Healthy Starts

The state of Australia's child and family health service system

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CPD CENTRE FOR POLICY DEVELOPMENT

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ACRONYMS USED IN THIS REPORT:

ACCO	Aboriginal Community Controlled Organisation
ACCHO	Aboriginal Community Controlled Health Organisation
AEDC	Australian Early Childhood Development Census
CALD	Culturally and Linguistically Diverse
ECD	Early Childhood Development
ECEC	Early Childhood Education and Care
EPDS	Edinburgh Postnatal Depression Scale
GP	General Practice / General Practitioners
MBS	Medicare Benefits Schedule
MECSH	Maternal Early Childhood Sustained Home Visiting
SNHV	Sustained Nurse Home Visiting

Executive summary

Australia is at a pivotal moment in early childhood reform. From increases in Paid Parental Leave, a commitment from the Prime Minister to universal early childhood education and care, national collaboration on *Thriving Kids*, and the establishment of IDAC and PLACE, we have the opportunity to make Australia the best place to be a child and raise a family.

A high-performing early childhood development system requires strong, universal service foundations that support families from pregnancy through to school entry. While recent reforms have strengthened some parts of the early years system, the child and family health service system has received comparatively less attention. This is despite its essential role in supporting child and family health and wellbeing throughout the perinatal period, ensuring healthy pregnancies, identifying developmental and health needs early, and connecting families to care over time.

Recent reforms clearly show that families can thrive when they have earlier, more accessible and better coordinated support. In particular, *Thriving Kids* reflects an important shift towards supporting children and their families with developmental delay earlier and more inclusively.

Health services are often the first and most consistent points of contact for families in the early years, where trust is either built or eroded, shaping how families engage with both health care and broader supports over time. Without a strong and coherent child and family health service system, risks to the child or family can go undetected, services fail to maintain the trust and engagement of families, and opportunities for early intervention are often missed.

A strong child and family health service system must support both children and the parents, carers and kin who care for them. This includes recognising maternal physical and mental health after birth not only as important in its own right, but as central to children's development, family wellbeing and sustained engagement with services.

The child and family health service system is also central to several broader reform shifts needed across early childhood policy: from treatment to prevention; from targeted, crisis-driven responses to flexible access to support connected with the universal system; and from specialist care delivered outside everyday settings to earlier, community-based support in the places where children and families live, learn and build relationships.

Drawing on national and jurisdictional data, desktop research, policy and clinical guidance, and sector and community insights, this report maps the health and development journeys of children and families from conception to age five. It focuses on the system as it is currently experienced by families, identifying systemic challenges and opportunities.

The report identifies three key transitions where support either connects or fragments. CPD uses these transitions to show the intersecting health services, funding streams, practitioners and settings that families interact with to support the health, development and wellbeing of children and their families:

1. **Pregnancy recognition and antenatal care**
2. **Support from birth to home**
3. **Development beyond the newborn period**

Based on this mapping, the report identifies the system-wide policy barriers to children and families' accessing a high-quality child and family health service system. These include:

1	**Availability and access to services can be limited**	Access to health services across the first 2000 days varies widely depending on where families live, what services exist locally, and whether those services can offer continuity of care and choice. Workforce shortages across general practice, midwifery and child and family health nursing mean many services operate at or beyond capacity, limiting appointment length, outreach and relational care. These pressures are particularly acute in regional, remote and fast-growing outer-metropolitan communities, where families may face long wait times, closed books, limited transport options and little or no access to continuity-based maternity care or enhanced and sustained home visiting.
2	**The cost to parents and families is too high**	The cost of health in the early years can delay families' first contact with the system and reduce opportunities for prevention, screening and relationship-based support. This is particularly significant in pregnancy and the early years, where timely engagement with general practice, maternity care and Child and Family Health services shape the care pathways that follow. Rising out-of-pocket costs, limited bulk billing[1], inadequate rebates for longer and more complex consultations, and Medicare eligibility restrictions in some states[2] mean that early pregnancy support, screening and referral can depend on a family's ability to pay.
3	**Services are not consistently culturally safe**	The child and family health service system is not consistently designed to deliver culturally safe care. For many Aboriginal and Torres Strait Islander and culturally and linguistically diverse families, access is shaped not only by whether services exist, but whether they are trusted, linguistically accessible and responsive to family, culture and community context. Experiences of racism, dismissal, cultural disconnection and punitive responses can undermine trust and deter families from engaging with care. Culturally safe, community-led models such as ACCHOs, Birthing on Country and Connected Beginnings show what effective care can look like, but these models are not consistently available or sustainably funded.
4	**Services are not constantly inclusive of children with developmental needs and diverse families**	The system does not consistently engage children with developmental support needs and their families in an inclusive and accessible way. Developmental concerns are not always identified early, and families can struggle to have their concerns heard and be connected to timely support. Diagnosis-based pathways can delay access and medicalise developmental differences, particularly for children with emerging or lower-level support needs. More inclusive pathways, such as those proposed through *Thriving Kids*, would allow children, parents, carers and kin to receive support based on identified needs rather than diagnosis alone.
5	**Service design settings constrain flexibility, investment in prevention and continuity of care**	Across maternity care, general practice and Child and Family Health services, funding, eligibility and program design limit how support can scale as family circumstances change. Too often, services are structured as binary – standard or targeted, eligible or ineligible – rather than as a continuum of support that can flex in intensity according to need. Short appointments, rigid eligibility criteria, underfunded services and limited access to continuity-based models make it difficult for practitioners to build trust, identify concerns early and provide preventative, relational support before needs escalate.

6	**A lack of system and service integration**	Families often experience the child and family health service system as a series of disconnected encounters rather than as a seamless pathway. Referral and handover processes between general practice, maternity services, hospitals and Child and Family Health services remain inconsistent across jurisdictions, with many transitions relying on manual processes, local discretion or parent-initiated contact. Funding models do not properly support coordination, health and early education pathways are rarely integrated, and fragmented digital systems mean continuity of care depends too heavily on individual practitioners rather than system design.
7	**Low public awareness and knowledge of Child and Family Health services**	Families can only engage with services they know exist and understand how to access. Public knowledge of Child and Family Health services remains low compared with hospital-based maternity care or general practice, and many families do not understand the role of these services or when to re-engage after the early postnatal period. Inconsistent service names across jurisdictions, fragmented information, unclear self-referral pathways and reliance on written materials make the system difficult to navigate, particularly for families with low health literacy, limited English, unstable housing, limited digital access or low trust in institutions.
8	**Limited data and digital infrastructure**	Australia's child and family health service system still relies heavily on paper-based records and manual communication, leaving families to carry responsibility for continuity. Pregnancy records, child health books, birth notifications and developmental monitoring systems are not consistently digitised or interoperable across general practice, hospitals, Child and Family Health services and other providers. This limits timely coordination, creates risks that referrals or follow-up are missed, and reduces governments' ability to understand who is accessing services, when families disengage and where universal services are failing to reach children and families.
9	**A lack of national oversight prevents consistency in quality and investment**	System governance and professional guidance across the first 2000 days is fragmented across the Commonwealth, states and territories, and local government. This split in responsibilities has produced parallel systems that do not consistently align around shared outcomes, service planning, workforce expectations, data collection or accountability. Unlike maternity care, which is supported by stronger national clinical guidance, reporting and implementation levers, developmental monitoring and Child and Family Health services lack a nationally consistent performance framework, minimum service expectations and clear accountability. As a result, access to high-quality, best-practice care depends too heavily on geography.
10	**Social determinants are not consistently built into care pathways**	Australia's child and family health service system is not designed to respond effectively to the social conditions that shape families' lives or to comprehensively support the whole family in context. Housing stability, nutrition, income, transport, employment conditions, parent and caregiver mental health, family violence and social support all influence whether families can attend appointments, follow guidance and sustain engagement with care. While some services screen for social risks, identification does not always lead to support, and care pathways often treat these issues as external to health. This limits the system's ability to provide genuinely preventative, family-centred support.

