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## 12 Child health workforce

### Key points

- Child health services provide regular checks on the health and development of young children, with a focus on health promotion, prevention and the early detection of diseases and disorders. Such services support the health and wellbeing goals outlined in the National Early Childhood Development Strategy.
- Child health services are generally, but not exclusively, staffed by nurses with postgraduate qualifications in child health. Aboriginal and Torres Strait Islander health workers also play a role in delivering child health services to many Indigenous children.
- While child health services appear to be effective, more research is needed to determine the optimal content, number and timing of child health visits, and the best mix of skills and qualifications for the child health workforce.
- Around two per cent of the nursing workforce, or 5800 nurses, are employed in child health. Over half these nurses work part time, and less than four per cent are male. In line with their higher levels of qualifications and experience, child and family health nurses (CFHNs) are, on average, older than other nurses.
- In some jurisdictions, child health services do not employ sufficient nurses to deliver the recommended number of child health visits to every child, and only a small proportion of children receive at least half the scheduled visits.
- Although there are shortages of nurses in Australia and worldwide, child health nursing is a relatively attractive nursing speciality. Because of this, the supply of CFHNs is likely to increase in response to any increases in government demand for, and funding of, child health services.
- The effectiveness of scholarships in encouraging additional nurses to obtain qualifications in child health or to practice in areas of high demand should be assessed. Scholarships should only be provided where they are targeted at nurses who would not otherwise have chosen to practice in areas of workforce shortage.
- Victorian CFHNs are required to also be qualified midwives. There is insufficient evidence of the impact of this additional qualification on child health outcomes to justify extending compulsory midwifery qualifications to other jurisdictions.
- Governments should provide access CFHNs in as wide a range of locations as possible. Where this is not possible, such as small communities in very remote areas, other health professionals — such as remote area nurses and Aboriginal and Torres Strait Islander health workers — should receive training in child health.

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In addition to education and care, the early childhood development sector includes a range of other services designed to promote the health and wellbeing of young children. These include child health services and family support services (chapter 13). Child health services are attended on a voluntary basis, and have a particular role in promoting infant health and development, with children under one year of age being more likely to attend child health services than early childhood education and care (ECEC) services.

In considering the workforce for child health services, the Commission has focused on universal primary care services aimed at children and families. Other health services for children are generally provided in hospitals or by medical practitioners or allied health professionals. Workers in those settings form part of the health workforce, and were considered as part of the Commission's study of the health workforce (PC 2005). Similarly, allied health and early intervention professionals who provide services for children with additional needs are considered in chapter 8. Also, while acknowledging the importance of antenatal care in improving child outcomes (Government of South Australia, sub. 66), the Commission has focused on child health services provided to children from birth to school age.

Like many other developed countries (appendix D), Australia has a well-developed system of universal health services for young children, provided by community-based nurses. The job titles used by these nurses vary across Australia. Common titles include maternal and child and family health nurses (Victoria and the Australian Capital Territory), child and family health nurses (Western Australia, Queensland, and the Northern Territory), child and youth health nurses (South Australia) and child and family health nurses (New South Wales and Tasmania) (Kruske, Barclay and Schmied 2006). In Tasmania, such nurses are referred to as either child and family health nurses (Tasmanian College of Child and Family Health Nurses, sub. DR149), or Child Health and Parenting Service (CHAPS) nurses (Tasmanian Government, sub. 77).

In addition to differing titles, the qualifications and roles of these nurses also differ between jurisdictions (see below). Without ignoring their varied roles, for simplicity, the Commission has chosen to refer to all such nurses as 'child and family health nurses' (CFHNs).

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CFHNs are often the first point of contact for well-child care and parenting advice (Schmied et al. 2008). This reflects the changing nature of the CFHN role, in which the concerns about malnutrition and infectious disease that prompted the establishment of child health services now have less prominence (Vimpani 2004). In their stead, CFHNs:

... provide health education to families to promote health and wellbeing and prevent illness; offer support and guidance to families while developing parenting skills; assess child growth, development and behaviour at key ages and stages; guide and inform families in relation to family health, breastfeeding, immunisations, nutrition, accident prevention and child behaviour; and provide access to information on child and family services. (ANF sub. 80, p. 2)

In addition, CFHNs promote the parent–child relationship and parental social and emotional wellbeing, as well as participate in community capacity building activities in response to local needs such as parenting groups (CHoRUS, sub. DR159).

Some jurisdictions also provide additional definition to the CFHN role, and guidance to the CFHN workforce, through publications such as the New South Wales Child and Family Health Nursing Professional Practice Framework, which advocates the use of anticipatory guidance and other skills to assist CFHNs in their role (NSW Department of Health 2011).

In comparison with the ECEC workforce, CFHNs engage with children and their families very early in the life of the child, with most contact in the first 12 months of life (CHoRUS, sub. DR159). As one of the main contacts families have with health professionals in the early years of their child’s life, CFHNs also refer children to other health professionals, such as speech pathologists (Patricia Grant et al., sub. DR200). (The workforce for children with additional needs is considered in chapter 8.)

In some areas, child health services also employ Aboriginal and Torres Strait Islander health workers. These workers play an important role in increasing the accessibility of the services in which they work to Indigenous children and families. When child health services are accessible and effective, they can enhance development outcomes for Indigenous children by, for example, promoting the early identification and treatment of hearing impediments that affect children’s capacity to learn and socialise.

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## 12.1 Characteristics of the child health workforce

CFHNs comprise a small proportion of the nursing workforce. The exact size of the child health nursing workforce is unknown, as it includes:

- nurses currently working in child health
- nurses who hold postgraduate qualifications in child health (who may not be currently working in child health).

### Nurses working in child health

In 2008, 5788 nurses reported working in child and family health.<sup>1</sup> This represents around two per cent of nurses employed in clinical practice (AIHW 2010). While most nurses who report being employed in child and family health work in child health services, some may also work in other settings, such as children's hospitals or as school nurses.

On average, nurses who report working in child and family health are older than nurses working in other areas of clinical practice, are more likely to be female, to work part time and to be registered nurses (as opposed to vocationally trained, enrolled nurses) (table 12.1).

Similar observations about the CFHN workforce were made by study participants. For instance, the Municipal Association of Victoria reported that, of the 925 nurses employed in maternal and child health services in Victoria in 2010, 72 per cent worked part time and 14 per cent were aged 60 years or older. Only one male CFHN was reported (sub. 68). In Tasmania, 13 per cent of CFHNs were aged 60 years or older (Tasmanian Government, sub. 77).

