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Management of Maternal and Child Health Services in Victoria Australia: Education or Health Portfolio

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Abstract

In Victoria, Maternal and Child Health (MCH) service is currently located within the State Government's Department of Education and EarlyChildhood Development (DEECD) portfolio. This department is accountable for the planning and provision of early childhood services in partnership with local government. The MCH service has experienced many changes in State Government departmental portfolios over the years.It was therefore considered relevant to explore the knowledge, attitudes and beliefs held by the MCH workforce in regards to the portfolio that they considered should manage the MCH service.A qualitative exploratory descriptive approach was used to explore the Knowledge, attitudes and beliefs of the Victorian MCH nurses regarding the positioning portfolio for the service. The involved interviewing 12 key stakeholders and 36 MCH nurses until data saturation was reached. Presented are the findings that indicated that the majority of the participants believed that the service did not belong well currently in either Victorian Government Education or Health portfolio. The strength of this opinion, however, highlights the need for some collaborative discussion with all concerned parties in order to appropriately position the MCH service in order to achieve optimum outcomes for children in Victoria.

Keywords: Maternal & Child Health, Education, Health, Early Childhood Reform

1. Background

The Maternal and Child Health (MCH) workforce has been regarded as a speciality field of nursing in Victoria for many years with their increased level of complex care and client responsibility (Edgecombe, 2009; Scott, 2011; Schmied, Donovan, Kruske, Kemp, Homer & Fowler, 2011).

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Furthermore, it has been recognised in the literature that the early years provide the foundation for lifelong physical, social and emotional wellbeing (Shonkoff&Meisels, 2000), with MCH nurses being uniquely placed to influence these critical periods in a child's life by promoting consistency of service. MCH nurses are internationally recognised highly skilled independent specialist nurses who take a holistic approach to health care along with being at the fore front of Early Childhood service contribution in the community.

Victorian MCH nursesare qualified as General Nurses, Midwives, and have attained a Post Graduate Diploma or Master's degree in Child and Family Health Nursing (DEECD, 2013).Following the birth of a baby the local council is notified via a birth notification from the hospital that a baby has been born in the local area. These babies are then allocated to a specific MCH community centre to undertake the care and then the MCH nurse contacts the mother to initiate a home visit. The MCH nurses visit 95 to 98 % of all Victorian mothers with newborns at home within two weeks following discharge from hospital (DEECD, 2011). After this home visit, women then attend the MCH center for their infants' Key Ages and Stages (KAS) assessments. This means during the assessment of the baby the MCH nurse checks the baby's gross and fine motor development, cognitive development and attends a physical assessment. During these visits the mother's physical, social and emotional health is also reviewed. The MCH service is a universal primary health-care service which is offered across the state. The MCH service program includes health assessment, health promotion, preventative education, early detection and intervention.

In Victoria, MCH nurses are employed by local government authorities while the MCH service is currently located within the State Government's Department of Education and EarlyChildhood Development (DEECD) portfolio. This department is accountable for the planning and provision of early childhood services in partnership with local government (Schmied et al, 2011).The MCH service has experienced many changes in State Government departmental portfolios over the years.These changes had occurred as a result of changes in Government as one political party makes changes when they are in office that were changed again if the political party changed at the next election. In 2007 the MCH service was moved from the Department of Human Services[now Department of Health] to the DEECDportfolio (DEECD, 2013).

This change from health to education had occurred because one of the aims of the political party of the day was to improve the education of children. With MCH caring for infants from 0 to 6 years old it was deemed important to move the service from the Health to the Education portfolio to help achieve that aim. Thistherefore placed theMCHservices in Victoria as the only jurisdiction in Australia to be located in the Education portfolio.The MCH services in all the other jurisdictions across Australia aresituated within a Health portfolio.It was therefore considered relevant to explore theknowledge, attitudes and beliefs held by the MCH workforcein regards to the portfolio that they considered should manage the MCH service.To date there has been no published literature exploring this particular topic. This study intends to address this deficit.

2. Methods

A qualitative exploratory descriptive (QED) research methodology informed by Patton (2002) and Sandelowski (2000)was employed for this study. This approach was undertaken as it is an appropriate methodology for collecting information when little is known about the phenomena and where data is too complex to be captured using other methods(Maxwell, 2006; Patton, 2002).