This report makes the case for greater investment, focus and reform in the child and family health service system. A subsequent report will build from this evidence base to recommend how we can expand on the system architecture we have now, to ensure an integrated, consistent and equitable health system for all children and families in the future. This future child and family health service system should be progressively universal: available to all families, embedded in mainstream and community-based services, and able to be flexible in intensity according to need. It should provide culturally safe, inclusive and continuous support from pregnancy through to school entry; strengthen trust and engagement over time; connect families across health, early education, disability, family support and community services; and identify developmental and family needs before they escalate.

Strengthening the child and family health service system to be a core universal foundation is essential to shifting the early childhood system towards prevention, equity and earlier support in everyday settings, and to ensuring that all children and families are supported to thrive from the very beginning.

A note on terminology

Terminology referring to universal, community-based health and development services varies significantly across Australia. Through our research and consultation, CPD identified a wide range of service labels and naming conventions.

In this report, the following terminology is used for clarity and consistency:

- **Child and family health service system** – refers to the overarching system of care that supports families and children from the point of pregnancy recognition through to school entry (birth to five years). This includes all universal and targeted services that play a role in child and family wellbeing - such as general practice, antenatal and postnatal hospital care, midwifery, Child and Family Health services, allied health, and parenting and developmental support programs. The term is used to describe this continuum of health, development, and early parenting supports.
- **Child and Family Health services** – refers specifically to the state- and territory-funded services that provide universal postnatal, parenting, and early childhood development support. These are often referred to as 'well-child healthcare'. Key functions include delivering growth and developmental monitoring over time through the delivery of scheduled development checks at key ages; immunisations; health education; mental health assessments for caregivers; addressing the social determinants of health such as family violence; providing early intervention referrals; and delivering family-centred care.[3] These services are known under different titles across jurisdictions — for example, Maternal and Child Health (MCH) in Victoria, Child and Family Health Service (CaFHS) in South Australia, or Child and Family Health Services in New South Wales.
- **Early childhood development (ECD) system** - refers to the overarching set of systems that support children and their families in the early years. This includes early childhood education and care (ECEC), the child and family health service system and paid parental leave. It also extends to wraparound and place-based initiatives, and other programs such as playgroups, parenting programs and the NDIS.
- **Developmental Monitoring** – refers to the ongoing monitoring of health and development in children from birth to five years, a key function of Child and Family Health services. The term developmental surveillance is also sometimes used. CPD has chosen not to use this term as it can imply that families are being watched, potentially creating fear or a sense of unsafety for Aboriginal and Torres Strait Islander families or families concerned about contact with the child protection system. While monitoring is likewise an imperfect term in this context, it has been used for consistency with the language used by the sector and in the literature.
- **Progressive Universalism** - refers to a system of high quality, universal and responsive services and payments that are holistic and joined up. Based on children and families' aspirations, strengths and goals, they are connected with additional non-stigmatising support and the system is able to respond as needs change over time. CPD has chosen progressive universalism to capture a system-wide approach to embedding equity across service design, governance and delivery.

INTRODUCTION

Released in 2021, *Starting Better: A guarantee for young children and families* outlines a five-point national entitlement for young children and families to ensure that every young child thrives. It is based on evidence that a strong, well-connected early childhood development system will lift developmental outcomes, tackle entrenched disadvantage, improve gender equality, boost productivity, and grow our national economic competitiveness.

The core elements of the guarantee are:

- more paid parental leave (up to 52 weeks per family), shared between partners;
- universal access to maternal and child health (MCH) care, consistent across all states and territories, with additional support for families who need it;
- universal access to at least 30 hours or three days of free or low-cost quality early childhood education and care per week before children start school, including two years of preschool education;
- extra support for families to navigate the system; and
- more effective transitions from early learning to primary school.

While the guarantee focuses on Maternal and Child Health, this report expands beyond this to also look at the other health systems that provide preventative care to children and families from pregnancy confirmation through to school entry. **This system plays a distinct role in supporting families early, identifying developmental and health needs, and connecting families to the broader system of care.**

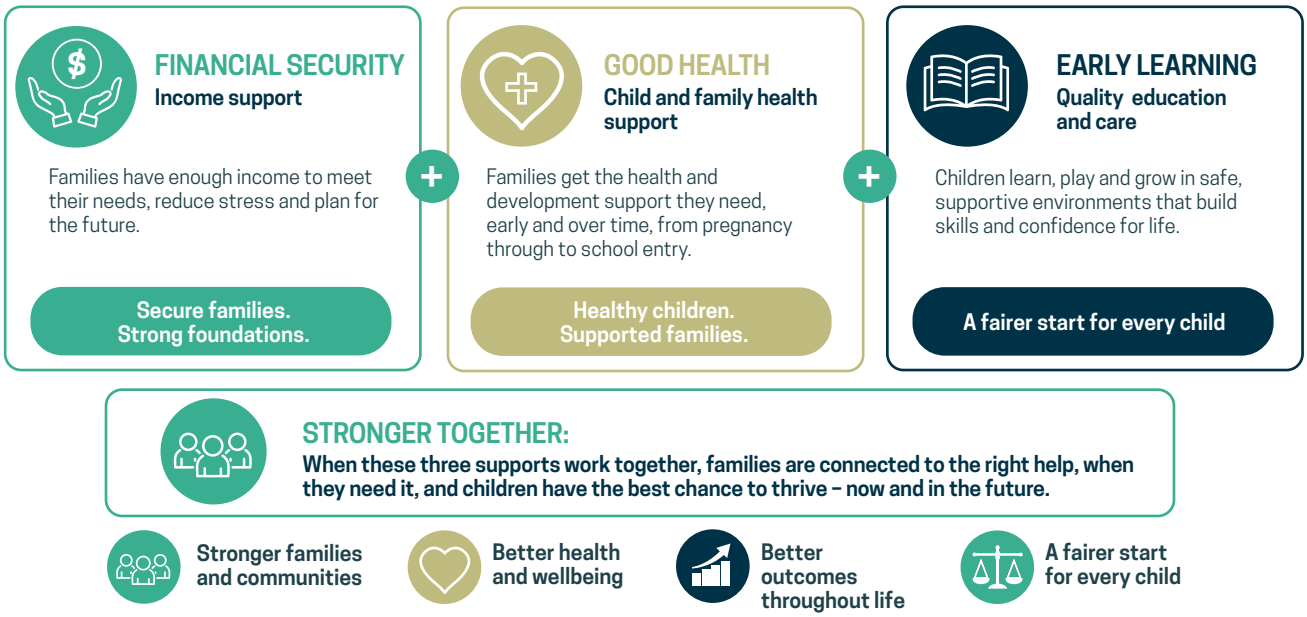
Strengthening the child and family health service system as a universal, preventative foundation is essential to realising the full benefits of early childhood reform across the guarantee.

Any reforms in the child and family health service system should not be implemented in isolation, but must be considered as a key part of a reformed early childhood development system as outlined by the guarantee. All components of the early childhood guarantee are critical to supporting thriving children, with each component of a well-connected system working together to support the best possible outcomes for children and families.

WHAT FAMILIES NEED TO SUPPORT CHILDREN TO THRIVE

A strong foundation in the early years builds lifelong wellbeing.

Families need three key supports working together – financial security, good health and early learning – so every child has the best start in life, in every community.



The child and family health service system plays a critical role in reducing inequities and shaping long-term outcomes. A well-designed child and family health service system can:

- **Identify developmental and health needs early**, enabling timely intervention when it has the greatest impact.
- **Proactively connect families to supports**, reducing pressure on families to navigate complex systems themselves.
- **Strengthen parental health, wellbeing and capability**, supporting early relationships and caregiving environments.
- **Provide continuity of care across key transitions**, building trust through sustained relationships with practitioners.
- **Improve access for families experiencing structural disadvantage**, through culturally safe, flexible and responsive service delivery.
- **Improve long-term outcomes and strengthen intergenerational equity**, reducing the risk of poor health, involvement with the justice system and contact with child protection.
- **Strengthen community connection**, linking families to other families, their community and reducing isolation.