Table 12.1 Selected characteristics of nurses working in child health

	<i>Average age</i>	<i>Male</i>	<i>Holds registration</i>	<i>Average working week</i>	<i>Work part time</i>
	Years	%	%	Hours	%
Nurses employed in family and child health	46.4	3.4	93.6	31.8	54.4
All nurses employed in clinical practice	44.1	9.4	81.3	33.4	47.9

Source: AIHW (2010).

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<sup>1</sup> In the Nursing and Midwifery Labour Force Survey (AIHW 2010), nurses were asked about their area of clinical practice. Those who selected 'family and child health' are referred to here as child and family health nurses.

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Nurses working in child and family health are more likely to hold post-registration or post-enrolment qualifications than nurses employed in other clinical areas, with 69 per cent of nurses working in child and family health having such qualifications. While postgraduate qualifications are required of CFHNs in some jurisdictions, nurses in similar roles in other jurisdictions may not have such qualifications (see below). Some nurses working in child and family health may also have relevant qualifications that are no longer offered, such as mothercraft nursing (DHS 2004b), and thus would not require postgraduate qualifications in child and family health.

Few data are available on staff turnover in child health services. Study participants did not consider turnover to be high (for instance, City of Casey, sub. 35; ANF, sub. 80). This would suggest that CFHNs ‘tend to remain in the field for many years’ (Victorian Government, sub. 87, p. 5). The Australian College of Children and Young People’s Nurses considered that the ‘predominant reason for turnover is retirement’ (ACCYPN, sub. 45, p.1), which also indicates that CFHNs have long careers in the sector.

### **Nurses with qualifications in child health**

It is difficult to obtain a comprehensive picture of the qualified CFHN workforce, for a number of reasons.

- Nursing registration data do not indicate whether nurses have qualifications in child health. Since 1 July 2010, the Nursing and Midwifery Board of Australia (NMBA) has been responsible for the professional registration of nurses and midwives. Unlike some of the state-based nurses boards it replaced, the NMBA does not ask for information on nurses’ specialist qualifications (such as child health qualifications) for registration purposes.
- Nurses with child health qualifications may not be employed in child health services. For instance, many nurses employed in general practice (as ‘practice nurses’) have postgraduate qualifications in child health nursing (Parker et al. 2009).
- Training and qualification requirements for CFHNs vary between jurisdictions. Some nurses with qualifications in child health may therefore not be considered to be qualified for child health roles in all jurisdictions.

### **Aboriginal and Torres Strait Islander health workers in child health**

In areas with large Indigenous populations, health services often employ Aboriginal and Torres Strait Islander health workers (AHWs). AHWs ‘generally provide a first

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point of contact for Indigenous people accessing health care services' (SCRGSP 2009, p. 7.16). The presence of these workers can encourage and support Indigenous families to access child health services, as in addition to their clinical role, AHWs 'play a key role in cultural brokerage between Western medical systems and Indigenous communities' (General Practice and Primary Health Care Northern Territory, sub. DR132, p. 6, cited in PC 2005).

As is the case with CFHNs, very few data are available on the relatively small number of AHWs who are involved in providing child health services. There are also very few reliable data on the AHW workforce as a whole.

AHWs are relatively poorly remunerated. For example, an AHW with a certificate III qualification employed under the Aboriginal Community Controlled Health Services Award 2010 would earn \$738.20 per week in their first year of employment. This compares to average weekly reported earnings for ECEC educators of \$753.50 (ABS 2010d), despite many educators not having certificate qualifications.

Health Workforce Australia is working to improve the available data on the AHW workforce, with a project currently underway that aims to:

... develop a national picture of the Aboriginal and Torres Strait Islander Health Worker workforce. This includes location, role, skills, qualifications and interface with other sections of the health workforce. It will also provide information to inform the development of national standards; scope of practice; workforce roles; career pathways and optimal mechanisms for interaction with other health professionals. (HWA nd)

This information will be particularly useful in planning for national registration of AHWs, which will commence on 1 July 2012.

## **Data on the child health workforce**

The absence of reliable data about CFHNs and AHWs who work in child health reduces governments' ability to effectively plan and deliver child health services. A number of study participants expressed concern about the limitations of data on the CFHN workforce (ACCYPN, sub. 45; NSW Government, sub. 79; ANF, sub. 80).

Several initiatives currently underway have the potential to improve the quality of data about CFHNs. The NMBA is moving towards a nationally uniform renewal date for nurse registration, along with standard registration categories. Such changes should improve data consistency at the national level. Some jurisdictions, notably Victoria, have also made efforts to obtain and examine data on the CFHN workforce (DHS 2004a).

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Employers and funders of child health services, notably state and territory governments, may nevertheless find it worthwhile to work with the NMBA and Health Workforce Australia to seek ways to progressively obtain and enhance administrative data collections on the child health workforce. In doing so, adhering to standard business reporting (SBR) principles may assist these organisations to collect better data in a more efficient manner (see PC 2009a for further detail).

## **12.2 Demand for child and family health nurses**

### **Universal child health services**

Government policy on universal child health services is the main driver of demand for CFHNs. Each jurisdiction has a schedule of universal child health visits with a CFHN, ranging from six visits in South Australia to ten visits in Victoria (appendix C). The first visit usually takes place in the child's home, while the remainder are generally conducted in a community health facility (DEECD and MAV 2009a; NSW Department of Health 2011). The variation in the number of visits offered reflects historical differences between jurisdictions and the inconsistent evidence base for child health services (box 12.1). There is also considerable variation in the number of child health visits offered in other countries (appendix D).

The tasks involved in child health visits can be varied and complex.

[Child health services provide] a comprehensive and focused approach for the promotion, prevention and early detection of the physical, emotional or social factors affecting young children and their families, and intervention where appropriate. (DEECD 2011b, p. 14)

As well as checking on the health and development of the child, health visits can entail assessing the child's safety, providing parental support and education, and making referrals to other services (AAMCFHN, sub. DR151; ACCYPN, sub. DR169; Maternal and Child Health Nurses, Wyndham City Council, sub. DR202).

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### Box 12.1 The evidence base for universal child health services

Evidence about the effectiveness of universal child health services is scarce, with 'limited Australian and international research examining the outcomes or impact of child and family health nursing services' (Schmied et al. 2008, p. 19).

