Submission
No 50

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

Organisation: Maternal, Child & Family Health Nurses Australia

Date Received: 12 August 2024

MATERNAL CHILD AND FAMILY HEALTH NURSES AUSTRALIA (MCAFHNA) SUBMISSION

inquiry into improving access to early childhood health and development checks (NSW Health)

AUGUST 12, 2024

MATERNAL CHILD & FAMILY HEALTH NURSES AUSTRALIA
SUITE 103, LEVEL 1, 3-5 WEST STREET
NORTH SYDNEY NSW 2060
T: 02 8323 7160

Maternal Child and Family Health Nurses Australia (MCaFHNA) submission - inquiry into improving access to early childhood health and development checks (NSW Health)

1. **Changes needed to address gaps in outcomes for vulnerable children, including those in rural and remote communities, Aboriginal communities, and culturally and linguistically diverse communities.**

MCaFHNA's Response

Key Points:

- Consider the workforce – is NSW Health employing staff with the appropriate education/qualifications to identify families at risk of vulnerability?
- National minimum standard (i.e. qualifications) to practice as a Child and Family Health Nurse is established.
- Children, caregivers and their families have the right to equal access to high-quality services and care.
- MCaFHNA recognises that maternal, child and family health nursing requires a highly specialised skill set gained through practice as a registered nurse (RN). It is MCaFHNA position that a minimum qualification of a Bachelor of Nursing or equivalent is foundational, with completion of a further postgraduate qualification, through a recognised tertiary institution, to maintain a Child and Family Health Nurse (CFHN) position.
- Consideration for provision within the services to provide a transition to practice program for student child and family health nurses while they are undertaking study, so they are ready to work on completing their tertiary qualification.
- Families who utilise child health service expect to receive care commensurate with these qualifications.
- Health equity is widely acknowledged to be an important policy objective in the health care field. Standardization in child health programs will support equity by providing all children with a standardised program.

2. **Barriers that affect parents' access to routine health and development checks that track their child's progress against developmental milestones.**

MCaFHNA's Response

Key Points:

- Access to standardised Child Health program, that incorporates key milestone checks, undertaken by appropriately qualified health practitioners.
- Child Health services are a key component of Primary Health Care. Based on evidence that the foundations for lifelong health, productivity and wellbeing are laid in childhood, the health sector has an important role to ensure that children not only survive but thrive (UNICEF, 2021).

- With evidence demonstrating that more effective and systematised child health services are required to deliver measurable improvements in the outcomes for children (United Kingdom Department of Health, 2013), standardisation in the delivery of a routine child health program is required, which incorporates current evidence, to provide a more effective, efficient, and systematised child health programs.
- Currently, engagement with Child Health Services across Australia is voluntary (unless there is Child Protection Service involvement). With an outcome of “children being physically and emotionally healthy”, having key milestone checks made mandatory provides the best opportunity to build strong foundations for optimal development and early identification of risk and protective factors known to influence health outcomes and implementing early interventions for maximising healthy development. (Department of Health, 2019; Moore, Arefadib, Deery & West, 2017).
- When a program aims to ‘improve outcomes for all children’ and, importantly, to ‘reduce inequalities in outcomes between groups of children’ (Council of Australian Governments, 2009), the use of a variety of child health assessments and schedules create a lack of consistency in what constitutes ‘best practice’ in child health services.
- Randomised clinical trials have repeatedly found that while development of a positive alliance (therapeutic relationship) is one of the best predictors of outcomes (Kopta, Leuger, Saunders, & Howard, 1999), establishing a therapeutic alliance or relationship takes time. Therefore, the majority of service visits/assessments should occur within the first 12 months after birth. The remainder of the key contacts should occur at 6 monthly intervals which enables the therapeutic relationship to continue as well as facilitates surveillance of ‘well child’ growth and development: parenting education and support, and health promotion (Leitner, 2001; Hagan, Shaw and Duncan, 2017).
- With anticipatory guidance underpinning this framework, it reinforces that families are primarily responsible for raising their children and that health services support this process.
- The National Standards for Practice of Maternal, Child and Family Health Nurses in Australia (Grant, Mitchell, & Cuthbertson. 2017), recognise the unique qualities of practice in each jurisdiction to maintain quality and safety in practice. The Standards of Practice for MCFHNs also articulate that the qualification of RN is the foundational qualification needed to be able to care for infants, children and families (including a variety of caregivers) from birth to school entry. Child and Family Health Nursing aims to optimise the health, development and well-being of young children - then infants, children and families are entitled to, and should, expect to receive the highest quality care from appropriately qualified staff.
- Consideration of Telehealth In rural and remote communities, with support structures to ensure the safety of both family and staff.
- Consideration of consistent data collection methods/systems. Currently, all States and Territories use different child health information systems, there is currently no

effective means to collect relevant outcome data i.e., national breastfeeding rates, developmental assessment results.