Additionally, CPD's work on *Avoidable Costs*[4] and the Front Project's *Cost of Late Intervention Report*[5] highlight the substantial costs that governments incur by failing to address the root causes of social issues. In short, failure to properly plan for and address harms now, leads to higher costs down the track. This shows up significantly in areas like acute healthcare, criminal justice and income support payments. A high quality child and family health service system can deliver better outcomes and better value for public investment.

THE CASE FOR REFORM

The architecture delivering Australia's universal public health system is long-established, embedded within the social contract and reflecting widely held community expectations of equitable access to health care regardless of circumstance.

Families with consistent access to the preventative care provided across the child and family health service system benefit from earlier identification of developmental, physical and mental health concerns, timely intervention and referral pathways, and ongoing support to navigate pregnancy, infancy and early childhood. This access can strengthen parent and caregiver wellbeing, increase confidence and capability in parenting, and support secure attachment and optimal child development. Children in these families are more likely to be developmentally on track, reap the benefits of attending ECEC and will start primary school ready to learn. As a result, they are also more likely to secure better health and educational outcomes beyond the early years, have reduced interactions with crisis services and the justice system, and have stronger social and economic participation.[6]

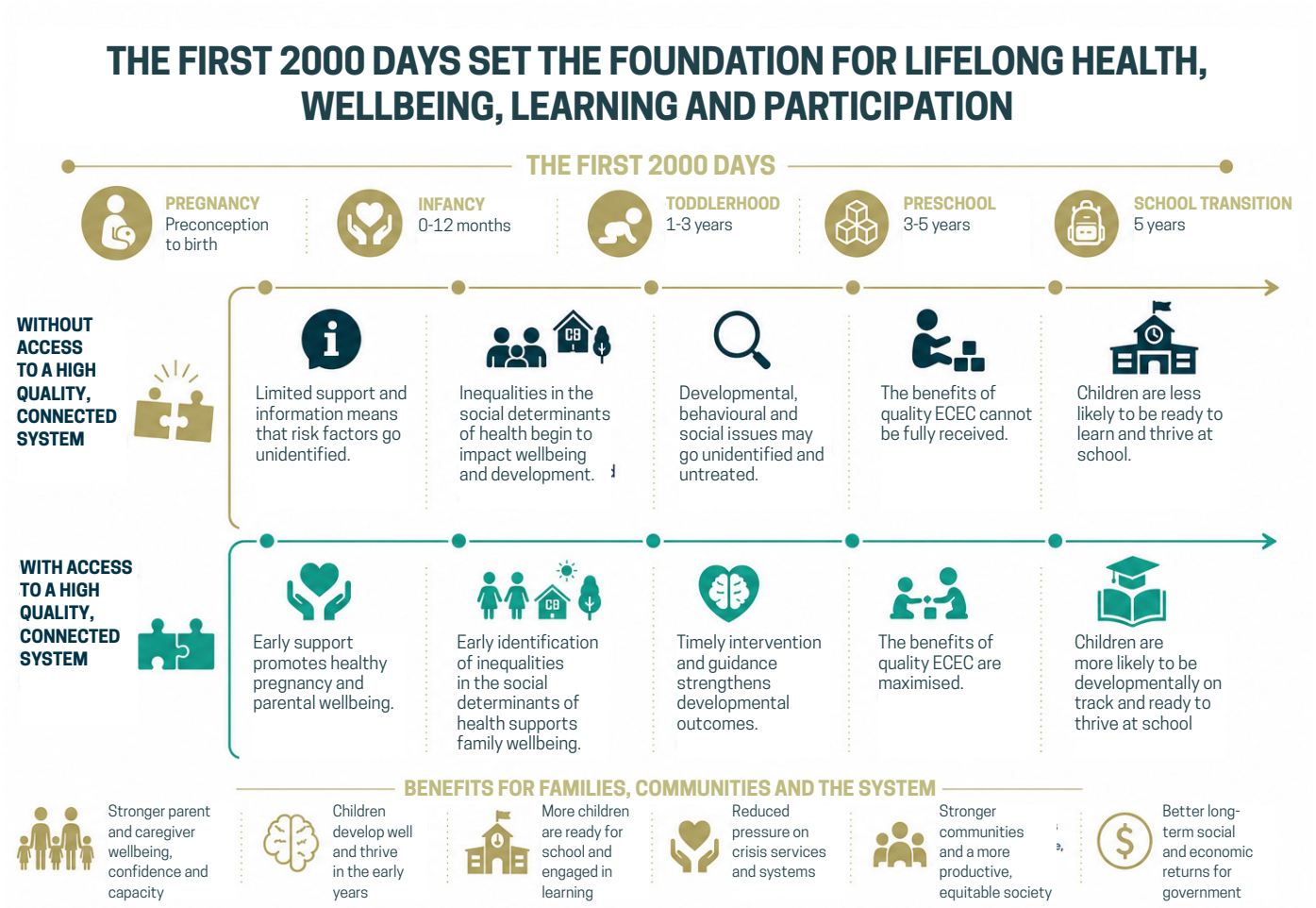
However, these outcomes are not the reality for an increasing number of Australian children and families. The Australian Early Development Census (AEDC) shows that early childhood development outcomes have plateaued or declined after a decade of improvement, with worsening trends in areas such as social competence and emotional maturity.[7] Around half of children identified as developmentally vulnerable do not catch up over time, highlighting the long-term consequences of unmet need in the early years.[8]

At the same time, children who would most benefit from quality health services are the least likely to access them, due to financial, cultural and linguistic barriers.[9] Currently, around one in six children in Australia are growing up in poverty,[10] with rates rising in recent years due to increasing housing costs and broader cost-of-living pressures.[11] Combined with this, AEDC data shows that children in the most socio-economically disadvantaged communities continue to be much less likely to be developmentally on track (41.2 per cent) than the least disadvantaged communities (61.1 per cent).

These inequities are particularly stark for Aboriginal and Torres Strait Islander children. Only around one-third are developmentally on track across all AEDC domains, compared to around half across all cohorts. The latest Close the Gap report shows that key early childhood and wellbeing targets are not on track,[12] although there are signs of progress in areas where Aboriginal Community Controlled Organisations (ACCOs) are leading the design and delivery of services.[13]

Parent wellbeing is also central to child development. Perinatal mental health conditions affect an estimated one in five mothers in Australia and can have serious effects on the health and wellbeing of women, babies and families when not identified and treated early.[14]

The broader system reinforces these trends. The *Thriving Kids* Advisory Group recently found that developmental delay is not consistently identified early in a child's life, when intervention can have the greatest impact, and highlighted fragmentation across services and missed opportunities to provide timely, coordinated support to families.[15] These patterns reflect a system that does not reliably engage all families early or provide consistent, coordinated support over time.



However, there is an opportunity to strengthen our child and family health service system so that it is progressively universal: **reaching all children and families with truly universal services that are capable of connecting them with whatever level of support is required.**

The announcement of *Thriving Kids* signals widespread recognition by government that supporting development through early-intervention is both a social and economic priority that requires the Commonwealth, states and territories to work together. The reforms signal a generational shift towards recognising the first 2000 days as a critical period for investment, creating momentum for earlier, more integrated and equitable support for children and families.

To realise its promise, *Thriving Kids* must be capable of engaging all population cohorts, ensuring that no children are excluded from early support due to inadequate access or the difficulty their families may face in navigating fragmented systems.

The child and family health service system has the potential to reach families at the earliest stages, build trusted relationships and identify developmental, health and wellbeing concerns before they escalate. The success of *Thriving Kids* and its short and long-term dividends for children, families and the broader community depends on strengthening the capacity of the child and family health service system to engage all children and families, particularly those facing the greatest barriers to access. Doing so can ensure the benefits of the reform are distributed equitably, permanently shifting disparate outcomes and promoting intergenerational equity.