In its most recent review of evidence for child health screening and surveillance, the National Health and Medical Research Council considered that:

Some of [the activities to prevent problems from occurring or to promote or enhance health outcomes] have a strong evidence base (eg immunisation, breastfeeding); for others there are some limited data suggesting they are likely to be effective in facilitating improved outcomes (eg early literacy, injury prevention programs); some appear to be intuitive yet at present there is no compelling evidence as to their effectiveness in improving outcomes (anticipatory guidance, the provision of information to parents). (NHMRC 2002, p. 221)

There is also little evidence about the number of health visits (or 'well-child checks') that should be universally available:

Because well-child checks follow a 'one-size-fits-all' approach, many families are subject to unnecessary visits, while children with biological, psychological, or social risks do not receive the services they need due to time and resource constraints. (Bergman, Plsek and Saunders 2006, p. 3)

To date, there has been no rigorous evaluation of universal services provided by child and family health nurses or the equivalent in other countries ... there is little knowledge of the frequency and intensity of services required to achieve optimum outcomes. (Schmied et al. 2008, p. 19)

While there is little evidence for the optimal number and timing of health visits, or for the best time to offer certain interventions, some jurisdictions have developed evidence-based frameworks for the delivery of child health services. For example, the Key Ages and Stages framework used in Victoria is based on evidence relating to specific child health outcomes (DEECD and MAV 2009a).

A number of tools used by CFHNs are also evidence based, such as Parents' Evaluation of Developmental Status and the Edinburgh Perinatal Depression Scale (Cox et al. 1996; Glascoe 2003).

Child health services are mainly delivered in community health settings (such as maternal and child health centres and baby health clinics) that offer face-to-face services (at either scheduled appointments or drop-in clinics), or in the child's home, through health visits. Some jurisdictions also provide telephone support and advice on child health (Victorian Association of Maternal and Child Health Nurses, sub. 15) or child health visits via the Royal Flying Doctor Service.

Child health services are also increasingly being offered in integrated services (chapter 15). For instance, the Benevolent Society's Women's Health and Mother Baby Hub offers integrated primary health services to women and families in Strathpine, Queensland (sub. 49).

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Differences in the number of funded child health visits leads to considerable differences between jurisdictions in demand for CFHNs, with higher demand in jurisdictions that provide more visits (such as Victoria, New South Wales, Queensland and the Northern Territory). A national approach to universal child health services has been proposed (Allen Consulting 2009), and five jurisdictions are now supporting research on its implementation (ARC 2009). If such an approach were to lead to changes in the number of visits offered by some jurisdictions, there could be considerable change in the demand for CFHNs in those jurisdictions. Such change appears unlikely, however, as the national framework is still under review (CHoRUS, sub. DR159), and its adoption is uncertain (appendix F).

Changes that have been recently introduced include health and wellbeing checks for three-year-olds (Treasury 2011c) and four-year-olds (DoHA 2010a). These checks are funded by the Australian Government and are generally delivered by general practitioners or practice nurses. Recently enacted legislation makes payment of the Family Tax Benefit Part A Supplement conditional on parents taking their children for a four-year-old health visit (Macklin 2011). The three-year-old check remains voluntary, and includes consideration of emotional health and wellbeing (Treasury 2011a).

Regardless of the number of child health visits offered, changes in birth rates or service usage rates will also affect demand. Birth rates have increased in Australia in recent years (chapter 2), driving increases in demand for child health services. Study participants commented on the increased demand (for example, ACCYPN, sub. 45) and noted that increases have been particularly pronounced in some metropolitan areas (City of Casey, sub. 35; Western Australian Auditor General 2010).

The Tasmanian Government suggested that families in low socioeconomic status areas tend to rely more heavily on child health services (sub. 77), which may increase service usage — and thus workforce demand — in those areas. However, others have found that families of infants and toddlers from a higher socioeconomic background are more likely to attend child health services than those from lower socioeconomic backgrounds (Blakemore, cited in McCarthur et al. 2010).

Although all jurisdictions technically offer a specific number of child health visits, some jurisdictions do not employ sufficient CFHNs to deliver those visits. This can limit the ability of CFHNs in those jurisdictions to meet the health needs of children and families (Disability Services Commission, sub. DR364). If jurisdictions that employ comparatively fewer CFHNs expanded recruitment to meet their stated objectives, there would be a large increase in demand for CFHNs in those areas. For

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example, only a small proportion of children in Western Australia receive even half of the seven visits that are technically offered (Western Australian Auditor General 2010). This suggests the potential for increased demand for CFHNs in that state.

If funding for child health services increases in line with increasing birth rates, there will be substantial growth in demand for CFHNs. For example, the annual number of births in Queensland rose by 42 per cent between 1999 and 2009 (ABS 2010b). This would provide a rationale for increasing funding for child health services. Conversely, in the absence of evidence that the reduction in the average number of child health visits delivered by some jurisdictions has had a negative impact on the health and development of children in those jurisdictions, there could potentially be a case for reducing funding to universal child health services. This would in turn reduce demand for CFHNs.

The variation between jurisdictions is not limited to the number and timing of health visits. As previously mentioned, qualification requirements also vary across jurisdictions. This highlights the lack of evidence on what constitutes best practice in child health services. Addressing this gap would help to inform child health policy, and potentially increase the efficiency of child health funding. Specifically, the optimal number and timing of child health visits, as well as the interventions scheduled for each visit should be explored. This will in turn inform the debate about the optimal skills and qualifications for CFHNs — for example, the importance of postgraduate child health qualifications and whether additional qualifications such as midwifery or mental health qualifications should also be required.

#### RECOMMENDATION 12.1

***To demonstrate the cost effectiveness of child health services and better inform consideration of the mix of skills and qualifications in the child health workforce, state and territory governments should work with child and family health nurses to improve the evidence base for child health services. In particular, further research should seek to determine the optimal content, number and timing of child health visits.***

Study participants were generally supportive of this recommendation, with occasional caveats. For example, La Trobe University agreed ‘with the need for strong evidence on which to base child and family health services, but increasing this evidence base to an acceptable level ... will take time’ (sub. DR171, p. 1).

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## Targeted child health services

### *Vulnerable families*

Disadvantaged and vulnerable children have the most to gain from child health services (Marmot 2010). Targeted child health services provide extra contact or support for such groups. For instance, both New South Wales and South Australia have home visiting programs targeting vulnerable families (CYWHS 2005; NSW Department of Health 2009). The number of families assisted by home visiting and other targeted child health services is relatively small. For instance, the Enhanced Maternal and Child Health Service in Victoria was used by 1132 families in 2009-10 (DEECD 2010a).

