with non-compensable ABI, and was also part of the broader restructuring of health and community services. Other activities that were also undertaken included the development and funding of a public slow stream rehabilitation program, the development and distribution of information kits on ABI, improved and increased training for people working with people with ABI, the funding of a number of regional ABI initiatives, shift within State Government away from providing services to purchasing services, and the State Government replacement of program based funding to unit cost funding for health and community services.
2.3 Political Events

Political events also had a role in the development of the problem and the solution. After MICHI was established, but before the pilot was funded a new government came into power. Given that MICHI was an initiative of the previous government there was some uncertainty about its future. While there was not a deep commitment to it at a political level, the new Community Services Minister, Michael John did express an interest in MICHI when in opposition. Additionally, the new government placed considerable emphasis on client oriented services and shifting the focus away from funding for services to funding for clients (see for example H&CS 1993). Case management was promoted by its proponents as a way of achieving this. Other changes such as an increased emphasis on corporatisation within the bureaucracy and the amalgamation of the previously separate departments of health and community services also worked to support this particular definition of the problem and the solution. The amalgamation of health and community services combined with corporatisation was of particular importance because it was instrumental in overcoming the previous problem of fiscal responsibility for people with ABI being passed back and forth with neither department wanting it.

2.4 Staying on the Agenda

Once the MCM case management service was operating there was considerable potential for the issue to be dropped from the agenda because the problem was solved (or more accurately, there were very significant improvements from the perspectives of all stakeholders). People with ABI received increased access to community based services. Hospital beds were cleared more quickly and easily. Fewer nursing home placements occurred. Fewer people with ABI found the need to take their situation to a minister or the news media. Also, following the 1996 State election, a new community services minister was appointed, and there was no certainty that the new minister would be as personally interested in ABI as the previous minister had been.

However, case management for people with non-compensable ABI did not fade from the policy agenda for several reasons. Because it was a pilot there was an ongoing interest and concern regarding its future - would it continue after the pilot phase? Because the service was a pilot many people monitored it closely to see if it would be successful and participated in its evaluation. The new community services minister expressed considerable interest in and understanding of ABI issues generally. Additionally bureaucrats still had substantial involvement in finding dollars and other solutions for some people with ABI, so they remained acutely aware of the issue. The existence of the service itself helped to raise the profile of ABI generally.

This agenda setting approach has been useful for identifying how ABI issues and case management rose to the top of the decision making agenda, and stayed there - how ABI became the flavour-of-the-month. It emphasised the convergence of the three separate but related streams - the problem, the solution and the politics - that led to the creation of a “window of opportunity” (Kingdon 1994) which resulted in the establishment of the pilot case management service, and the maintenance of the issue on the decision making agenda. However, a number of key aspects of the policy process remain substantially unexplored. These include a more in-depth examination of the actors, their relationships, availability of funding and the broader context which has structured the process.
Policy Networks and Interorganisational Dependencies

Policy networks and interorganisational dependencies are particularly useful approaches for examining the actions and interactions of policy actors. The concept of policy networks is used in a variety of ways in the literature. Here the focus will be on the more formal networks in which the participants are held together through their mutual resource (including knowledge, support and money) interdependencies, and common interest in people with non-compensable ABI.

Two “snapshots” of different moments in the policy process are presented below. The first focuses on the establishment of the pilot case management service, the second on ongoing conduct of the pilot and its evaluation which immediately preceded the Minister’s June 1996 decision. These snapshots are used to help communicate the dynamic nature of the process. A shortcoming of many analyses of policy networks is that they use only one snapshot and do not track the changing composition and dynamics of networks (Atkinson & Coleman 1992).

3.1 Snapshot I: Establishment of the Pilot

Benson (1983: 155) identifies five sets of structural interests that can be used to categorise actors in policy processes and which can help policy analysts to understand the mutual dependencies of different actors within networks. These five categories are: demand, support, administrative, provider and coordinating groups. In the establishment of the pilot case management service there were a number of key actors which are listed below using Benson’s five categories. It should be noted that actors within any of these groups are not necessarily united, and quite often pursue different and incompatible objectives, but at structural level their roles and interests are similar.