System design, power and Aboriginal and Torres Strait Islander leadership

Any discussion of the child and family health service system in Australia must acknowledge and address the legacy of colonisation and its implications on system design. Research has continuously reiterated that 'a western paradigm dominates the design and delivery of healthcare services in Australia, with a focus on reactive rather than preventative healthcare and a narrow conceptualisation of health and wellbeing that negates many of the social, cultural, economic, spiritual and political drivers of ill health'.[16] These legacies continue to shape how services are designed, funded and measured. They influence which forms of knowledge are valued, which outcomes are prioritised and how families experience care. For Aboriginal and Torres Strait Islander families in particular, these structural features can undermine engagement and trust, highlighting the need for culturally safe, strengths-based and community led models of perinatal and early childhood care.[17] This includes critique from Aboriginal and Torres Strait Islander scholars of the narrow application of some western developmental frameworks, including interpretations of attachment theory that prioritise a single primary caregiver-child relationship rather than recognising the broader kinship, family and community networks that support child development.[18]

The advocacy and expertise of Aboriginal and Torres Strait Islander practitioners, organisations, researchers and communities have for a long time guided understanding of what culturally safe, self-determined care looks like. Aboriginal and Torres Strait Islander communities have a long history of pioneering a service model that is holistic, person-centered and preventative, with culture at its core.

CPD has drawn on Aboriginal and Torres Strait Islander-led research, policy frameworks and community-controlled service models to better understand the barriers families face in the current system and to identify examples of effective, culturally safe practice. This includes highlighting approaches such as Birthing on Country and First Nations-led care within Aboriginal Community Controlled Health Organisations (ACCHOs), which demonstrate how services can be designed to strengthen trust, continuity of care, and culturally responsive support for families.

This report recognises cultural safety, relational care and community governance as system design issues, not optional add-ons. Where barriers are identified as prohibiting access to services for First Nations families, CPD emphasises the structural conditions that contribute to those barriers, including racism and legacies of colonisation. In this way, the transition framework used in this report places children within the broader context of family, community and culture, reflecting a relational understanding of development rather than focusing solely on individual caregiver relationships. The transition framework also reflects the importance of continuity and relationships across the first 2000 days, principles that have long underpinned Aboriginal and Torres Strait Islander models of care.

Aboriginal and Torres Strait Islander advocacy has already established formal mechanisms for First Nations people to direct the design and development of policies related to child and family health services and systems. Through the Closing the Gap Implementation Plans and the Early Childhood Care and Development Policy Partnership, there are now formal opportunities for Aboriginal and Torres Strait Islander representatives to guide and support policy and reform efforts. However, an Aboriginal-led independent review of Closing the Gap, found that there is still a 'significant gap between what was committed to in the Agreement and what communities are experiencing'.[19] CPD supports Aboriginal and Torres Strait Islander self-determination as a fundamental principle that should underpin all reform, with the infrastructure in place to ensure that policies for First Nations communities are designed for and by Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander advocacy and expertise continue to guide understanding of what best-practice should look like and CPD has approached this report with that leadership front of mind.

The child and family health service system we have now

There are a range of public and private health services available for children and families in the first 2000 days. This report focuses on the public system, which is made up of a mix of funding and provision across the Commonwealth, states and territories and local government. Together they form the child and family health service system. They include:

- **Commonwealth-funded primary care:** Medicare is the key Commonwealth funding mechanism. It covers some of the costs of some services for card holders, including antenatal and pregnancy care, general practitioners (GPs), paediatricians and some allied health services provided through care plans (e.g. mental health, physiotherapy, etc.) Many of these are private services subsidised by Medicare.
- **Child and Family Health services:** States and territories operate Child and Family Health services which provide free developmental monitoring and support, with some jurisdictions jointly funding and delivering services with local government. While these services are intended to be universal, their scope, eligibility, and availability differ markedly across and within jurisdictions. Queensland and the ACT require Medicare eligibility for access, but services are otherwise free to all families.
- **Public hospital maternity services:** Public hospital maternity services (including labour, birth and postnatal care) are jointly funded by the Commonwealth and states/territories under the National Health Reform Agreement, but are primarily operated and managed by state and territory governments.
- **Aboriginal Community Controlled Health Organisations (ACCHOs):** ACCHOs provide a wide range of primary, maternal, child, family health, and specialist services. These community-governed providers work across universal and enhanced service streams, focusing on cultural safety, relational continuity, and holistic care. They are mainly funded by the Commonwealth Government through direct health grants and Medicare, with supplementary state/territory funding.
- **Targeted and specialist programs:** Targeted programs for families in need of additional care and support vary in design, geographic reach and eligibility across states and territories. These include sustained home visiting programs, or other enhanced supports. They are funded through a mix of Commonwealth, state and territory, and occasionally local government arrangements.

THREE KEY TRANSITIONS ACROSS THE CHILD AND FAMILY HEALTH SERVICE SYSTEM

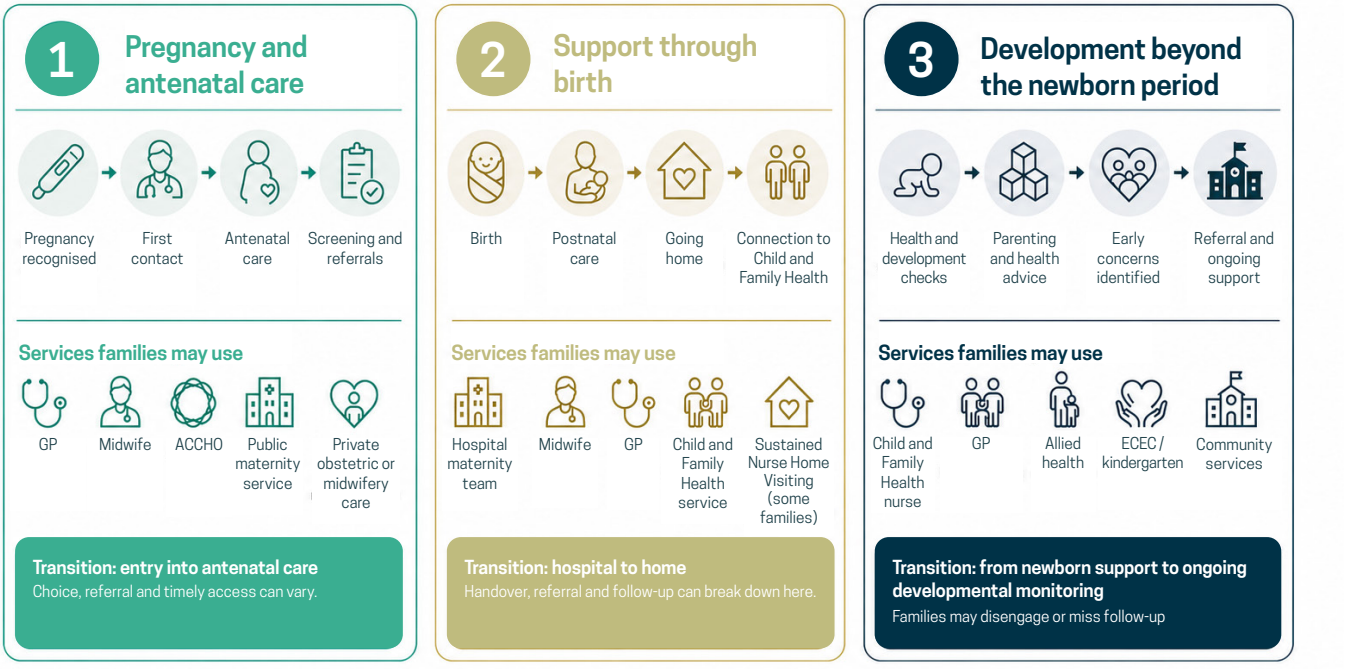
In the first 2000 days of a child's life, families experience key transitions. These are moments where responsibility shifts between services, funding streams, settings and practitioners. These transition points create both opportunity and risk. When they work well, they provide timely access to supports, strengthen relationships and continuity and enable early identification and support before needs escalate. When they work poorly, families can fall through gaps in referral and follow-up, face inconsistent advice or disengage all together. Analysing the transitions highlights where the system is currently connecting families to support, where it is fragmenting, and which system-level settings are driving those outcomes.[20]

With this broader context in mind, CPD has mapped the spectrum of health services available to families to support pregnancy, birth, health and development.