The study aimed to explore the knowledge, attitudes and beliefs of the key stakeholders (KSH) and MCH nursesin Victoria regardingwhich portfolio they considered should be managing the MCH service. Interviews were undertaken with the 12 KSH who were working either in management, academia,or service coordination from different influencing positions, for example; Municipal Association of Victoria (MAV) or Coordinators of Family and Children's Services andLocal Government. Interviews were also undertaken with36 MCH nurses across Victoria.Full ethics approval from RMIT University's Human Research Ethics Committee and DEECD was granted.

The participants were recruited using purposive sampling through advertising in the Victorian Association of Maternal and Child Health Nurses (VAMCHN) journal and at the DEECD state conference in 2010. Interested participants contacted the researcher with their expression of interest in participating and interviews were organised at a time and place to suit both parties. Recruitment continued until data saturation was reached (Sandelowski, 2000).

This resulted in 48 interviews being completed which included 12KSH and 36MCH nurses.Prior to the interviews, all participants were given a consent form to sign and a plain language statement explaining the research.

Participants were interviewed with audio recordings taking approximately 45minutes. The interviews consisted of questions relatedto National Registration, National Framework, Qualifications, Service Provision, Professional Development and Organisational Change.One of the questions asked in the interviews of the KSH and MCH nurses was where they believed the MCH service should be situated; within the Education or Health portfolio. This paper presents this aspect that emerged from the data. Transcripts were identified numerically to ensure confidentiality and anonymity. Data analysis followed steps specified by Dey (1993) with contentanalysis as the chosen method of analysis for this study and used NVIVO to assist with data management (Bazeley, 2007; Richards & Richards, 2003).

3. Results

The age of the KSH ranged from 46 to 55. All had extensive nursing experience and held midwifery qualifications. The experience level of the KSH sample was between 1 to 20 years in upper management, higher service delivery and education with the majority having more than 10 years' experience. The KSH qualifications ranged from Graduate Diploma to Master'sdegree, with 4 holding a Master of Business Management degree.The age range of MCH nurse participants was between 34 and 65plus years while their range of experience was 1 to 35 plus years. The majority of these participants had a Graduate Diploma qualification with 10 having a Master of Child and Family Health Nursing degree. All were nurses with extensive nursing experience and a midwifery qualification.

3.1 KSH Perspectives

It was a widely held opinion of the KSH that the MCH serviceworks cooperatively with primary health care and early intervention services.This was part of the reason for their location within the health portfolio.The majority of KSH, however, believed that despite this cooperation, it was difficult to position the MCH service within either Health or Education

*"…Education is one of our roles… as primary health and preventative health with anticipating family needs… I've always felt that we're on the outer since we have been under DEECD services… under the Department of Human services… it seemed to fit and flow better… I am divided on that one…"*KSH2

This is supported by a number of other KSH who expressed that they were unsure whether the MCH service should be situated in Education or Health portfolios. These KSH reinforced this opinion with a number of reasons as to why this was so;

*"…we get lost in education unfortunately… we have to keep a connection with either education or health… we need to think health rather than education... because that is actually losing the nursing and health promotion element…"*KSH5

Being under the education portfolio, however, was seen by a number of KSHto be an issue that was causing concerns with practitioners for a number of reasons. The quote also identifies that there are important aspects of both portfolio that are appropriate for the MCH service to be a part of;

*"… at the moment the focus is remained on education and MCH has become a secondary thing… I don't think it really matters which portfolio it's in… education and health are both lively important for children… health is dominated by the hospitals and education dominated by the schools… maybe we need some community service department…"*KSH4

In other words, the problem was that there are;

"… pluses and minuses with both… the danger of it staying with health was adopting the medical model… it could stay with education provided the department really take us on board not just as an afterthought…"KSH12

Overall the KSH did not believe the MCH service fitted well into either portfolio with one suggesting;

"… it can stay with education if there is a new department created… at the minute we are a health service in an education department and it's not working… the language is wrong… I don't think going back to a health model or the Department of Human Services is necessarily right either… "KSH3

3.2 MCH Nurse Perspectives

The MCH nurseswere collectively grouped into three groups depending on their years of experience (A: 1 to 5 years; B: 6 to 14 years; C: 15 years and over) and are identified in the data accordingly. The comments in the data indicated that the MCH nurseswere likewise divided on where they believed the MCHservice should be located. A number of MCH nursesbelieved the service should return to the Health portfolio for a variety of reasons, as identified in the following quotes;