Nurse home visiting programs are associated with improvements in some child outcomes and in parenting skills among vulnerable families (box 12.2). There was support amongst study participants for the further development of nurse home visiting programs (NIFTeY NSW, sub. 36; UnitingCare Children, Young People and Families, sub. 62).

### *Indigenous families*

Australian governments are seeking to reduce the gap in developmental outcomes between Indigenous and non-Indigenous children, with the Council of Australian Governments aiming to halve the gap in mortality rates for Indigenous children under five within a decade (COAG 2009b). Several targeted child health programs are designed to help reach this goal.

- The Australian Nurse–Family Partnership Program (ANFPP) supports pregnant Indigenous women to improve their own health and the health of their baby. It also provides parenting support and assistance in the early years of the child’s life (ANFPP 2010). It is closely based on the US Nurse Home Visiting Program (Olds et al. 2007).
- The New Directions Mothers and Babies program funds services to increase access to antenatal care and to improve the birth weights of Indigenous babies, as well as to provide child health checks and parental education (DOHA 2011; NSW Child and Family Health State-wide Services Network, sub. DR148).

To the extent that these programs increase Indigenous families’ access to, and use of, child health services, both increase demand for CFHNs.

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## Box 12.2 Nurse home visiting

### International evidence

Visiting pregnant women and new mothers at home, particularly those from vulnerable and disadvantaged groups, has become an increasingly important part of nursing practice in several countries. A review of reviews of ante- and post-natal home visiting programs found that they can be associated with:

- 'Improvements in parenting
- Reported improvements in some child behavioural problems
- Improved cognitive development, especially among some sub-groups of children such as those born prematurely or born with low birth weight
- A reduction in accidental injury among children
- Improved detection and management of post-natal depression
- Improved rates of breastfeeding' (Bull et al. 2004, p. 25).

Programs that target at-risk individuals tend to have larger effects on child outcomes (Sweet and Appelbaum 2004) and are significantly more cost effective (London Economics 2007).

While this evidence is promising, much of it emanates from the United States, principally from the Nurse Home Visiting Program (Olds et al. 2007), which targeted disadvantaged women in a number of US cities. Questions remain about the applicability of this research in other countries. There is also uncertainty about which model of home visiting best suits different families' needs, and the optimal duration of home visiting programs (Bull et al. 2004).

### Australian evidence

A randomised controlled trial of a targeted home visiting program was conducted in a multicultural, socioeconomically disadvantaged community in Sydney. It found that, compared to universal services, the targeted program was associated with:

- mothers becoming more emotionally and verbally responsive toward their child
- increased duration of breastfeeding
- a number of benefits to mothers suffering from psychosocial distress.

Notably though, no significant differences were observed in child mental, psychomotor, or behavioural development (Kemp et al. 2011).

## Child and family health nurses in general practice

CFHNs are trained in health promotion and preventive care and generally have experience in delivering such care in a community setting. Many nurses with child

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health qualifications work as practice nurses, mainly because, until quite recently, certificates and diplomas in child health nursing were some of the few qualifications that equipped nurses to work in community settings (Parker et al. 2009). Initiatives to encourage general practices to employ practice nurses, such as the Practice Incentives Program (Medicare Australia 2010), are therefore likely to increase demand for CFHNs, at least in the short term.

As the number of graduates of recently developed practice nursing courses increase, demand for CFHNs in general practice is likely to fall. The substantial number of qualified CFHNs working in general practice could therefore be thought of as a reserve pool of CFHNs, who may return to child health over time. That is not to say that all practice nurses could potentially work as CFHNs, rather that those holding the relevant qualifications could do so — subject to the currency of those qualifications.

### **12.3 Supply of child and family health nurses**

The ability to recruit and retain nurses to child health services depends on the attractiveness of employment in those services, compared to nurses' other employment options. While this is largely determined by the remuneration and conditions offered to CFHNs, other factors also contribute to making child health nursing attractive to many potential workforce entrants. For instance, professional autonomy and the ability to establish relationships with families contribute to the desirability of working in child health (ANF, sub. 80), as does the absence of shift work.

Indeed, child health nursing is one of the more attractive nursing specialties, with stakeholders reporting 'no shortage of nursing graduates wanting to work in children's health care' (ACPCHN 2002, p. 1). While CHoRUS considered that the appointment of lesser qualified nurses to child health positions to be evidence of workforce shortages (sub. DR159), this is more likely to be a reflection of government policy decisions, as governments are the main employers of CFHNs. However, there are barriers to entry to child health nursing, and removal of these barriers (see below) would increase the supply of CFHNs.

#### **Remuneration**

In all jurisdictions except Victoria, CFHNs are employed by state and territory governments. They generally receive the same wages as nurses with postgraduate qualifications in other fields of nursing, as they are employed under the same

awards and agreements as other nurses. However, there is considerable variation between jurisdictions in wage rates for CFHNs (table 12.2).

**Table 12.2 Wages for child and family health nurses**

Annual wage at first pay point, 1 January 2011<sup>a</sup>

	<i>NSW</i> <sup>b</sup>	<i>Vic</i> <sup>c</sup>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>NT</i>	<i>ACT</i>
\$	62 933	83 644	71 297	59 377	66 948	60 087	72 761	72 960

<sup>a</sup> Excluding allowances and loadings. <sup>b</sup> At fifth pay point. <sup>c</sup> Productivity Commission estimate based on enterprise agreements from 67 of the 79 local governments in Victoria.

*Sources:* ACT Public Sector Nursing and Midwifery Enterprise Agreement 2010-2011; Northern Territory Public Sector Nurses' 2008 – 2011 Union Collective Agreement; Nurses and Midwives Heads of Agreement 2010 (Tasmania); Nurses and Midwives (Queensland Health) Certified Agreement 2009; Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010; Public Health System Nurses' and Midwives' (State) Award 2011; Registered Nurses, Midwives and Enrolled Mental Health Nurses Australian Nursing Federation – WA Health Industrial Agreement 2007.

In Victoria, CFHNs are employed by local governments under municipal enterprise agreements. There is no formal mechanism for aligning CFHN wages with those of nurses in other local government areas or in the health system. While there are many enterprise agreements in Victoria, the various wages under these agreements are generally higher than those in most other jurisdictions. These differences in wage rates are likely to remain despite the introduction of modern awards, as current rates of pay in Victoria are well in excess of those in the modern award.