1. **Pregnancy recognition and antenatal care.** This transition starts a family's journey from when they find out they are pregnant and the care they receive throughout pregnancy. This is the first moment a family connects with the child and family service system. Timely pregnancy confirmation enables access to screening, early support, and models of antenatal care, including continuity-based options[21] where they exist. Early engagement increases the opportunity for informed decision-making and connection to preferred pathways. It also helps ensure care begins early enough for families to receive the recommended number of antenatal visits.
2. **Support through birth.** This transition encompasses the period throughout birth to initial postnatal care and follow up. Labour, birth and the early days lay the foundation for maternal recovery, infant wellbeing, and early attachment to family and caregivers. This is where the transition to the Child and Family Health service which should be seamless.
3. **Development beyond the newborn period.** This transition captures the movement from early postnatal supports to the system of health and development monitoring in early childhood up to five years of age. The months and years following birth are marked by rapid cognitive, emotional, and physical development for the child. This period presents a structured opportunity to maintain contact with families through universal health and development checks and to provide tailored support where needs emerge. These interactions can help families feel seen, supported, and confident, especially when delivered by trusted professionals in culturally safe, relational ways. Consistent contact over time strengthens early identification and response to developmental risks, supports parenting capability, and reinforces system continuity beyond the postnatal period.

A CHILD AND FAMILY HEALTH JOURNEY: FROM PREGNANCY TO AGE FIVE

A simple view of the main stages, services and transition points



TRANSITION 1: PREGNANCY RECOGNITION AND ANTENATAL CARE

The moment of pregnancy recognition and first contact with the health system is foundational. It marks the starting point for engagement with the child and family health service system, shapes physical and mental healthcare, access to screening, early support, and continuity-based models of care.

Entry into Care

It is recommended that a woman's first antenatal visit occur before 10 weeks' gestation to allow for timely screening, model of care selection, and care planning.[22] GPs remain the most common first point of contact, due to their central role in pregnancy confirmation and referral initiation.

However, families may enter care through a range of providers, including midwives, ACCHOs, hospital emergency departments, or emerging digital and pharmacy-based pathways. These pathways reflect differences in cultural safety, service familiarity, proximity, and cost. While these alternatives remain limited in availability, they may offer more accessible or culturally safe first contact options for families who face barriers in accessing a GP. ACCHOs in particular offer culturally responsive, relationship-based care that may include pregnancy confirmation, screening, and referral to maternity services.[23]

National data shows that only 59% of first-time mothers received antenatal care by 10 weeks' gestation in 2022, despite guidelines recommending early contact.[24] Ensuring that first contact is made before 10 weeks' gestation is significant, as it impacts the total number of visits a woman makes and, consequently, these low early contact rates have implications for meeting the recommended visit thresholds across pregnancy. Data for low-risk pregnancies shows that only 56% of first time mothers met the recommended 10 visit threshold in 2022, while 82% of women who had previously given birth reached the 7 visit benchmark recommended for subsequent uncomplicated pregnancies.[25]

Early pregnancy identification and engagement with the health system is essential, particularly when any existing physical or mental health concerns will require additional support throughout the perinatal period. Late engagement compresses essential milestones, limits opportunities for screening and informed decision-making, and reduces access to continuity models such as midwifery group practice, which often require early booking due to limited availability. Delayed entry can also mean missed early screening opportunities, such as dating scans and combined first trimester screening, ideally completed before 13 weeks' gestation.[26] Early contact also creates an important pathway for support in the event of early pregnancy complications or loss, including timely assessment, information, emotional support and referral where needed.

Antenatal Care

Following confirmation of pregnancy, families are referred to a model of care.[27] These models of care differ in provider type, level of continuity, cultural responsiveness, and integration with the broader health system. While national clinical guidelines outline the elements of safe, high-quality care, they do not mandate specific service structures.[28] The organisation and delivery of care is shaped by jurisdictional discretion, local service design, and workforce availability.

Continuity of care models such as Midwifery Group Practice are recommended as best practice.[29] This is where a family is supported by the same midwife or small team throughout pregnancy, labour, and the postnatal period. Aboriginal maternity group practice services provide culturally safe, holistic care to Aboriginal and Torres Strait Islander families through continuous, community-based support. Examples include the Moort Boodjari Mia program in Western Australia[30] or the Nangnak Baban Murrup Maternity Group Practice clinic in Victoria.[31] These programs aim to improve health outcomes by offering antenatal/postnatal care, often through or alongside a local ACCHO. They also create space for involvement of both parents and grandparents, reflecting a broader, family-centred model of care. However, Midwifery Group Practice and other continuity models account for only a minority of maternity care options.

Continuity of care can also be provided through antenatal and postnatal models that do not include birth care. For example, the Midwifery Antenatal and Postnatal Service (MAPS) allocates women a primary midwife for the antenatal and postnatal period, while labour and birth care is provided separately through standard maternity services.[32] This type of model is particularly relevant for community-based services and ACCHOs, which may not provide care through labour and birth but can offer relational continuity from pregnancy and connect families into broader child and family health supports across the early years.

Public hospital maternity care remains the most common category, with models that provide continuity of care through the whole maternity period limited and inconsistently delivered across jurisdictions. See **Appendix 1** for an overview of the major antenatal care models available to families in Australia, a summary of their key features, level of continuity and relative availability across jurisdictions.

In line with the national guidelines, antenatal care typically includes clinical measures and risk screening for mental health, domestic and family violence, smoking and alcohol use, and family and domestic violence exposure.[33] However, pathways to care for those identified at risk vary greatly. Enhanced federal funding during the National Perinatal Depression Initiative (2009 - 2015) was used to introduce routine mental health screening through most of Australia's public obstetric settings and additionally provided some pathways to care. Since cessation of funding, pathways to care are shaped by jurisdictional discretion, local service design, and workforce availability.

In some settings, alternative approaches are emerging, including the Baby Coming You Ready program, a co-designed, trauma-informed digital tool for expecting and new First Nations parents that supports conversations about social and emotional wellbeing, strengths and support needs using culturally relevant formats.[34]

TRANSITION 2: SUPPORT THROUGH BIRTH

This transition encompasses the crucial period through labour and birth, and the initial follow ups. It lays the foundation for maternal recovery including care for both physical and mental health, infant wellbeing, and the infant's early attachment to family and caregivers. It is a critical period for breastfeeding to commence and for families to be connected to breastfeeding support if needed. For families that birth in hospital, this transition represents the interface between hospital-based maternity services and Child and Family Health services. For those that birth in other settings, such as at home, it also represents an important juncture to ensure continuity of care. Successful coordination is critical to ensuring seamless follow-up and connection to state based Child and Family Health services.

Birth and Postnatal Care

The vast majority of babies in Australia are born in hospitals (97% in 2023), with only a small proportion born in birth centres, at home or in other settings (such as before arrival at hospital).[35] Care during labour and the immediate postpartum period is usually led by hospital-based maternity teams. While some women experience continuity through continuity of carer models, many are attended by rostered clinicians they have not met before.