Table 1: Key Actors by Structural Interest Related to the Establishment of the Case Management Service

<table>
<thead>
<tr>
<th>DEMAND GROUPS</th>
<th>SUPPORT GROUPS</th>
<th>ADMINISTRATIVE GROUPS</th>
<th>PROVIDER GROUPS</th>
<th>COORDINATING GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with non-compensable ABI</td>
<td>Headway Victoria, Brotherhood of St. Laurence (indirectly and at a generalist level)</td>
<td>Various sections within what was then Health Department Victoria and Community Services Victoria, particularly Disability Services, Acute Care and Aged Care</td>
<td>Health Department Victoria, Community Services Victoria, Victorian Department of Transport / Transport Accident Commission, Commonwealth Dept Health, Housing and Local Government (through funding provided to the State and the Commonwealth State Disability Agreement 1991), Public Acute, Rehabilitation and Psychiatric Hospitals</td>
<td>Ministerial Implementation Committee on Head Injury (MICHI)</td>
</tr>
</tbody>
</table>
In the above table, the government departments listed as provider groups provide a range of specific services, as well as providing funding and coordination of many other services.

The exchanges between these different interests occurred at both formal and informal levels, although the best remembered and documented exchanges are the formal ones which occurred primarily through MICHI. All of the above interests were represented on MICHI except the Commonwealth. Headway’s role in this process was primarily to represent people with ABI and their families who were not otherwise present in MICHI. In relation to the establishment of the pilot case management service, MICHI’s energy centred on two key issues: the characteristics of the service and obtaining funding.

Key debates within MICHI about the pilot included:

- whether or not the case managers should have funds to purchase services;
- whether the service should be hospital or community organisation based; and
- the ethics of funding yet another pilot service with no certain future.

The case management literature argues strongly that only if case managers have funds to purchase services can they have the potential to promote systemic changes, creating a more appropriate service system for their clients (Austin 1993). Within MICHI there were several proponents of this view. However, Disability Services (then part of Community Services Victoria) argued that case managers should not have funds to purchase services. Many of the services that clients needed access to were publicly funded and change was unlikely to be made in these by funding being made available (private services would be purchased, and public services would be unchanged). Without funding the emphasis would be on making public services more flexible and responsible. There were several pools of money (State, Commonwealth and charitable) that could be applied for on an individual basis to purchase services or equipment. Essentially it was argued that structural change was important but that it could be driven in ways other than making case managers fundholders. These other ways included seeing the state as interventionist and having a role in promoting structural change through its policy and funding activities.

It was also argued that if case managers were fundholders the service could become too expensive to be viable in the current climate of economic restraint and cost-cutting. The need to keep it “affordable” won the day, and funds to purchase services were not made part of the overall funding and structure of the pilot service. If the pilot was to continue after its initial three year period, future funding would have to come from Community Services (which became part of Department of Health and Community Services, and is now part of the Department of Human Services). Strong support for fundholding was also reduced because none of the stakeholders had anything to lose by not having case managers be fundholders, as long as some funds were available from other sources and structural change was promoted through other means.

The issue of whether the pilot service should be located within a hospital or a community service was strongly contested. Hospital interests within MICHI argued that it should be hospital based so that case management could begin early. This would also bring more resources into hospitals. Others with experience and interest in community based services argued that only by being based in the community would the pilot have access to the networks of people and services to support the community reintegration of people with ABI. No consensus was achieved, but a decision was made to locate it within a major community service provider. The reasons for this decision are not clear, and it is likely that significant lobbying took place at an informal level. It could be argued that hospitals’ generally poor record relative to discharge planning, working with people after they leave hospital and liaising with community based services worked against them. Recently, the state government has been shifting resources away from acute care towards community services. Also, if the pilot case management service was based in a hospital this had the potential to reduce co-operation between the service and other hospitals. Finally, if the service was successful hospitals would gain through earlier and easier discharges for people with ABI regardless of where it was located.
Some issues were notable for their absence from the debate. Examples of these include the value of case management and the pilot’s target population. That the value of case management was taken as a given by stakeholders at this point suggests that the concerns noted above in the agenda setting section had been put aside or accommodated by this time. Issues regarding the appropriate target population were settled exclusively in favour of government and hospital interests. Younger people with strokes were excluded because of concerns about making the service affordable (for the government) and the view that including people with strokes would open the flood-gates. It should be noted that after the pilot service was established, the service’s coordinator used her discretion to include these people. Later the eligibility guidelines were formally changed and the pilot was not overwhelmed.