More importantly however, wage variation between jurisdictions has come about because CFHNs are generally paid at the same rate as other nurses (although CFHNs do not receive shift penalty payments and so tend to have lower take-home pay — see below). This wage parity is important in ensuring the ongoing attractiveness of child health nursing within jurisdictions, and would appear to be the main reason why study participants did not express concerns about the adequacy of remuneration for CFHNs.

However, the Tasmanian Government (sub. 77) noted that, despite notionally equal rates of pay, differences in salary packaging arrangements between hospitals and child health services can affect the relative attractiveness of the remuneration offered by child health services. Local governments in Victoria raised similar concerns (Municipal Association of Victoria, sub. 68), with the City of Greater Geelong suggesting that nurses 'are likely to suffer significant pay losses (including superannuation, salary sacrifice and the inability to transfer other entitlements such as long service leave from the public hospital system to local government) if they choose to become [child health] nurses' (sub. 20, p. 6). Despite this, as funders or employers of nurses in both hospitals and child health services, state and territory governments could, over time, choose to reduce such differences if necessary.

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While the jurisdictional variation in wage rates may lead CFHNs to move to higher-paying jurisdictions, this tendency is limited by variations in qualification requirements (see below).

## **Employment conditions**

### *Working hours*

As noted in table 12.1, more than half of the nurses employed in child and family health work part time. Part-time work is more common among nurses employed in child health than among nurses employed in any other clinical area except midwifery (AIHW 2010).

Study participants also considered rostering arrangements in child health services to be attractive. For example, the Australian Nursing Federation considered that CFHNs ‘have largely predictable and stable rostering arrangements when compared to their acute sector nursing and midwifery colleagues. The requirement for them to work shift work is minimal’ (sub. 80, p. 3). Similarly, the City of Casey considered flexible working hours to be a benefit of working in child health services (sub. 35). The availability of part-time work, together with the absence of shift work and control over working hours, is attractive for many nurses, despite not receiving shift penalty payments.

### *Location*

As community-based nurses, employment opportunities for CFHNs are geographically dispersed, broadly in line with the distribution of the population. Positions in inner city areas are attractive and easy to fill, perhaps because nurses tend to work locally and prefer not to commute long distances. Because turnover is low, vacancies in these areas arise relatively infrequently. Most vacancies arise in child health services in outer metropolitan growth areas and rural areas. There were reports that positions in these areas can be difficult to fill (City of Greater Geelong, sub. 20; City of Casey, sub. 35), but few data on vacancies are available at the local level.

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## 12.4 Training and workforce planning for child and family health nurses

### Training and qualifications

#### *Training child and family health nurses*

The undergraduate nursing curriculum does not focus on child health, and provides limited exposure to nursing practice beyond the acute care sector (Parker et al. 2009). Nurses therefore require additional training in order to provide child health services, and most CFHNs hold a postgraduate certificate or diploma in child health. Masters degrees are also increasingly common (ANF, sub. 80; Victorian Association of Maternal and CFHNs, sub. 15).

While these courses generally equip CFHNs with appropriate skills and knowledge, there is considerable variation in course length, names of courses, mode of delivery, entry requirements and theoretical and clinical practice requirements (Kruske and Barclay 2006). There are also concerns that the number of clinical placements in child health nursing is inadequate (NHWT 2009). The Australian College of Children's and Young People's Nurses reported that some courses have only 15 hours of clinical placement (sub. 45). This could affect the quality of graduates from child health nursing courses.

Limited clinical contact hours within the maternal and child health sector whilst undertaking the postgraduate course often does not enable confidence for autonomous practice on completion of the course and entry to the field. (ANF, sub. 80, p. 12)

To the extent that CFHNs work autonomously, clinical contact hours are especially valuable — it is difficult for graduates in any profession to be able to work autonomously from day one, particularly in isolation from peers. Therefore clinical practice will continue to be important in course structure and design for CFHNs.

Although these concerns have been raised, study participants did not express concern about graduate quality. Indeed, in Victoria, more than three quarters of graduates of maternal and child health nursing courses apply for, and gain, employment as a CFHN (Victorian Association of Maternal and CFHNs, sub. 15). This suggests that Victorian child health graduates have appropriate skills (though they may differ from graduates in other states due to the requirement for Victorian CFHNs to also be qualified midwives — see below).

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## *Scholarships for postgraduate study*

### *Initial considerations*

In Victoria, a number of scholarships are available for nurses undertaking postgraduate training in child health. The Department of Education and Early Childhood Development offers 15 such scholarships per year, valued at \$3500 each (MAV 2010). Some local governments also offer scholarships of various sizes for postgraduate study in child health.

Several study participants considered these scholarship programs to have been effective in addressing localised workforce shortages, including in rural areas (ANF, sub. 80). While they have helped to attract more CFHNs to some regional areas (City of Greater Geelong, sub. 20), they have not been effective in all rural areas, and have been ineffective in Northwest Tasmania (Tasmanian College of Child and Family Health Nurses, sub. DR149). To the extent that scholarships attract nurses to areas of unmet demand, they are beneficial. However, data are not available to confirm that scholarships have encouraged additional nurses to obtain qualifications in child health or to move to areas of unmet need, and evidence is yet to be gathered to show if scholarships encourage the retention of CFHNs in underserved areas. As a result, the provision of scholarships should to be approached with caution.

### *Responses to the draft report*

In its draft report, the Commission recommended that the cost effectiveness of scholarships be reviewed by governments before the expansion of any scholarship program.

The Commission received over 170 submissions that, among other concerns, expressed objections to limitations on scholarship funding. Those who had received scholarships generally conveyed that the financial assistance helped them through their child health studies, and several participants stated that they would not have been able to undertake study without a scholarship.

While the Commission recognises that financial difficulties can influence decisions to obtain qualifications, this alone does not justify government expenditure on scholarship programs. First, the provision of a scholarship does not necessarily result in an additional person attaining the desired qualification. For example, a scholarship recipient may have already decided to undertake study before applying for the scholarship, and so the award of this scholarship has no impact on the number of people entering the workforce. Second, even if the scholarship does

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encourage an individual to undertake study where they otherwise would not have done so, the more highly qualified worker may not necessarily be needed to meet workforce requirements.

