**Submission by NT Department of Health to Australian Government Productivity Commission Draft Research Report: *Early Childhood Development Workforce.***

NT Department of Health is pleased to be able to provide these comments to Australian Government Productivity Commission Draft Research Report: *Early Childhood Development Workforce.*

Overall this draft Report provides a detailed & thorough analysis of the workforce issues around this key area of service provision for children & families in Australia. While the draft Report defines the Early Child Development (ECD) sector from an appropriately broad perspective, the focus of the Report's chapters & recommendations is on the Early Childhood Education & Care (ECEC) sector reflecting the Terms of Reference of the request from the Australian Government.

While the intent is to consider the national ECD sector, the differentiation of the workforce issues that confront the different sectors of this ECD workforce across Australia could be more clearly expressed. Thus, while the Early Childhood Health workforce in Australia is largely composed of professionals with graduate qualifications, who are mostly formally licensed & who usually work in well developed professional systems, the bulk of the draft Report and its recommendations focus on the training and licensing issues of importance to the provision of ECEC services in Australia. Some of the workforce issues affecting the Early Childhood Health workforce are reviewed in Chapter 12 of the draft Report, however the recommendations of this chapter could provide greater guidance to jurisdictions attempting to provide this key service for their children as there are modest offerings in relation to the Early Childhood Health workforce elsewhere in the recommendations.

Significantly, while the draft Report legitimately considers the cost-effectiveness of child health services in Australia, to better inform consideration of future child health workforce needs, the critical analysis of the evidence is limited in relation to the delivery of measurable improvements in outcomes for children from the provision of ECEC services in the consideration of future ECEC workforce requirements.

The draft Report could have usefully included consideration of the growing body of evidence that not all ECD funding & programs have been able to demonstrate measurable improvement in outcomes for children (as described in the attached NT Early Childhood Series Paper No. 4 *The value of investment in the early years: Balancing costs of childhood services*[1]). Reports such as the UK Audit Commission Report *Giving children a healthy start* (February 2010)[2] have identified that significant public expenditure on Early Childhood Development programs has produced little evidence of measurable health & development benefits for children. Importantly, that Report also identified that, while there was evidence of ECD interventions that were producing measurable improvements for children in UK, there was concern that ECD services in UK were failing to adopt the programs that were more effective. It would, thus, appear to be a clear priority for this analysis of ECD workforce issues in Australia to attempt to ensure greater cost-benefit from ECD services in Australia than that demonstrated in UK.

It needs to be noted in the context of this draft Report that while most ECEC & ECD programs draw upon the efficacy studies of a few key Early Childhood Development interventions to substantiate their programs, the referenced interventions are seldom

implemented with fidelity, even in the face of evidence of loss of efficacy (as described in the attached NT Early Childhood Series Paper No. 2 *The first 5 years: Starting early*[3] & NT Early Childhood Series Paper No. 3 *A population approach to early childhood services: Implementation for outcomes*[4]). Furthermore, while many interventions & programs may be regarded as promising, it is essential that these promising interventions first demonstrate their efficacy before any attempt is made to implement them more widely[5].

The significantly compromised health, educational & other life outcomes that continue to be documented for children from vulnerable families in Australia[6], in the face of often significant growth in funding for ECD & ECEC programs[7], graphically demonstrate the importance of both funding agencies & service providers of ECD services in Australia undertaking much more critical consideration of ECD programs and of the workforce that delivers them.

It would appropriate for the draft Report to consider the findings from the Cost Quality Study undertaken in 1999 by Lally in USA[8], which identified that for some child outcomes, the children whose mothers had lower levels of education (children often at greater risk of not doing well in school) were more sensitive to the negative effects of poor quality child care and received greater benefits from high quality child care. Importantly, for these children attending typical child care centres, these influences of child care quality were sustained into their second grade. Studies such as these require proponents of ECD & ECEC services to be much more cautious about the impact on vulnerable children of ECD & ECEC services.

Specific comments in respect of *Chapter 12 Child Health Workforce* of the draft Report:

- It is important that the draft Report acknowledges that while it continues to be unclear in published evidence that health checks alone have any measurable impact on improving outcomes for children, the current system of well-child care based on an ongoing program of contacts with a child health nurse represents nationally accepted best practice.