Eligibility requirements also focused on people who were in hospital or had recently (within three months) been discharged. Headway in particular was quite disappointed (and presumably so were the people being excluded) because this meant that many people who were “already out there” would not have access to the pilot service. This requirement was clearly driven by hospital and bureaucratic interests which both identified the problem primarily as one of clearing costly hospital beds. Headway did not mount a serious challenge to this situation largely because it was not at that time a particularly powerful player and was dealing with internal issues (the appointment of a new CEO). People with ABI had no official voice in this process, other than through Headway. However, it should also be noted that other organisations without an “official” mandate to speak for consumers, but with a reasonable claim to knowing and understanding some consumer issues, were represented on MICHI, particularly ARBIAS which works closely with people with ABI at a community level and has a community based management committee.

Bishop Challen, chairman of MICHI, was particularly concerned about the ethics of funding a pilot service when there was no commitment by the state government to fund it on an ongoing basis. This concern was echoed by other stakeholders who believed they had a lot to gain if the pilot became an ongoing service. The members of state government departments involved with MICHI were less committed to an ongoing service, and were not empowered to make this commitment. Before proceeding with the pilot, the Bishop wrote to the Minister for Health seeking assurances that there was a commitment to an ongoing service. The Minister responded cautiously because it was difficult for her to make a commitment prior to establishing the success or otherwise of the pilot. But in principle she supported the idea. This was sufficient to gain the Bishop’s support.

This exchange also resulted in the Health Minister directing that sufficient dollars be earmarked for continuation of the service, but H&CS was emphasised that this did not automatically mean that the service would be funded when the pilot finished. Funding for such programs is provided by the Commonwealth to the states through the Commonwealth State Disability Agreements. Funds were set aside for 1996-97, the last year of the current CSDA and funding beyond 1996-97 is dependent on the negotiation of the next CSDA. The act of setting aside funds at this stage had considerable impact later. In June 1996 when the Minister for Community Services was considering whether or not to provide funding for the case management service, the availability of the funds was a significant factor.

The role of MICHI, to implement the HIIP recommendations, required it to secure funds to do this. The Health Department Victoria and Community Services Victoria made positive comments about making funding available, but did not make funds available to pilot the case management service. They did however identify an alternative source of funds - the Transport Accident Commission. The TAC (the statutory authority providing third party insurance for Victoria’s no-fault traffic accident scheme also had a considerable interest in people with compensable ABI) was at the time a significant income generator for the State. How the funding was secured is unclear, but it is known that the Health and Community Services Ministers lobbied the Transport Minister quite strongly, and that Bishop Challen also asked him to make the funds available. The TAC made a one-off grant of two million dollars to MICHI, approximately half of which went to funding the case
management service. Moves were afoot at the time to privatise the TAC and this too may have been a factor in the negotiations. Part of the agreement was that the health and community services departments would also provide some funding, but this never eventuated.

3.2 Snapshot II: The Pilot and its Evaluation

The period of time in which the pilot operated (August 1993-August 1996) was essentially an implementation phase, within the context of a broader policy development process. The implementation of the pilot was a trial to see if the proposed solution would work as anticipated, and the evaluation of the pilot was one of the methods used to judge the success of the pilot. The implementation of the pilot service and its ongoing operation was a complex and detailed process, most of which is not reported here (for details see Summers & Segal 1996). The focus here is on those elements of this process that appear to be most significant regarding the subsequent decision by the Minister for Community Services to provide a further 12 months funding for the service.

As already noted, the pilot has generally been considered to be successful by all major stakeholders, and the evaluators. This success has itself been a resource used by stakeholders to argue for future funding. But understanding its success and its subsequent refunding requires understanding how the different stakeholders are mutually dependent, and the integral role the service has had in linking these people together to everyone’s advantage.

As the focus of activity changed, so did the policy network and the dependencies between actors. Again, using Benson’s five categories the new list of actors is presented below.
### Table 2: Key Actors by Structural Interest Related to the Operation of the Case Management Service

#### DEMAND GROUPS
- People with non-compensable ABI
- Families/friends of people with non-compensable ABI

#### SUPPORT GROUPS
- Headway Victoria

#### ADMINISTRATIVE GROUPS
- Various sections within the amalgamated Health and Community Services Department, including Disability Services, Acute Care, Aged Care and Disability Service’s ABI Project
- Brotherhood of St Laurence (which under Bishop Challen’s direction had responsibility for administering the MICHI projects after MICHI was disbanded)