"… Health… we deal with the physical and mental health primarily of mothers and infants… I see that we are more providing education… to obtain healthy outcomes…" MCHC1

Likewise other MCH nursessupported the fact that the service should be in the Health portfolio but for different reasons to those previously identified. TheseMCH nurseswere definite in what their position was as a health professional and expressed the view that, this should be the basis on which the decision as to which portfolio the service is situated;

"… if I wanted to be a teacher I would be a teacher… I am a nurse I belong where health belongs... the education department… we just don't fit there… we are like a round peg in a square hole…" MCHB6

In other words;

"… it should be in the Health Portfolio... because that is what we are all about… we are all about health… yes we do educate but we educate them on their health…" MCHA11

Nevertheless, a number of MCH nursesin the data believed that the service should be positioned in Education. A number of reasons were stated in support of this position;

"…in education… it's saying that this is the beginning of this child's foundations for their educational career… at the same time there has got to be the health element there because we are looking at typically developing behaviour…" MCHC2

Interestingly the following MCH nurses believed the Education portfolio would be better as it was a political safety net. This was because of the relative government spending on education at that time compared to the uncertainty of funding for the Health portfolio:

"… a tricky one... I think it is correct in the Education Portfolio because politically it is less under attack from politicians who always slash the health budget and who are less likely to want to destroy the Education service because of the undisputed value of the early years…" MCHA12.

To some MCH nursesit did not matter which portfolio the service was situated in, it was more important that the service was valued within either portfolio for its contribution to the community;

"… I haven't had any problems with it moving over to the DEECD…It doesn't matter… as long as it is well respected in whichever department is that's okay…" MCHC8

Then there were a number of MCH nurseswho were uncertain as to which portfolio the service should be situated. In addition they perceived where to position the service was a difficult decision to make;

*"… I sit on the fence because.... Health is about education…"*MCHA1

While there were a number of MCH nurses who believed that the service could be in either Health or Education, there were also a number that indicated that they would like to have the service remodelled into an amalgam of both portfolios or in fact a separate portfolio altogether. In other words;

"… both... we play a very big part in education and are also advocates for health…" MCHA10

In other words;

"… we sit in between both… we don't really sit it ether camp very well… we work with the well not the unwell… we also do anticipatory guidance… really we have a foot in both camps so where ever we sit it's not ideal and we always want to be in the other camp…"
MCHB11

This last quote encapsulates the complexity of the issue and why there was a suggested solution made by both groups, KSH and MCH, for a completely different department.

4. Discussion

The KSH and MCH overall were unsure as to which portfolio the serviceshould be situated in, with a strong belief in the requirement for a portfolio that encompassed both health and education or a separate portfolio altogether.The MCH service has been seen as a very successful service over the years (Edgecombe, 2009; Scott, 2011). Part of the reasons why the service was deemed successful could be associated with which department the service was attached to as this influenced policy direction, budget and the service framework. As a result of the move to the Education portfolio, for instance, the Victorian MCH service has been seen to develop more of a research based practice model.This belief, however, was not reflected in the data given the perceptions held by a number of KSH and MCH nurses of the incongruence of a health service model being delivered by an education portfolio.

Furthermore, the way the respective portfolios define themselves highlights conclusive differences in reference to the MCH service. For instance, the Department of Health's core objectives lie with 'achieving the best health and wellbeing for all Victorians' through planning, policy development, funding and regulating health services (Victorian Department of Health, 2013). It is well documented in the literature that health promotion is a large component of the MCH service and that it is integral in the wellbeing of the early childhood population (DEECD, 2013). The DEECD in contrast, offer in their mission statement to, 'ensure a high quality and coherent birth to adulthood learning and development system to build the capacity of every Victorian'.

This is followed by DEECD's key responsibilities' to; inform outcomes that the department strives to achieve within its birth to adulthood learning and development agenda with outcomes to reflect that children have the best start in life to achieve optimal health, development and wellbeing (DEECD, 2013). Thisin itself, however, does not reflect the essence of the MCH service and their contribution to the health and wellbeing of Victorian families. Specifically, the MCH service contributes to public health through health promotion which entails assessment, offering the parents anticipatory guidance and preventative strategies to promote optimal health and wellbeing of families. In addition, the observation of families is routinely undertaken in order to identify deviations from normal and this enables the vulnerable families that require further support to be identified and engaged in early intervention. Health promotion empowers people to increase their control over their health and make changes to improve health outcomes, which are very much the role of the MCH service (Diener and Chan, 2011).