  Indeed, while the Australian Government continues to invest significant funds in regular health checks of vulnerable children by medical practitioners, in the face of this lack of evidence, there is accumulating evidence that vulnerable infants in remote Northern Territory have greater contact with clinicians (doctors & nurses) to address significant health problems than most children in Australia, but have the least utilisation of programs of well-child care & normal parenting support[9].

  It is salutary that the programs with the greatest level of evidence of efficacy (*Nurse Family Partnership*[10]) rely on a regular schedule of contact between a nurse & a vulnerable mother/ caregiver which supports the mother's interaction with her child, and does not focus on treatments or remediation of problems.

- It would be helpful for this chapter to include additional explanation about the development of *Healthy Under 5 Kids Education Package* (p 234) to avoid any possible misapprehension that such a program would be preferable to formal graduate child health training:

  > The HU5K Education package was developed to support Remote Area Nurses and Aboriginal Health Workers in NT, who are expected to deliver child health services in the *Healthy Under 5 Kids* program. Access to specialist qualified child

health staff continues to be extremely limited for children & families living in remote areas of Australia - due to a number of factors, including that few of these nurses have child health qualifications; that few qualified child health nurses take up positions in remote areas of Australia; & that there are few dedicated child health positions in remote areas. The realities of providing health services in remote communities (with often low population numbers permitting low staffing numbers) mean that staff in those situations must have wide skill sets. At the time, there were also few credible training programs in child health geared for Aboriginal Health Workers.

The HU5K education was never intended to replace the role of the specialist child health nurse - the package was designed to enhance the skills and knowledge of existing staff in remote communities who needed to provide health services to children. Charles Darwin University was engaged to develop the package so that it would meet the learning requirements for adult learners, as well as to permit a link between health practice and post-graduate study.

Since the HU5K Education Package was launched, there has been interest in the package from across Australia amongst organisations that have staff providing health services to children and families in remote areas.

- *Box 12.3 Healthy Under 5 Kids Education Package* (p 234) – requires an amendment in the last paragraph: "...Completion can be also counted towards a Graduate Diploma in Child and Family Health at Charles Darwin University" *should say, "...Completion with additional assessment can be counted towards a Graduate Diploma in Child and Family Health at Charles Darwin University".*

- Although many child health services refer to the provision of *universal child health services*, most evaluations have shown that they are more likely to be utilised by families with higher levels of financial & personal resources, and that few of these services can demonstrate the engagement of a significant proportion of vulnerable families, in spite of the intent & efforts of staff delivering these services. The exception to this would be child health services that attain very high measured coverage rates. Indeed, the provision of population-level services and programs is often more likely to deliver reductions in health inequities than can be delivered by services or programs that simply "target" vulnerable groups. This is especially so if the service or program has been shown to be of less benefit for children of more advantaged families.

- It is important to recognise that while the *Nurse Family Partnership*[10] nurse home visiting program has very strong evidence of significant & measurable improvement in health, developmental & other life outcomes in several randomised controlled studies through the use of nurses to support new mothers over several years, the same program has demonstrated lack of efficacy when that support is provided by workers other than nurses. It is important to understand that the nature of the interaction of the nurse with the mother/ caregiver in this program is very different to the kind of services delivered by most infant & child health programs in Australia. Indeed, few Australian child health services have changed the nature of the services that they deliver to utilise this much more structured program. This apparent resistance of child health services to adopt this proven evidence-based program requires investigation.

- There continues to be marked heterogeneity in the delivery of Child Health Services across Australia, which in some instances is continued into the

jurisdictions themselves – a heterogeneity which cannot be justified by any similar variation in the needs of children in Australia.

A series of expert papers addressing Early Childhood Development that has been prepared by Menzies School of Health Research to inform the development of the NT Early Childhood Plan could usefully contribute to the Productivity Commission's further consideration of the ECD workforce & of the cost-benefit of the services that this workforce delivers.

References:


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4. Robinson G, Silburn SR, 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.
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