#### PROVIDER GROUPS
- The Melbourne City Mission Case Management Service
- Acute hospitals
- Rehabilitation hospitals
- Psychiatric hospitals
- Day hospitals
- Local governments
- Community Health Centres
- Many non-government service providers such as Yooralla Society of Victoria, and ARBIAS
- HACC programs
- Commonwealth Rehabilitation Service
- Transport Accident Commission
- Office of the Public Advocate
- Guardianship Board

Intellectual Disability Services
Health & Community Services (particularly as funders of individual “care packages”)
- ABI Workers’ Forum
- Victorian Coalition of ABI Service Providers
- Centre for Health Program Evaluation (responsible for evaluating the pilot)
- Various groups of professionals: rehabilitation medicine specialists; social workers, physiotherapists, occupational therapists, counsellors, etc
- Other providers of secondary importance (in a policy sense) include numerous government departments and services related to areas such as housing, transportation, education and income support

#### COORDINATING GROUPS
- The Pilot Case Management Service’s Executive Committee, a participant from each of the following: the Brotherhood of St Laurence; Headway and Disability Services (part of Health & Community Services)
- The Pilot Case Management Service’s Reference Group, approximately 20 service providers from across the State, and one person with an ABI

The Policy Network Diagram on the next page illustrates the flow of services, information, funding and other resources used to support people with ABI and their families. The thick black arrows through the middle of the diagram illustrate the movement of people with
ABI. The thinner arrows illustrate the flow or resources. For instance, the case management program (centre) provides support and assistance to community based service providers (bottom centre). This in turn increases the capacity of community based service providers to provide the appropriate services to clients and families (top centre). Only the primary activities in relation to providing assistance to clients and families are illustrated. The intention of this diagram is not to show all of the complex interdependencies, but rather to be a starting point for this. To adequately illustrate all of the interconnections would make the diagram unreadable and meaningless. Illustrating all of the interconnections between the different stakeholders (in square boxes) would require arrows drawn to connect each box with every other box, and the inclusion of descriptions of the activities linking the stakeholders (in ovals). Many of these interdependencies are discussed throughout the text of this case study. Also for the sake of clarity four key actors are not represented in the diagram. These are Headway, Disability Service’s ABI Project, the Evaluators and the Commonwealth. The role of the Commonwealth through the CSDA has already been discussed. The others warrant particular attention.

Headway has several interests. It is an advocate for people with ABI (compensable and non-compensable) and receives funding from the Commonwealth, so is not directly dependent on State funding. However, it is often dependent on the state to fund and implement solutions for people with ABI. It has gradually become a significant and relatively powerful policy actor. This has been achieved through a range of activities including being a source of expertise about ABI and people with ABI; being involved in a wide range of policy and service activities related to people with ABI; and advocating for the rights of people with ABI, individually and collectively, to have access to appropriate and good quality services. Of particular relevance to this case study was Headway’s pursuit of a news media strategy that resulted in a relatively high media profile of ABI and the problems many people with ABI have encountered with the health and community services system. This in turn helped to keep ABI on the policy agenda at a senior political and bureaucratic level.

Headway also provides assistance and services to people with ABI. Initially it felt quite threatened with the development of the case management service, but later found that while the service did take over some of its workload, this gave Headway some space to pursue other high priority activities. Over time a relationship developed between the two services that was complementary and synergistic, effectively strengthening both services and helping them to more strongly advocate on behalf of people with ABI. In spite of their close relationship, Headway is still a competitor for scarce resources, and would like the opportunity to tender for the provision of the case management service in the future.

Headway was a strong supporter for the establishment and ongoing funding of a case management service, largely because it wanted a better deal for people with ABI, but also because it saw itself as a potential provider of the service.
Figure 1: Policy Network Diagram
In 1994 Disability Services created its ABI Project with two full-time staff. Their role was to develop policies and a strategic plan for ABI across all Health and Community Service departments, and keep track of a number of ABI pilot projects funded in different regions. They were also the liaison point between the pilot service (and its evaluation) and the Victorian Department of Health and Community Services (H&CS) (now Human Services), one staff member was on the Executive Committee. (To oversee the implementation of the pilot case management service and make recommendations about its future, MICHI appointed the Executive Committee which also included a representative of the Brotherhood of St Laurence and a representative from Headway Victoria.)