National guidelines recommend that length of stay and transfer to community care should be decided in consultation with the woman,[36] with the World Health Organisation recommending that after an uncomplicated vaginal birth in a health facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after birth. This allows for maternal recovery, observation of infant wellbeing, hearing screening, initiation of breastfeeding, and parental education. In public hospitals, many women are discharged within 24 to 48 hours, although some may leave as early as 6 hours after birth if clinically appropriate and adequate postnatal supports are in place.[37] Private hospital stays tend to be longer, particularly following surgical births. In 2023, 74% of mothers had a postnatal hospital stay of three days or less, reflecting a trend towards shorter hospitalisations over recent years.[38]

Although the numbers are still small, there has been a doubling of the number of home births from 923 in 2019 to 2,081 in 2023. Home birthing programs can be publicly funded, and are often an option for families who would prefer privacy and choice, are more comfortable at home with familiar surroundings,[39] prefer a non-medicalised and non-institutional environment, or have had prior traumatic experiences of hospital birth.[40]

For many First Nations communities, *Birthing on Country* is a foundational component of best-practice childbirth. It is important to recognise that for more than 60 000 years, Aboriginal and Torres Strait Islander families have lived and birthed on the Country of their ancestors.[41] Birthing on Country as a practice model has emerged in the context of colonisation where women were removed to birth in other settings.[42] For many First Nations women today, Birthing on Country is usually spoken about in terms of giving birth on the land of their own birth or that of the father of her child.[43] However, it also extends to the socio-cultural and spiritual dimensions of birth as a critical life event.[44] It is considered the best start to life for Aboriginal and Torres Strait Islander women and babies and their families because it provides an integrated, holistic and culturally appropriate model of care that accommodates socio-cultural and spiritual needs not addressed within mainstream systems.[45]

Initiatives such as *Replanting the Birthing Trees* further emphasise the importance of restoring culturally safe, community-led birthing spaces that reconnect families with Country, kinship systems and traditional knowledge. Embedding these approaches strengthens continuity of care and supports healing, reinforcing birth as a relational and culturally grounded experience rather than solely a clinical event.[46]

Going home: support after discharge

The transition from hospital to home is the interface between maternity services and Child and Family Health services. It is a moment of significant change where responsibility for care shifts between hospital-based maternity services, community-based Child and Family Health services and/or general practice. During this change, clear communication, coordinated care planning and culturally safe, structured transitions are important.[47]

Following birth, families will return to their home setting. Postnatal discharge often involves a range of healthcare providers and may include assessments of the family, baby and/or home environment; arrangements for follow up visits or contact, and education for family members.[48] Best practice sees this contact with the family occur within 24-48 hours, with a minimum of three contacts arranged over

the postnatal period (ranging from 6-12 weeks after birth). Some families may need additional visits and these should be tailored to clinical need, context and family preference.

There is no single national process governing the transition from hospital to home. Instead, referral and follow-up arrangements are determined by each state and territory, and often vary further between local health services. In some jurisdictions, such as Victoria and South Australia, prescribed birth notification or referral processes mean hospitals have responsibility for sending a family's contact details to the local Child and Family Health service. In others, connection to Child and Family Health services relies more heavily on manual referrals or parent-initiated contact. For families accessing private antenatal, birth and postnatal care, opportunities to connect in with Child and Family Health services are even further limited. For a full breakdown of how this transition occurs in each state and territory, see **Appendix 2.**

Handover between maternity and Child and Family Health services also varies significantly. Research describes inconsistent handover processes, and gaps in the transfer of psychosocial and contextual information. This information is important because it helps Child and Family Health services understand the family's physical and mental health, social circumstances and support needs, particularly where families may need additional or ongoing support.[49, 50]

Home visiting

A first home visit is not consistently offered to all families in Australia and varies by jurisdiction. Home visiting programs also vary in intensity. Enhanced home visiting typically involves a short-term increase in postnatal visits or additional support layered into Child and Family Health services, often in response to emerging needs such as breastfeeding difficulties or early parenting challenges.

For families that need greater support, sustained nurse home visiting (SNHV) programs provide structured, long-term support through regular home visits from pregnancy into early childhood. SNHV programs typically aim to promote health equity through a focus on families experiencing vulnerability and/or disadvantage who are at risk of poorer maternal and child health and developmental outcomes.[51] They are designed to deliver multiple services or interventions within the family's home environment and generally target protective factors related to prenatal health, caregiver mental health, caregiving, and early parental life-course outcomes.[52]

Across Australia, both enhanced and sustained nurse home visiting programs vary significantly between jurisdictions. Enhanced home visiting is most commonly delivered as part of Child and Family Health services, particularly in states such as New South Wales, South Australia, and Victoria where additional visits may be offered to families identified as requiring short-term support.

While a range of SNHV models have been trialled across Australia, access is limited. Programs such as the Maternal Early Childhood Sustained Home-visiting (MECSH) model operate in selected sites in New South Wales,[53] Victoria, Queensland and other jurisdictions, rather than as a universally available feature of the child and family health service system.

TRANSITION 3: SUPPORTING DEVELOPMENT BEYOND THE NEWBORN PERIOD

The period following the newborn stage marks a shift towards monitoring and support of a child's growth, development and wellbeing and also extends to broad support for family health and wellbeing. Transition three is the movement from early postnatal supports to the system of universal health and development monitoring provided in early childhood. This transition is critical as it influences whether emerging developmental needs are identified early, whether the health system maintains the engagement of families, and whether care is coordinated across multiple providers. It is also fundamental in supporting the overall health and wellbeing of children and their families. It can serve as a backbone of the Early Child Development (ECD) system, providing consistent support from birth to school entry.

Child health and development monitoring

Developmental monitoring[54] refers to the ongoing observation and assessment of a child's health, growth, development and wellbeing over time. Across Australia, developmental monitoring is guided by each jurisdiction's schedule of 'well child' checks, documented in the child's personal health record book (the Blue, Green, Red, Purple and Yellow books). These books outline key developmental milestones, recommended checks, immunisations, and parent questions. New South Wales is currently piloting a digital version,[55] and Victoria has just announced a digital record with additional features to be launched over time.[56] However, most families still rely on paper-based records.

A significant part of developmental monitoring occurs through scheduled developmental checks, which provide structured opportunities to identify emerging concerns, support families and connect children to additional services where needed. These checks are guided by evidence-based and validated assessment tools, including a co-designed development screening tool for Aboriginal and Torres Strait Islander children.[57] However, access to these culturally appropriate tools is still very limited.

Developmental monitoring is primarily focused on the child, with no systematic approach to holistically supporting parent and family wellbeing across Australia. While Child and Family Health Nurses and GPs develop trusting relationships, the extent to which practitioners delivering developmental checks can also monitor and support the health and wellbeing concerns of parents and caregivers is varied.

Unlike antenatal and postnatal care, which are supported by nationally endorsed clinical guidelines,[58] there is no shared national approach or best practice guidelines setting expectations for developmental monitoring.[59] There is also no national framework guiding how developmental monitoring should be conducted at a population level, including how parent and caregiver wellbeing should be monitored and supported, having regard to its significant impact on child health and development. Guidance is also lacking on exactly when and how checks should be structured or delivered beyond the early postnatal period, leaving responsibility largely to the states and territories.

As a result, the number of recommended child development checks varies significantly, (ranging from five in Western Australia to 14 in the Northern Territory).[60,61] For a comparison of each jurisdiction's schedule of checks, see **Appendix 3.** As children grow older, routine contact with health services becomes less frequent, and ongoing participation in developmental checks becomes increasingly dependent on family engagement. While all jurisdictions recommend a cluster of scheduled visits in the first year, typically around 4 weeks, 6–8 weeks, 4 months, and 12 months, fewer checks are routinely offered beyond 18 months, particularly in the absence of identified concerns. Victoria's Key Ages and Stages schedule[62] offers a more extended sequence of ten consultations through to 3.5 years of age,[63] but in other jurisdictions, only one or two additional checks may be suggested before school entry.