3. **Recruitment and retention of health professionals to address workforce shortages.**

MCaFHNA's Response

Key Points:

- Children, caregivers and their families have the right to equal access to high-quality services and care. MCaFHNA recognises that maternal, child and family health nursing require a highly specialised skill set gained through practice as a RN. Families who utilise child health service expect to receive care commensurate with these qualifications.
- There is no minimum standard to practice as a Maternal Child Family Health Nurse in Australia across the States and Territories. NSW Health Local Health Districts (LHD) advertise for Child and Family Health Nurse (CFHN) positions to include the RN with evidence of current APHPRA registration and recency of practice, however, there are some LHD's who do not identify the specific CFHN qualification within the advertisement and will accept an RN. Some of the advertisement wording may include- 'willingness to complete a CFHN qualification', however completion of this qualification is not always reviewed.
- The National Standards for Practice of Maternal, Child and Family Health Nurses in Australia (Grant, Mitchell, & Cuthbertson. 2017), recognise the unique qualities of practice in each jurisdiction to maintain quality and safety in practice. The Standards of Practice for MCFHN's also articulate that the qualification of RN is the foundational qualification needed to be able to care for infants, children and families (including a variety of caregivers) from birth to school entry.
- With the aim of Maternal Child and Family Health nursing being to optimize the health, development and wellbeing of young children - then infants, children and families are entitled to, and should, expect to receive the highest quality care from appropriately qualified staff.
- Investigate different models of health care e.g. Maari Ma Health Aboriginal Corporation About Us | Maari Ma Health or the NT Healthy Under 5 Kids -Partnering Families (HU5K-PF) model digitallibrary-tst.health.nt.gov.au. These examples use a 'hub and spoke model' where there is Aboriginal Health workers and RN's without additional qualifications, but they have access to a qualified Child and Family Health Nurse. The Maari Ma model also utilises on site staff (Health Start staff) for some of the service, and qualified CFH Nurses for specialist appointments i.e. when developmental screening is required. These models are standardised (esp. HU5K-PF) to ensure scope of practice is upheld and referral pathways clearly documented.

4. **Funding for early intervention programs and screening to ensure children are given support for developmental issues, including telehealth and other models.**

MCaFHNA's Response

Key Points:

- With all States and Territories using different child health information systems, there is currently no effective means to collect relevant outcome data e.g. national breastfeeding rates, developmental assessment results.
- The provision of universal well-child health and development programs, to meet the fundamental needs of all children, is generally recognised as central to the improvement of most population outcomes across Australia and many other developed countries (Robinson, Silburn, & Arney, 2011; Australian Government Department of Health [DoH], 2013; McLean et al, 2014; Newham et al, 2020). The importance of this approach is demonstrated by the implementation of guidelines which aim for a universal reach approach seeking to maximise health, development, and well-being outcomes for children (Australian Health Ministers' Advisory Council, 2011; COAG, 2009; McLean et al, 2014).
- Although Australia has a universal health care system, there is no standardisation in the content or context of state and territory child and family health programs. This issue extends further to include the number of contact visits required to achieve outcomes and the content of the consultations.
- Currently each State/Territory also have their own version of the Child Health Record Book. In addition to this print version, providing a digital copy of a national Child Health Record would enable health practitioners to complete information for the caregiver irrespective of whomever attends the visit with the infant and whether they have the print version of the child's book with them.
- When a program aims to 'improve outcomes for all children' and, importantly, to 'reduce inequalities in outcomes between groups of children' (Council of Australian Governments, 2009), the use of different well child health assessments and schedules across States and Territories, create a lack of consistency in what constitutes 'best practice' in child health services and for families about what is most important in terms of health care for infants, toddlers and young children.
- The health care model has to support prevention and early intervention. Recent models of universal well child health and development programs have evolved from an emphasis on monitoring growth and screening for physical disorders to evidence supporting early intervention which includes comprehensive surveillance of development and health together with health promotion activities (Oberklaid et al, 2002; Department of Health and Human Services [DHHS], 2019a). Current models now seek to enable early identification and management of problems, promote protective factors, and identify and ameliorate risk factors (Rossiter et al, 2018). The

National Framework for Universal Child and Family Health Services (Australian Health Ministers' Advisory Council, 2011) supports this process as offering opportunities to positively impact upon the growth and development of children.