Over time the ABI Project became a vital resource to H&CS through its development of expertise on ABI issues. Considine (1994: 202) points out that in policy areas which are highly complex, organisations increasingly depend on experts and expert information. It is also important to note that the ABI Project staff received their initial training in social work giving them a particular affinity with the case management service which was patterned on a traditional social work model, and also provided a common point of understanding with the coordinator of the case management service who had also been trained in the same social work traditions. Social workers can be seen (and certainly see themselves) as experts on case management. Given that the ABI Project staff were the main source of information to H&CS about ABI and the pilot service, this common ground was of pivotal importance.

The evaluation of the pilot service took place during the first 30 months of the services’ existence. The evaluation created a formal process in which all of the stakeholders (including clients and their families) were canvassed. The evaluation also resulted in the generation and distribution of information (through interim reports, meetings and presentations) to many of the key actors in the policy process including the case management service, the Executive Committee, the Reference Group and H&CS (especially the ABI Project staff). As conclusions and recommendations were being developed an ongoing dialogue was undertaken with these actors, including a draft of the final report that was distributed and discussed widely. This helped to generate support for the recommendations in the final report and ensure that the evaluation was an integral part of the policy process.

In addition to the Network Diagram, the interdependencies between the policy actors can also be illustrated through a number of examples. The funding made available by Disability Services for the development of “individual care packages” is one such example. The success of the pilot service in moving some very high needs clients out of hospitals and into the community was dependent on the availability of significant funds - sometimes around $50,000 and as high as $110,000 per annum. Acute Care Services (part of H&CS) made one million dollars (from the case-mix incentive pool) available to Disability Services to assist with this. This provision of funding across different programs was made possible primarily through Dr John Paterson’s (the Secretary of H&CS) one-department-one-budget corporatisation of H&CS. This process depended on more than just dollars however. The case management service provided expertise in identifying and documenting client and family needs, arranging formal medical and allied health assessments, and locating or helping to develop the necessary services. Gaining the cooperation of services was usually attempted through persuasion and the provision of assistance and support by case managers. However, when necessary and appropriate Headway and/or H&CS were asked to apply pressure.

Typically these high needs clients were the source of most negative news media coverage and complaints to ministers. Consequently the success of this process meant fewer complaints to ministers, fewer negative stories in the news media (and even a few positive ones), and key bureaucrats did not find large amounts of their time going to case management activities. In the words of Osborne and Gaebler (1992) the bureaucrats could get on with the job of “steering, not rowing” with the case management service in place, which is in line with the current approach in the Victorian Government.
So far, the activities of the policy network have been discussed primarily in instrumental terms. Networks, or policy systems also have “a set of developmental relationships in the way it allows for communication of moral and ethical norms, and the building of trust and solidarity between actors” (Considine 1994: 130). Policy networks serve not only policy roles, but also social ones and the social and policy roles shape one another. In this case study the policy process leading up to the establishment of the case management service, and its subsequent implementation fostered the creation of a policy community. This built on previous, but small and less successful, activities and considerably increased the degree of cohesion and communication to what had previously been a fragmented group of people often working in relative isolation from one another. This social role helped to reinforce the interdependencies central to the implementation of the service and create an atmosphere or culture of cooperation and mutual assistance across a wide range of disparate actors.

With the success of the pilot case management service also came the dependency of many policy network actors on it, including hospitals, bureaucrats, community based service providers and Headway. This dependency helped to create general support for its continuance. As one of the key actors noted when being interviewed: “If the service was not continued there would be an enormous stink.”
4 Context and Constraints

Much of the recent policy literature emphasises the importance of examining not only the activities and actors within policy process, but also considering the broader context and underlying structures that shape the process (Dalton et al 1996; Considine 1994; Ham & Hill 1993; Atkinson & Coleman 1992; Benson 1983).

Benson (1983: 149) approached this issue by proposing that the “policy sector is a multilevelled social structure”, and identified two levels of structures with the second level shaping, rather than determining, the first:

Level I:
1. Administrative arrangements (division of labour)
2. Policy paradigms
3. Interorganisational dependencies

Level II:
1. Interest-power structures
2. Rules of structure formation

Level II is essentially Benson’s approach to considering the context of policy processes. To understand administrative arrangements and policy paradigms Benson argues that these must be viewed in relation to the underlying power structure. This is contained in the second level, interest-power structures. “The interests and power of various groups are embedded in the administrative apparatus and policy commitments of the sector” (Benson 1983: 154). Benson developed the five categories of actors used in the above network discussion to identify the different structured interests in the policy process. With the shift in the case study from policy development to implementation the interests and power of various groups changed, and with this the administrative structure and the interorganisational dependencies changed.