Sustaining developmental monitoring into the toddler and preschool years assumes that parents and caregivers remain engaged, see value in attending, can access services, and feel that services are culturally safe or otherwise appropriate for their unique needs. These conditions may not hold for all families. Despite being universally available in principle, participation in developmental checks drops significantly after infancy. Available evidence indicates that many families begin to disengage from scheduled developmental checks after their child's first birthday. In Western Australia, for example, attendance at the 12-month Purple Book check has hovered around 50%, declining to approximately 30% by the 2 year check.[64] In New South Wales, 17% of children had no contact with Child and Family Health services in the first 2000 days and 36% had only 1–7 visits, despite an entitlement to eight free checks.[65]

Delivery of developmental checks

In most jurisdictions, child and family health nurses lead these checks within Child and Family Health services, due to their specialised training in child development, early parenting and early identification of developmental delay.[66] Many Child and Family Health services are based within multidisciplinary child and family health centres, which may also offer parenting groups, health promotion programs, and links to other services such as speech therapy, social work, or early childhood education - providing families wraparound supports in addition to the scheduled checks. Other Child and Family Health services are standalone and primarily focused on delivering developmental checks.

Families may also choose or default to GPs for developmental checks, particularly where Child and Family Health services are harder to find, less well known, or difficult to access due to long wait times, or geographic constraints.

GPs play an important role in undertaking development checks, but their capacity and capability varies depending on individual training, experience and availability of time during standard consultations. While the Royal Australian College of General Practitioners curriculum recognises GP responsibility for growth and developmental assessment, there is no mandatory requirement for GPs to undertake specific child development training or complete standardised developmental checks.[67] GPs also do not routinely assess child growth, behaviour or development during regular consultations for ill health.[68] GPs have also indicated that they would like more training in developmental surveillance, including in areas such as identifying cognitive impairments[69] and detection of developmental delay, especially in bilingual families.[70] Beyond individual capability, GPs can also operate in relative isolation from other parts of the child and family services system, limiting their ability to influence broader care pathways, particularly where referral options are constrained by long wait lists or fragmented service responses.

Aboriginal and Torres Strait Islander children remain eligible for a Medicare Benefits Schedule (MBS) funded health assessment. However, this is a broad, holistic health assessment rather than a dedicated developmental assessment item, and recent changes have removed age-specific clinical activities in favour of more general preventive health and assessment guidance.

The 2026–27 Federal Budget, announced a new Medicare-funded three-year-old health assessment, available from 1 November 2026, allowing GPs and prescribed medical practitioners to assess the health and development of Medicare-eligible three-year-olds and refer them to appropriate supports, including *Thriving Kids*.

Outside of this new three-year-old health assessment, GPs are still largely reliant on standard MBS attendance items such as Level B, under 20 minutes, or Level C, 20–40 minutes, for developmental concerns raised at other ages. These items are incommensurate with the hour-long appointments that Child and Family Health services use to undertake comprehensive development checks, and may not support thorough developmental assessment without additional funding or private billing.

SYSTEMIC BARRIERS

Based on CPD's mapping of children and families experiences across the child and family health service system, ten systemic barriers have been identified. While each of the three transitions introduce distinct challenges, many of the same underlying structural and design issues cut across the system.

These barriers can be understood against emerging principles of high-quality Child and Family Health services, including equity and access, prevention, partnership with families, trauma-informed care, inclusion, continuity and evidence-informed practice.[71] Although focused specifically on Child and Family Health services, these principles are relevant to the broader health in the early years system considered in this report.

TEN SYSTEMIC BARRIERS IN THE CHILD AND FAMILY HEALTH SERVICE SYSTEM

A summary of the key barriers families face across the first 2000 days

1 Availability and access to services can be limited

Workforce shortages across GPs, midwives, and Child and Family Health nurses constrain access, particularly in regional and remote areas.

2 Cost is too high

The cost of health in the early years can delay first contact, prevention, screening and relationship-based support.

3 Services are not consistently culturally safe

Mainstream services are not consistently designed to deliver culturally safe care, and racism and mistrust can undermine engagement.

4 Services are not consistently inclusive of all children with developmental needs and diverse families

The system is not consistently designed to engage children with developmental support needs and diverse families in an inclusive and accessible way.

5 Service design settings constrain flexibility, investment in prevention and continuity of care

The system lacks the flexibility to respond to different levels of need, and funding models make continuity of care hard to sustain.

6 A lack of system and service integration

Fragmented coordination, inconsistent referral systems, and weak information sharing mean continuity of care depends too much on local practice.

7 Low public awareness and knowledge of Child and Family Health Services

formation about health pathways is fragmented, public visibility of CFH services is low, and inconsistent program language creates confusion.

8 Limited data and digital infrastructure

Heavy reliance on paper records and manual communication fragments coordination and limits system visibility

9 A lack of national oversight prevents consistency in quality and investment

Governance is fragmented between the Commonwealth and states, leading to inconsistent implementation and limited accountability.

10 Social determinants are not consistently built into care pathways

Health services often treat housing, nutrition and income as external, failing to respond to structural conditions that shape family wellbeing.

These barriers interact across pregnancy, birth, postnatal care and early childhood

1. AVAILABILITY AND ACCESS TO SERVICES CAN BE LIMITED

Access to health services across the first 2000 days including general physical and mental health care, as well as maternity care and developmental monitoring through GPs, maternity care and Child and Family Health services, varies widely depending on where families live, what services exist locally, and whether those services can offer continuity of care and choice.

There are not enough workers to meet family needs. GPs, midwives, and child and family health nurses are in short supply across much of Australia, particularly in regional and remote areas, but also in fast-growing outer-metropolitan communities. Many services operate at or beyond capacity, limiting the length and quality of appointments and constraining their ability to offer outreach or relational care. Outside of integrated models, the various practitioners supporting families through transitions also generally don't operate as part of a team that provides wraparound care. In public hospitals and community health services, high turnover and vacancy rates have further reduced continuity. Even in urban areas, waiting times for long consultations are increasing, and many practices have closed their books to new patients altogether.

There are particular shortages in the child and family health nursing workforce. Remuneration commensurate with the high skill and qualification needed to become a child and family health nurse deters nurses from choosing this specialty and has resulted in far fewer enrollments and an ageing workforce.[72] The average age of a child and family health nurse in New South Wales is 51, with around one third of the workforce aged over 60.[73] Workforce pathways are inconsistent across jurisdictions, with each state and territory holding different qualification requirements. This further exacerbates inconsistent delivery and quality of care, and reduces workforce mobility.

Continuity-based maternity care models, such as Midwifery Group Practice, are proven to improve outcomes and family satisfaction,[74] yet remain geographically limited and capacity-constrained.[75] Access depends largely on whether a hospital or health district has an established program and available staff, rather than on women's preferences or clinical suitability. Many women who wish to receive continuity-based care are placed on waiting lists or assigned to standard hospital clinics by default, simply because no local places are available. Geographic inequities amplify these barriers, with many regional and remote areas either having no local services or being limited due to workforce shortages. Limited transport options and the high cost of travel further restrict engagement for communities who are particularly underserviced.[76]

Enhanced and sustained home visiting

Home visiting is a mode of outreach within the child and family health service system: instead of requiring families to attend a clinic, services are delivered in the home or another trusted community setting. This can include enhanced home visiting, where families receive additional or more flexible support above the universal schedule, and sustained nurse home visiting, where families receive structured, regular nurse-led support over a longer period, often from pregnancy or early infancy through to the first two years of a child's life.

Unlike one-off checks or clinic appointments, enhanced and sustained models give practitioners more time to build trust, understand family circumstances, support parent-child relationships, identify emerging health or developmental concerns early, and connect families to additional services where needed. The models differ in duration, intensity and structure, but share a common purpose to make support more accessible and responsive for families who need more than the routine universal offer.