To a policy maker, the value of scholarships lie in their ability to either encourage academic excellence, or change participation decisions (that is, to change a person's decision from 'don't study' to 'study'). Child-health related scholarships are generally aimed at achieving the latter. When choosing whether or not to engage in study, a person with an interest in child health will consider several factors affected by that choice — some positive, such as additional future wages that come with higher qualifications, and some negative, such as the required time and money costs. They will weigh up these factors and make a decision accordingly.

While the provision of scholarships reduces the negative factors associated with study, it is likely that — in the absence of scholarships — the negative factors are still outweighed by positive ones for many individuals, and hence they would still choose to undertake study even when they would otherwise have received a scholarship. This was evident in submissions that underlined the enthusiasm of students of child health.

... you will never have a problem in finding people to do the courses to [obtain additional qualifications]. So many people are passionate about it and all are willing to put in the hard work to get there! (Andrea Furness, sub. DR107, p. 1)

The [Maternal and Child Health] program has never been short of students. We always attract a large cohort of students wanting to join the program ... (Associate Professor Lina Shahwan-Akl, sub. DR121, p. 2)

The demand for Child, Family and Community (CFC) Nursing courses at La Trobe University remains strong and the number of applications is increasing. In the past two years applications for the CFC courses have been higher than for any other postgraduate nursing or midwifery course at La Trobe University. (La Trobe University, sub. DR171, p. 4)

Even when considering that the decisions of some individuals may be swayed by the provision of a scholarship, it might not be beneficial to subsidise these individuals to undertake child health studies. At least one local council in Victoria is now in the 'position of having MCH students graduating with no permanent positions to offer' (Helen Watson, sub. DR139, p. 3). This supports the Commission's finding that, in comparison to other areas of nursing, child health is an attractive specialisation. Therefore, the provision of child health scholarships on a state- or territory-wide basis may be inefficient.

In keeping with the policy goal of increasing the supply of CFHNs in underserved areas, the Commission considers that scholarships and other incentives should only

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be targeted to nurses who would not otherwise have chosen to practice in demonstrated areas of workforce shortage. Prior to the provision of scholarship programs, such as that advocated by the Australian Nursing Federation (sub. 80), clear evidence should be obtained to show that scholarship programs are a cost-effective way of attracting additional nurses to areas of need. Initiatives that promote the retention of existing CFHNs in hard-to-staff areas, such as preceptorships<sup>2</sup> and professional support programs, also merit consideration.

RECOMMENDATION 12.2

***Incentives to attract nurses to study child health, and to retain child and family health nurses in underserved locations, should be tested for their cost effectiveness. Scholarships for postgraduate study in child health nursing should only be provided where they are targeted at nurses who would not otherwise have chosen to practice in demonstrated areas of workforce shortage. Alternatives, such as increased funding for professional support programs, should also be considered.***

In responses to this recommendation, there was some confusion about its scope. It should be noted that the Commission is not recommending the removal of Commonwealth-supported places for child health courses. In fact, it is anticipated that with the move to a demand-driven model of higher education funding support for postgraduate studies such as in child health will be easier to access. Chapter 10 discusses these higher education reforms in greater detail.

#### *Jurisdictional variation in qualifications required of child and family health nurses*

Qualification requirements for CFHNs vary between jurisdictions. For example, while New South Wales considers postgraduate qualifications to be ideal, they ‘are not mandatory and can be gained after entering the area of practice’ (NSW Government, sub. 79, p. 8). New South Wales therefore employs generalist nurses in child health roles (NSW Department of Health 2009). Other jurisdictions prefer CFHNs to hold a graduate diploma or masters degree in child health, rather than a graduate certificate, but will relax this requirement in certain circumstances.

These differences mean that some nurses with qualifications in child health are not considered to be employable in child health roles in some jurisdictions, which can create a barrier to movement of CFHNs between jurisdictions. In jurisdictions that require or prefer nurses to have a postgraduate qualification in child health, these

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<sup>2</sup> A preceptor is ‘an experienced practitioner who teaches, instructs, supervises and serves as a role model for student or graduate nurses, for a set period of time, in a formalised programme’ (Usher et al. 1999, p. 507 quoted in Mills, Francis and Bonner 2005).

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barriers can be overcome by nurses who are willing to undertake a relatively short period of additional study (for example, a graduate certificate generally takes six months to complete). The requirement for CFHNs to also be midwives is more problematic.

### *Requirement for child and family health nurses to also be midwives*

#### *Initial considerations*

In Victoria, maternal and child health services are required to employ registered nurses with qualifications in midwifery, in addition to child health qualifications (DEECD and MAV 2009b). Victorian universities offering postgraduate courses in child health nursing have therefore required nurses to hold midwifery qualifications prior to commencing studies in child health nursing.

Some study participants supported the midwifery requirements, considering that:

For maternal and child health nurses to competently provide the care required for families and children today, they require the current level of education, experience and expertise in this specialised field. (Victorian Association of Maternal and Child Health Nurses, sub. 15, p. 3)

Others considered that more emphasis should be placed on ensuring that new mothers receive certain types of support commonly provided by midwives, such as breastfeeding support and advice on maternal nutrition (Diana Aspinall, sub. 33). Other potential rationales for requiring CFHNs to hold qualifications in midwifery are that:

- CFHNs sometimes visit families within a few days of the birth of a child (ANF, sub. 80)
- midwifery qualifications can increase families' confidence in child health services, which can in turn increase service usage rates.

However, there are a number of important disadvantages of requiring CFHNs to have qualifications in midwifery. First, the time and cost of obtaining qualifications in midwifery, in addition to other qualifications, 'creates an additional hurdle to workforce recruitment' (AAMCFHN, sub. DR151, p. 3). These considerable costs, which include foregone income and course fees, could reduce the number of potential entrants to the field, contributing to workforce shortages in some areas (Centre for Community Child Health, sub. 81; City of Greater Geelong, sub. 20). Also, this requirement may draw existing midwives into child health, and thus contribute to workforce shortages in the maternity services sector.

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Second, workers with additional qualifications require ongoing recompense for those qualifications in the form of higher wages, as can be seen in the relatively high wages paid to CFHNs in Victoria (table 12.2). All other things equal, this can restrict the number of nurses that can be employed and the number of child health visits that can be provided for a given level of funding. Moreland City Council acknowledged that ‘requiring midwifery makes recruitment difficult and the costs of employing higher’ (sub. DR154, p. 4).