Using its dominant role in the power structure, the state bureaucracy was largely responsible for generating, and generating support for, a definition of the problem which emphasised access to services, drawing attention away from the more expensive problem/solution of not enough public services to meet people’s needs. And as has already been noted, the target group for the case management service was defined by the interests of the most powerful participants - the Victorian health and community services bureaucracies and hospitals - in the policy process. Both the definition of the problem and the shape of the solution influenced the administrative structures and interorganisational dependencies which followed.

The other part of the second level, the rules of deep structure formation, refers to the rules which are “related to the role of state agencies in advanced capitalist societies in assisting the process of capital accumulation and performing the function of legitimation” (Ham & Hill 1993: 177). Essentially these rules establish the boundaries of what activities the state can and should engage in. “The variations in policy paradigms and administrative arrangements are limited by the necessity to maintain the accumulation process and to produce justifications for the order of things” (Benson 1993: 161). In this case study the rules of structure formation can be seen as supporting the dominant paradigm in which the state is distancing itself from providing services, and moving to a purchaser/provider split that emphasises the role of the market rather than the state in service provision. Hence no other way of providing case management services other than contracting out was ever considered. Another aspect of this dominant paradigm is the almost exclusive focus on and concern with economic issues, particularly those associated with reducing state government expenditure (driven largely by the “fiscal crisis” referred to by Stevenson and Burke earlier). Within this context case management was seen favourably as a way of making better use of existing services and reducing hospital costs, and this fostered its initial support by government and its eventual funding.
The rules of structure formation could also be seen as significant in the mobilisation of state resources to solve the problem of inadequate access to services by people with non-compensable ABI. The level of complaints and dissatisfaction (and their appearance in the mass media) had increased to the extent that the legitimacy of the current arrangements were being challenged. This is part of the broader problem to as the “contradiction of the welfare state” (a phrase coined by Claus Offe in 1984 to refer to the tension between the capitalist state’s role in providing welfare and assisting in capital accumulation).

Other authors such as Dalton et al (1996) emphasise the need to see policy processes within the context of broader historical and social processes. Of particular relevance here are technological advancements (which have resulted in people with moderate to severe ABI surviving when previously they would have died); presumptions about the sexual division of labour and the availability of women at home willing and able to care for their disabled relatives; the shift towards the contract state; de-institutionalisation of people with disabilities; and the rise of the consumer and disability social movements which have driven the focus on the rights of people with disabilities to participate as full citizens in society and to have access to services that can support them in this pursuit.
5   Participative and Democratic Policy Processes?

While Benson’s approach is useful for getting at some of these underlying issues, it does not bring into focus some key issues essential to examining the level of citizen participation in the policy process. For example, people with non-compensable ABI appear prominently in Benson’s demand group and hence are given a key role in the discussion of interorganisational dependencies. This could easily be interpreted to mean that they have been active participants in the policy process. This is true in the sense that they have demanded and consumed services. However, it does not explore the issue of whether or not they were active participants in the identification and definition of the problem (except as research subjects); or in the development and implementation of solutions (except as consumers of services).

The importance of wide participation in policy processes should not be underestimated. The central premise of the Ottawa Charter for Health Promotion defines health promotion in terms of people’s control over their own health, which includes involvement in policy processes. Similar views are expressed in the policy literature, for instance Considine notes: “participation provides a means for the creation of the social capital from which all central democratic objectives spring, including, legitimacy, co-operation and innovation” (from Bernardy, Boisgoutier and Gouyet 1993 in Considine 1994:131). Considine goes on to observe that “it is possible to argue that as a first principle that all policy making must be based on the widest possible level of participation...[it is] a means to improve decision making or implementation, and as a process for binding, improving and securing the group or system” (131).