Despite the evidence of the nature and complexity of the MCH service, it would appear from the data that there is a perception that DEECD lacks an appreciation of what the service entails and therefore, the question remains whether this is the correct portfolio for the MCH service to be situated in. This is further evidenced by the Auditor General's report on Access and Quality of the Early Childhood Development Services(Victorian Auditor General's Report, 2011). The report highlighted the importance of not only promoting the health and learning development of young children, but that the quality of the programs enhance and have a marked effect on the children's longer-term health, educational and social outcomes. This is especially evident with the children from vulnerable and disadvantaged families. The DEECD has been accountable for planning and providing MCH services since 2007 (DEECD, 2013), which also includes enhanced MCH services for vulnerable children, disadvantaged families and universal kindergarten. The audit by the Auditor General examined whether access to early childhood services has improved over this time and if services were meeting the required standards.

The significant finding tabled from the DEECD report (DEECD, 2013) however,were that access to universal MCH, vulnerable children, disadvantaged families and universal kindergarten had in fact improved, with records indicating increased participation rates over the past five year period to 2010.

Despite this, the Auditor General's Report (2011) identified that DEECD could not demonstrate that early childhood services were being offered especially for vulnerable children and families in areas of significant need. The audit further identified that the department's inability to consistently identify all vulnerable children and disadvantaged families meant it did not know to what extent these children were missing out on the benefits of specific services developed and funded to meet their needs. In addition, the report indicated that DEECD does not sufficiently understand or effectively manage early childhood services (Auditor General's Report, 2011).

There is no doubt that DEECD has had a number of achievements since taking on the MCH service, such as refining the structure of the service as well as instigating professional development of 1,200 MCH nurses (DEECD, 2009) in key areas such as, domestic violence, postnatal depression, QUIT smoking, SIDS and sleep settling. Part of the issue here is, however, whether the MCH nurses value being under DEECD or instead that the department does not recognize the complexity and uniqueness of the service that MCH nurses provide. The principle behind the MCH service is health, which could further explain this confusion. It is clear from this that MCH nurses do not see themselves as educators promoting early childhood development, when their role primarily encompasses health promotion. This reflects the general confusion regarding the definition of health promotion as identified in the literature. For instance, Dunkley (2000) suggested that health education is often confused with health promotion. Health promotion is actually about activities that seek to promote healthy lifestyles with education being a part of that process. These terms, however, are not interchangeable. Health promotion is all encompassing with the MCH service being in a unique position with families to guide the adoption of a healthy lifestyle while raising awareness of health and development issues. This study clearly demonstrated the need for further investigation of the most appropriate portfolio to manage the MCH service. The MCH nurses reflected in the data on how the MCH service could move forward to enhance the synchrony between the service providers and management in order to benefit the community. However, for many MCH nurses the question remains; are the governing bodies trying to put a square peg in a round hole having the MCH service in the Education portfolio or are they trying to 'round the pegs or square the holes' with the MCH service to make it fit. A suggestion made from the participant's data in this study was the development of a separate portfolio all together. This of course would hardly be a realistic outcome.

The strength of this opinion, however, highlights the need for some collaborative discussion with all concerned parties in order to appropriately position the MCH service in order to achieve optimum outcomes for children in Victoria.

5. Conclusion

This article offers insight into the beliefs and opinions of the KSH and MCH nurses in regards to which portfolio they believe the Victorian MCH service would be best positioned. The findings indicate that the KSH and MCHnurses believe the service would be better positioned in aState Government portfolio other than the Educationor Health.This is because both of these portfolios have different emphases and do not capture the true essence of the Victorian MCH service. With the current review of the MCHservice commissioned by DEECD in 2013, it is trusted that the review will identify the most appropriate positioning of the service in order to maintain the integrity that has given Victoria the high health outcomes identified to date. It is recommended that further investment in collaborative research as to where the MCH service would be situated should be undertaken with a multi-level cross sectional perspective from relevant key professional bodies from Victoria, KSH involved with service delivery and the MCH workforce.

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