Third, as discussed above, these requirements restrict movement of nurses between jurisdictions (ACCYPN, sub. 45). The Australian Association of Maternal, Child and Family Health Nurses also expressed concern about barriers to interstate movement, suggesting that:

... the level of qualification should be uniform across States and Territories to facilitate movement between jurisdictions ... it becomes an issue if nurses’ qualifications are not transferrable, so that they may be refused employment in one jurisdiction but accepted in another to do the same work. (sub. DR151, p. 3)

Not only does the requirement for CFHNs to also be midwives restrict movement within Australia, but experienced CFHNs from other countries may be discouraged from joining the Australian workforce if they are required to do additional study (Elizabeth Fraser Palk, sub. DR187).

Fourth, while the costs of the additional qualification requirements are considerable, the benefits are both diffuse and uncertain. While the Commission was told, mainly by Victorian nurses, that Victorian children have better health outcomes than their counterparts in other states as a result of being seen by more highly qualified CFHNs, it received little objective evidence to support this claim. Several study participants offered Victorian service attendance rates as evidence of the benefits of midwifery qualifications. While important, these data are not sufficient to show that the benefits of a particular level of service provision outweigh its costs. The Municipal Association of Victoria considered that:

The lack of evidence ... does not provide for sufficient rationale for removing the requirement ... Rather it highlights the need for greater investment in quality research on the impacts of child health services to inform future policy. (sub. DR156, p. 9)

The Commission agrees that more evidence will help guide policy and funding in a more efficient way. However, significant costs — such as those that clearly arise from the imposition of a midwifery requirement on CFHNs — should not be imposed on the community without clear evidence of benefits that exceed those costs.

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*Responses to the draft report*

In the draft report, the Commission recommended that jurisdictions should not require CFHNs to hold midwifery qualifications. The Commission received numerous responses from Victorian participants opposing this recommendation. Many study participants suggested that Victorian maternal and child health services are fundamentally different from those in other jurisdictions, with CFHNs regularly drawing on knowledge gained from midwifery qualifications.

[The issue of midwifery qualifications] is complex due to the variation in models of care across jurisdictions. [In Victoria, there is] an initial home visit occurring within days of the birth, followed by regular scheduled consultations ... It is for this reason that midwifery is an essential qualification for these [Maternal and Child Health] nurses. [In other jurisdictions,] this may not occur until the baby is six or more weeks old. Midwifery qualifications, while advantageous, may not be as critical in this model of care. (ANF, sub. DR165, p. 2)

Another common theme was that as postnatal hospital stays become shorter, in-home care for mothers becomes more important. Input was also received by some Victorian mothers, who conveyed a high degree of satisfaction with Victorian services.

The Commission acknowledges that Victorian child health services have a different focus than services in other jurisdictions. The title ‘*maternal* and child health nurse’ highlights the fact that — as well as attending to the health of the child — Victorian CFHNs have a significant additional focus on maternal health. This approach is documented in the Maternal and Child Health Service Program Standards (DEECD and MAV 2009b).

While maternal health issues are outside the scope of this report, the Commission considers that if CFHNs are also expected to provide maternal health care, they should be qualified to fulfil this role. Midwifery courses include units covering antenatal and postnatal care as well as the birthing process. For maternal and child health nurses, it is primarily the knowledge of postnatal care which is relevant to their responsibilities. Knowledge of antenatal care and the birthing process provide context, but have less direct relevance to the role.

Some study participants noted that CFHNs sometimes offer antenatal advice during health visits to mothers who are coincidentally pregnant with another child (for example, Bronwyn Dajczer, sub. DR132; Elizabeth Ferguson, sub. DR131; Nicole Youl, sub. DR141). However, CFHNs are not the main providers of antenatal care — this role is fulfilled by obstetricians, hospital midwives or general practitioners. While CFHNs may identify and address gaps in the maternity care system, these

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gaps are best addressed directly, as attempts to do so through the child health system are likely to be inefficient.

So although qualifications are necessary to enable CFHNs to provide some care to mothers, the imposition of an entire midwifery qualification may be excessive. The City of Casey concurred, offering that ‘postgraduate level maternal and child health study could include any relevant midwifery units’ (sub. DR172, p. 4).

I believe [a short obstetrics course undertaken in the UK] fully prepared me for entry to study health visiting ... It was a great disappointment to me to find that I was unable to practice in the same profession in Victoria without undergoing a full twelve month midwifery education. During the twelve month post graduate diploma I can honestly state that the only new skills and competencies I developed were in the area of birth. (Elizabeth Fraser Palk, sub. DR187, pp. 5–6)

However, in the absence of a shorter qualification focusing on postnatal care, the Commission accepts that midwifery qualifications may be appropriate to address postnatal maternal health issues which may be encountered in health visits. Also, since Victoria does not suffer from a systemic shortage of CFHNs, some of the potential costs of imposing this barrier to becoming a CFHN are not realised. Given the reservations it has about the net benefits of the qualification requirement however, the Commission considers that the midwifery qualification requirements should not be extended to other jurisdictions.

Midwifery qualification requirements were in place in jurisdictions other than Victoria, however they have since been removed (Victorian Association of Maternal and Child Health Nurses, sub. DR152). The Commission received no input from study participants identifying a reduction in service quality in these jurisdictions as a result of this removal.

#### RECOMMENDATION 12.3

*In order to reduce unnecessary costs and obstacles to attracting new child and family health nurses, state and territory governments should not require child and family health nurses to have qualifications in midwifery in addition to their qualifications in nursing and in child health, where such a requirement does not already exist.*

## Planning and supporting the child health workforce of the future

### *Age of the workforce*

Several study participants (for instance, NSW Government, sub. 79; Victorian Association of Maternal and Child Health Nurses, sub. 15) expressed concern about

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the age of the CFHN workforce — CFHNs are on average two years older than the nursing workforce as a whole (see table 12.1 above). However, given the additional training required of CFHNs, it is both reasonable and expected that CFHNs are older than the nursing workforce as a whole. The Australian Nursing Federation considered that ‘the higher than average age range for [child health] nurses is probably reflective of the work experience and educational preparation requirements for the role, as many nurses enter this field after considerable experience in other areas’ (sub. 80, p. 3). The Commission concurs, and does not have particular concerns about the age of the CFHN workforce.

While some concerns were raised about the ability of child health services to replace the ageing workforce (for instance, ACCYPN, sub. DR169), the relative attractiveness of child health specialty, evidenced by strong demand for postgraduate child health courses, suggests that workforce turnover should be manageable.