- Participation in child health services can be an important protective factor in the lives of children at risk of vulnerability. Developmentally vulnerable children can be found across the entire socioeconomic spectrum (Rossiter et al, 2018). In addition to supporting the health and development of children, child health services also act as an important gateway to other secondary and tertiary services, informal supports and services such as supported playgroups.
- Central to providing a program that is responsive to the needs of families, a universal framework should integrate current evidence into a schedule of periodic visits with targeted interventions such as additional consultations; telephone consultations; groups; and community-strengthening activities. This program should also provide flexibility in service delivery (Rossiter et al, 2018; DHHS, 2019a, Pote et al, 2019).
- It is globally recognised that children who start school with developmental vulnerability have lifelong consequences. With AEDC scores, nationally showing the percentage of children who were on track on 5 domains decreased for the first time since 2009 and around 1 in 5 children were developmentally vulnerable in one or more domains (Australian Early Development Census, 2022) the need for early intervention is critical. One such initiative is to proactively undertake a development screening for all children at either 12 months or 18 months, especially in areas known to have 2 or more developmental vulnerabilities. Until data is able to be gathered and scrutinised from developmental screening (ASQ3) and aligned with AECD data for 6-year-olds, CFH programs will not know if developmental screening is affecting AEDC scores for vulnerability.
- Ensuring access for early intervention that is accessible in all jurisdictions and within a timely manner (i.e., within 3 months) for all children under school age) requires a new approach. Currently, CFHNs cannot apply for a Medicare provider number as an eligible health professional recognised for Medicare services. Without this, the only way a CFHN can refer to a specialist (i.e., Paediatrician) is through a General Practitioner (GP). This pathway can cause unacceptable delays in referral. For example, rural, remote and very remote locations where timely access to a General Practitioner is challenging. E.g., service access is via an external provider through drive in-drive out (DIDO or /Fly in-Fly out (FIFO). Of greater concern, is when GPs dismiss the concern held by the CFHN and does not progress the referral.
- In addition, there is also a financial burden to families in this process, especially with the current contraction of bulk billing services (these are only available to Health Card Concession-HCC- holders) i.e., families who do not have a Medicare card (Visa status, refugee etc.), or middle/lower income who are ineligible for a HCC. Without recognition of CFNH's as an eligible health professional (recognised for Medicare services), families must pay the full fee of a specialist appointment as there is no Medicare rebate available to them. Families want to act on a CFHN concern and

referral. In most jurisdictions, waiting lists are prohibitive and as families also need to go through a GP to access a referral, this delay is lengthened further.

- Enabling CFHN's to become eligible health professionals recognised for Medicare services - specifically to directly refer to a Paediatrician where a developmental delay has been identified through an appropriate screening tool (Australian Health Ministers' Advisory Council, 2011) is crucial for early diagnosis and intervention.

5. Any other related matters.

MCaFHNA's Response

Key Points:

- In the Guide to the National Quality Standard (Australian Children's Education and Care Quality Authority (Australian Children's Education and Care Quality Authority [ACECQA], 2013), there is an acknowledgement that the drive to change the focus to the early years is based on clear evidence that this period of children's lives is very important for their present and future health, development and wellbeing. This submission is a step towards a consensus across all activities in universal child health assessments, mapping outcomes against domains identified in the Early Childhood Development [ECD] Outcomes Framework (Australian Institute of Health and Welfare [AIHW], 2011) which can then inform progress towards the National Early Childhood Development Strategy (Council of Australian Governments [COAG], 2009) and the proposed Early Years Strategy.
- Randomised clinical trials have repeatedly found that while development of a positive alliance (therapeutic relationship) is one of the best predictors of outcomes (Kopta, Leuger, Saunders, & Howard, 1999), establishing a therapeutic alliance or relationship takes time. Therefore, the majority of occasions of service or schedules visits/assessment should occur within the first 12 months after birth. The remainder of the key contacts should occur at 6 monthly intervals which enables the therapeutic relationship to continue as well as facilitates surveillance of 'well child' growth and development: parenting education and support, and health promotion (Leitner, 2001; Hagan, Shaw and Duncan, 2017).
- It is hoped that this new structure will break down traditional State and Territory program silos to avoid infants and toddlers 'falling through gaps' and not reaching their full potential prior to 3 years.
- Equity is widely acknowledged to be an important policy objective in the health care field and equality should feature prominently in health policy decisions. Differences between child health programs create barriers. Standardization in child health programs will ensure equality is achieved by providing all children with a standardised program through a key contacts schedule. In this way, equity can only be realised if equality is achieved first, i.e., all children have access to the same standardised program, irrespective of where they live.

- With anticipatory guidance underpinning this framework, it reinforces that families are primarily responsible for raising their children and that health services support this process.

Reference List

Australian Children's Education and Care Quality Authority. (2013). *Guide to the National Quality Standard*. Sydney: Australian Children's Education and Care Quality Authority.