Serious attempts were made to include clients of the case management service in its establishment and ongoing operation. The disability rights movement has long argued that people with disabilities should participate in the management of organisations that are providing services to people with disabilities. This argument became embodied in the Disability Act 1986, and Objective 13 of the Act states that: “Services should be designed and administered so as to provide people with disabilities with, and encourage them to make use of, avenues for participating in the planning and operation of services which they receive.” MICH members, driven largely by Headway, wrestled with how this might best be done for the pilot service. In the end an unгляinly (and ultimately unsuccessful) compromise was settled on in which the pilot service was to convene and resource a reference group made up of primarily service providers but including some people with ABI, and Headway was funded to convene a series of meetings with the pilot’s clients to discuss their experiences and satisfaction/problems with the pilot. Only two people with ABI attended the reference group, and the client group convened by Headway on a few occasions was not particularly interested in discussing their satisfaction/problems with the pilot.

In spite of these failures a degree of client participation was achieved, although perhaps not in ideal ways and certainly not in ways originally anticipated. The principles underpinning the case management service ensured a strong consumer voice at an individual level. The cornerstone of all case management activities with clients was an emphasis on encouraging and supporting clients to make their own decisions. The experiences of case managers with clients was informally drawn together by the pilot service’s coordinator to help shape the general directions and priorities of the service. These were also formally collected and analysed as part of the evaluation, and used to provide information and recommendations about the shape and future of the service.

Clients also participated extensively in the evaluation through in-depth semi-structured interviews that were undertaken by the evaluators. From this, their experiences, views and ideas found their way into the policy process. Perhaps it would have been better if a method of directly involving clients in the process could have been found. It could be argued that by having their voices interpreted by intermediaries such as Headway, case managers and evaluators, something significant was lost. This process of involvement also resulted in clients being essentially excluded from what Considine (1994) terms “developmental relationships” which are an important social aspect of participating in
policy networks. More direct participation would also help to ameliorate two of the most serious problems for many people with ABI - a sense of powerlessness and social isolation. At a practical level it must be kept in mind that many people with ABI (but certainly not all) are unable, or at the very least find it quite difficult, to participate in typical policy processes such as meetings and committees, and therefore additional ways of involving them need to be developed and used.
6 Conclusion

This case study has clearly demonstrated the value of policy theory to increasing the understanding of policy processes related to health promoting programs. Dalton et al’s (1996:106-107) observation that “developing policy is a process of contest which calls upon the use of rational arguments and research but is shaped at all stages by power at all its levels, debates about values and organisational opportunities and constraints” summarises many aspects of this case study very well.

Evidence of attempts at a rational policy process could be seen throughout the case study, including the use of research, the establishment of a pilot, and the setting aside of funds several years in advance should they be needed to fund an ongoing case management service. However, the rise of ABI onto the policy and decision making agenda and the concomitant identification of case management as the solution, and the subsequent success of the pilot and its re-funding could not be adequately explained by rational or linear accounts of the process. The power of the different policy actors shaped the definition of the problem and the solution, and the exchanges of resources/power in the implementation of the case management service was central to its success. Policy entrepreneurs (Kingdon 1984) were ready and able to take advantage of the opportunities created when the problem, solution and politics came together to enable the establishment of the pilot. Financial constraints helped to create these opportunities as well as limit the size and scope of the pilot service. Dominant views, particularly within the state government and bureaucracy also shaped what was and was not possible regarding the establishment of the pilot service.

While the different policy actors clearly held different views about what constituted appropriate policy processes, this case study was shaped by a dominant view of the necessity of involving major stakeholders throughout the process. It was an essentially consultative process based on the belief that this would draw on relevant expertise in identifying the problem and developing the solution, and help to generate the cooperation and commitment of the wide range of interests necessary for its successful implementation. But it was a consultative process with limitations, as the construction of the problem and solution emphasised. Unlike most policy accounts in health promotion, this one demonstrates that the state was not only active in the process, but also had its own interests to pursue and protect. The ultimate power to decide whether or not to fund an ongoing case management service for people with ABI rested with the Minister for Community Services. Regardless of the success of the pilot, the Minister could probably have rejected the proposal to fund the service without seriously damaging his support base and legitimacy - ABI is an important issue for those involved, but across the political landscape it is one small issue.


Head Injury Impact Project 1991, Acquired Brain Damage Data Base Study, Vols 1 & 2, a joint initiative of Health Department Victoria, Community Services Victoria & Transport Accident Commission.


Health and Community Services 1993, New Directions: The Changing Face of Disability Services, a Disability Services Publication, Melbourne.

Health Department Victoria & State Trust Corporation of Victoria 1988, Project Alternatives, summary report of a joint project undertaken by Health Department Victoria and State Trust Corporation of Victoria, Melbourne.