#### FINDING 12.1

*While child and family health nurses are, on average, older than other nurses, this reflects their higher level of qualifications and experience and does not appear to be a cause for concern.*

#### *Professional development and support*

All registered nurses, including CFHNs, must undertake 20 hours per year of continuing professional development (CPD) in order to maintain their professional registration (NMBA 2010). Nursing organisations considered it important that, in addition to professional development, CFHNs are able to access appropriate professional support (ACCYPN, sub. 45; ANF, sub. 80). This is particularly the case for nurses commencing practice in child health, because ‘it is professionally and personally difficult for nurses/midwives to enter the field without having a defined process of preceptorship with an experienced [child health] nurse’ (ANF, sub 80, p. 12). Formal support structures are also more important for professionals who work alone.

The Tasmanian population is small and dispersed so most [child and family health] nurses delivering universal services work alone or with other disciplines so often do not have the collegial support that nurses in hospitals experience. (Tasmanian Government, sub. 77, p. 10)

To counter this potential isolation, many employers of CFHNs provide preceptorships or formal mentoring programs (for example, Tasmanian Government, sub. 77). Some, such as the City of Stonnington in Melbourne, have

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formally undertaken to do so as part of enterprise agreements (ANF, sub. 80). In areas where such programs are in place, they appear to be addressing professional support needs.

In rural and remote areas, however, professional development programs are scarce (ACCYPN, sub. 45), and other means of providing professional support and networking opportunities may be required. In the Northern Territory, a recent study of the nursing and midwifery workforce suggested a potential approach.

Create an online ‘virtual community’ for past, present and future NT nurses which lets them interact with each other and so reduce the sense of isolation. (Garnett et al. 2008, p. 5)

In chapter 10, the Commission recommended the expansion of such ‘virtual communities’ for the early childhood teacher workforce. A similar approach for the CFHN workforce is also likely to prove beneficial. Where development of online communities for nurses is already underway, any such initiatives for CFHNs should form part of the broader system. This may require the purchase of new equipment as, in some jurisdictions, many CFHNs do not have access to adequate information technology (Western Australian Auditor General 2010).

While the level of professional support for CFHNs seems adequate in most situations, there may be scope to review the content of professional support programs. Most CFHNs will work with culturally and linguistically diverse families during their careers (NSW Child and Family Health State-wide Services Network, sub. DR148). Cultural and communication barriers may inhibit the ability of CFHNs to address the needs of these families. In addition to other measures such as access to interpreting services, it may therefore be appropriate to provide cultural awareness and sensitivity training to CFHNs.

### *Providing child health visits in remote areas*

Though children who live in remote and very remote communities are more likely to experience poor health and to be developmentally vulnerable (Centre for Community Child Health and Telethon Institute for Child Health Research 2009), many do not have access to child health services and do not receive child health visits. Study participants suggested that the remote health workforce faces many other competing demands.

The core business of health professionals in remote services is health and it is our experience that they are generally too overwhelmed by health needs of the full range of people in the community to focus specifically on early childhood. (RRACSSU Central, sub. 42, p. 3; Batchelor Institute, sub. 46, p. 3)

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Many nurses in remote areas also have little training or experience in child health. While acknowledging the pressure faced by health professionals in remote areas, the Commission considers that methods need to be found to ensure that children in remote areas receive child health visits, as they stand to derive the greatest benefit from preventive services.

In many remote areas, employment of a dedicated CFHN is unlikely to be possible or practical, and generalist roles with a child health component are unlikely to be attractive to many CFHNs (ACCYPN, sub. 45). Therefore — in the absence of a dedicated CFHN — child health services will need to be structured and staffed in different ways. In some areas, visiting CFHNs can deliver child health services. For instance, the Royal Flying Doctor Service has provided child health services in Queensland since the early 1990s (King et al. 2001). In other areas, the existing workforce — such as remote area nurses and AHWs — will need to be trained to provide child health checks. This training could be modelled on the Northern Territory ‘Healthy Under 5 Kids’ program (box 12.3). In Queensland, AHWs are able to undertake a Certificate IV in Maternal and Child Health qualification (ACCYPN, sub. DR169).

Many stakeholders reported that they were ‘extremely concerned’ (CHoRUS, sub. DR159, p. 7) that replacing CFHNs with less qualified workers would undermine the effectiveness of child health services. The Commission reiterates that — while having a CFHN deliver health visits is preferable — the employment of lesser qualified workers to fulfil this role may be optimal in situations where a qualified CFHN cannot be supplied. This approach was supported by La Trobe University, which considered that:

Until sufficient numbers of qualified child and family health nurses are available, the recommendation to educate remote area nurses and Aboriginal health workers in child health checks should be supported. (sub. DR171, p. 5)

#### RECOMMENDATION 12.4

***Governments should provide access to child and family health nurses in as wide a range of locations as possible. In areas where this is not possible, other health professionals, such as remote area nurses and Aboriginal and Torres Strait Islander health workers, should receive training in child health.***

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**Box 12.3 Healthy Under 5 Kids Education Package**

The Healthy Under 5 Kids Education Package is a stand-alone, self-directed education package for remote-area practitioners who do not have a background in child health. It is designed to support them in the delivery of preventive child health care, including age-specific child health checks, growth assessments and vaccinations.

The package takes 20 hours to complete. This study time is generally spread over approximately 12 weeks. Since its launch in August 2010, 120 workers, including remote area nurses, Aboriginal and Torres Strait Islander health workers and other staff in remote areas, have enrolled in the package.

Nurses are able to obtain continuing professional development (CPD) points for completion of the training package. Completion (with additional assessment) can be counted towards a Graduate Diploma in Child and Family Health at Charles Darwin University.

*Sources:* Northern Territory Government (nd); Northern Territory Department of Health, sub. DR365.

Despite the likely benefit of the child health training recommended by the Commission, attempts to make it compulsory before nurses or AHWs take up posts in remote areas should be avoided, as such requirements are likely to reduce the available workforce in those areas. Moreover, training packages can be designed for remote delivery, and thus can be undertaken by health professionals who are already working in remote areas.

Chapter 9 considers rural and remote issues for the early childhood education and care workforce. Many of the recommendations in chapter 9, including those relating to housing, professional development and support, will also be relevant to health workers. For instance, health professionals providing child health services in remote areas should have access to housing and to relevant technology for training and development purposes.