Australian Early Development Census. *Data Explorer*. 2021 Department of Education. Retrieved from: https://www.aedc.gov.au/data-explorer/

Australian Institute of Health and Welfare 2011. *National outcome measures for early childhood development: development of an indicator-based reporting framework*. Cat. no. PHE 134. Canberra: AIHW. Retrieved from: <https://www.aihw.gov.au/getmedia/4b41f3af-33aa-4ad7-b867-fe4f9ef51a6e/12424.pdf.aspx?inline=true>

Australian Government Department of Health (2013) *National Framework for Universal Child and Family Health Services*. Retrieved from: <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/nat-fram-ucfhs-html~framework~health-development>

Australian Health Ministers' Advisory Council. (2011). *National Framework for Universal Child and Family Health Services*. Canberra: Australian Government Department of Health and Ageing. Retrieved from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/AFF3C1C460BA5300CA257BF0001A8D86/$File/NFUCFHS.PDF>

Council of Australian Governments. (2009). *Investing in the Early Years-A National Early Childhood Development Strategy*. Canberra: Commonwealth of Australia. Retrieved from: <https://www.startingblocks.gov.au/media/1104/national_ecd_strategy.pdf>

Department of Health. *National Action Plan for the Health of Children and Young People 2020-2030*. Department of Health. Australia. 2019.

Department of Health and Human Services (2019a). *Maternal and child health program standards*. Melbourne: Victorian Government. Retrieved from: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/maternal-child-health-service-guidelines>

Grant, J., Mitchell., C & Cuthbertson, L. (2017). *National Standards of Practice for Maternal, Child and Family Health Nursing Practice in Australia*, Adelaide, Flinders Press. Retrieved March 2023 from https://www.mcafhna.org.au/public/138/files/National%20Standards%20of%20Practice%20for%20MCaFHNA%20(1).pdf

Hagan JF, Shaw JS, Duncan PM, eds. (2017) *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics.

Kopta, S. M., Leuger, R. J., Saunders, S. S., & Howard, K. I. (1999). *Individual psychotherapy outcome and process research: Challenge leading to great turmoil or positive transition? Annual Review of Psychology, 50*(2), 441-469.

Leitner, L. M. (2001). *The Humanistic Psychologist*, 29 (1), 98-113. doi: 10.1080/08873267.2001.9977009.

McLean, K., Goldfeld, S., Molloy, C., Wake, M., & Oberklaid, F. (2014). *Screening and surveillance in early childhood health: Rapid review of evidence for effectiveness and efficiency of models*. Haymarket: The Sax Institute.

Moore T, Arefadib N, Deery A, West S. (2017). *The First Thousand Days: An Evidence Paper*. Victoria. Centre for Community Child Health, Murdoch Children's Research Institute..

Newham, James. J., McLean, Karen., Ginja, Samuel., Hurt, Lisa., Molloy, Carly., Lingam, Raghu. And Goldfeld, Sharon. (2020). *Brief evidence-based interventions for universal child health services: a restricted evidence assessment of the literature*. BMC Public Health 20:993 <https://doi.org/10.1186/s12889-020-09104-7>

Oberklaid, F., Wake, M., Harris, C., Hesketh, K. and Wright, M. (2002). *Child Health Screening and Surveillance: A Critical Review of the Evidence*. Canberra, ACT: National Health and Medical Research Council. Retrieved from: <https://www.rch.org.au/uploadedFiles/Main/Content/ccch/EY_mod3_Ob.pdf>

Pote, I., Doubell, Lara., Brims, Lucy., Larbie, Judy., Stock, Laura and Lewing, Ben. (2019). *Engaging disadvantaged and vulnerable parents An evidence review*. London: Early Intervention Foundation. Retrieved from: <https://www.eif.org.uk/reports/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review>

Robinson, G., Silburn, S. R., & Arney, F. (2011). *A population approach to early childhood services: Implementation for outcomes. Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan*. Darwin: Northern Territory Government.

Rossiter, Chris., Fowler, Catherine., Hesson, Amiee., Kruske, Sue., Homer, Caroline. S.E., and Schmeid, Virginia. (2018). *Australian parents' use of universal child and family health services: a consumer survey*. Health & social care in the community, 27(2), 472–482. <https://doi.org/10.1111/hsc.12667>

United Kingdom Department of Health. (2013) *Improving Children and Young People's Health Outcomes: a system wide response.* London: United Kingdom Department of Health. Retrieved from: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214928/9328-TSO-2900598-DH-SystemWideResponse.pdf

World Health Organisation. *Investing in our future: a comprehensive agenda for the health and well-being of children and adolescents*. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2021. Licence: CC BY-NC-SA 3.0 IGO. Retrieved from <https://www.who.int/publications/i/item/9789240037793>