Australian models such as *right@home*[77], MECSH[78] and Victoria's Enhanced Maternal and Child Health Services show different ways that enhanced and sustained home visiting can be delivered through Child and Family Health services. The evidence suggests that well-designed home visiting models can improve parent wellbeing, parenting confidence, parent-child interaction, the home learning environment, child health and development and family connection to services.[79]

Despite this evidence, enhanced and sustained home visiting programs are not available everywhere. Even in jurisdictions or specific localities where they are available, access depends on state budgets and local health district priorities.[80] This has created a postcode lottery where families' chances of receiving a sustained response are largely determined by where they live. For example, Sustaining NSW families is only available to families who live in an area where the program is offered and meet eligibility criteria.[81] Similarly, a 2026 audit of Victoria's Enhanced Maternal and Child Health program found that the program is supporting families experiencing challenges, but the department does not adequately track demand to inform its funding allocations.[82]

Eligibility criteria also limit access. Some enhanced or sustained programs use proxy indicators (such as young maternal age, receipt of income support or other administrative markers) to determine eligibility. These criteria can be blunt and stigmatising, and may exclude families experiencing significant stress or emerging vulnerability who do not meet threshold requirements.

Where sustained or enhanced programs work well, there is a greater emphasis on the judgement of the nurse who knows the family and can assess their current circumstances, capacity to adapt and self-manage, and need for additional support, rather than relying solely on static risk markers.[83]

The Australian Nurse-Family Partnership Program (ANFPP) was funded for approximately 10 years to deliver sustained home visiting for women pregnant with an Aboriginal baby, through partnerships with ACCHOs.[84] Although the model was adapted from the US model, it remained rigid through a structured model of regular nurse home visits. Stakeholders have suggested that context specific, locally designed and driven sustained home visiting models are far more effective and culturally safe. Options are currently being explored and evaluated to instead fund enhanced or sustained programs for Aboriginal and Torres Strait Islander families in a more culturally appropriate and adaptable way, allowing local communities the flexibility to design a program that works for them.

Despite clear evidence of success, particularly for vulnerable families, sustained or enhanced home visiting is yet to be consistently funded or embedded as a reliable part of Australia's child and family health service system. Greater and more sustained investment is needed to make support available to families who would benefit from it, while allowing enough flexibility for services to be relational, culturally safe and responsive.

2. THE COST TO PARENTS AND FAMILIES IS TOO HIGH

The cost of health in the early years can delay families' first contact with the system and reduce opportunities for prevention, screening and relationship-based support. This is particularly significant in pregnancy and the early years, where timely engagement with general practice, maternity care and Child and Family Health services shape the care pathways that follow.

Rising out of pocket costs and the inconsistent availability of bulk-billing reduce families' access to general practice, including timely early antenatal care such as pregnancy confirmation, screening referrals, care planning and maternity referral, and other pregnancy support.[85] **As free support from Child and Family Health services usually begins after birth, there is a gap for many families during pregnancy to free or low cost care.** Where bulk-billing is not available, long or complex consultations with GPs have out of pocket costs that deter early engagement, especially for families on low incomes. Even with MBS rebates, families are often paying between $40 and $60 gap fees.[86] Recent Commonwealth investment to expand bulk-billing incentives is an important step towards reducing out-of-pocket costs for Medicare eligible families. However, affordability barriers may remain where bulk-billing is not locally available, where longer or more complex consultations are not adequately supported, or where families are not Medicare-eligible. This means early pregnancy support, screening and referral often sit within fee-for-service GP pathways where there are out of pocket costs.

The first GP appointment in pregnancy often requires more time than the rebate supports. These appointments can cover pregnancy confirmation, education, screening referrals, emotional and social wellbeing, and care planning.[87] However, this first antenatal planning and referral consultation only attracts a rebate of $47.15 as of 2025, well below the actual cost of delivering a comprehensive appointment. The lack of alignment between the rebate and the time required often results in additional out-of-pocket costs for women seeking care.

While Child and Family Health services are usually free, some states limit access based on medicare eligibility. This means that temporary visa holders, international students and asylum seekers may face full private fees in those states.[88] Stakeholders have reported this as a significant issue, noting that options to waive or override fees vary between states and services.

These affordability and eligibility barriers exacerbate disadvantage, particularly where no low-cost or culturally safe alternative care is available. In areas with limited or no affordable GP or Child and Family Health service, families may delay or skip early contact altogether, compressing the care schedule and reducing opportunities for early screening, prevention, and relational support.

3. SERVICES ARE NOT CONSISTENTLY CULTURALLY SAFE

The child and family health service system is not consistently designed to deliver culturally safe care. For many Aboriginal and Torres Strait Islander and culturally and linguistically diverse families (CALD), access is shaped not only by whether services exist, but whether they are trusted, culturally safe, linguistically accessible and responsive to family and community contexts. Culturally safe care is critical for improving health and development outcomes for these families. When services do not recognise and appropriately respond to cultural identity, language, family structures and experiences of racism or exclusion, families do not have access to the support that they need, missing out on key opportunities for early intervention and referral.

Mainstream services can undermine trust when they are not culturally safe. Despite decades of national policy commitments, Aboriginal and Torres Strait Islander and culturally and linguistically diverse families continue to report experiences of racism, dismissal, and cultural disconnection across maternity, general practice, and Child and Family Health services.[89] This creates a significant systemic barrier which undermines trust, reducing families' willingness to access a system that they know is not designed to meet their needs and that is not effective.[90] Many First Nations families describe fear or mistrust of mainstream health services, limited recognition of Aboriginal ways of knowing and parenting, and a lack of Aboriginal staff within hospitals and Child and Family Health services.[91] This mistrust is reinforced by reports that in some maternity services, women who do not attend antenatal appointments have been notified to child protection. These concerns are occurring in the context of increasing child protection involvement in the perinatal period, with rising numbers of notifications and interventions in the first year of life.[92] Aboriginal health leaders, including the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), have warned that such practices are punitive, culturally unsafe and likely to deter women from engaging with maternity care.[93] Some Aboriginal and Torres Strait Islander women will not access any care if they do not have acceptable maternity care choices that are culturally and emotionally safe.[94] For some First Nations families, the resultant mistrust of medical and hospital systems contributes to a preference for community-based or non-institutional perinatal care.[95]

Culturally safe, community-led models are effective, but not consistently available. The ACCO sector plays a critical role in delivering culturally safe and community-led support for Aboriginal and Torres Strait Islander children and families. Birthing on Country initiatives and ACCHOs show how culturally embedded, community-governed care can achieve better outcomes, lower preterm birth rates, increase antenatal engagement and improve maternal satisfaction. In addition, these models are particularly needed to protect the culturally and spiritually enriching pregnancy and birth traditions that are integral for the social and emotional wellbeing of Aboriginal people.[96] Successful models such as Connected Beginnings, a community-led and designed program, integrates health, family support and education to support families of children from birth to school age.[97] Culturally safe and community led models are not yet available universally, particularly outside metropolitan and large regional centres.[98] Short-term and fragmented funding is a barrier for many ACCHOs, with long term, secure funding needed to be able to deliver these services.

Assessment and screening tools can reinforce mistrust when they are not culturally validated or strengths-based. Existing assessment and screening tools are not always well aligned with the needs and contexts of Aboriginal and Torres Strait Islander children and families. Tools that are deficits-based or focused on risk can exacerbate the environment of mistrust and dissuade First Nations women from accessing support.[99] As an example, the Edinburgh Postnatal Depression Scale (EPDS), while widely used and validated across many populations, has not been validated for use with Aboriginal and Torres Strait Islander women. This has raised concerns about its cultural appropriateness and accuracy in identifying distress in its context. Evidence suggests that difficulties using the EPDS may contribute to lower screening rates and limit its effectiveness in supporting culturally safe care.[100] Findings from Western Australia suggest that midwives and child and family health nurses found the EPDS difficult to use in practice and were actively seeking a more culturally appropriate alternative.[101]

Culturally safe strengths based tools, such as the Baby Coming You Ready digital platform, have been found to recognise and support 'Aboriginal and Torres Strait Islander women's resilience, self-efficacy and strengths in the perinatal period.'[102] Baby Coming You Ready is a co-designed, trauma-informed digital assessment tool that uses culturally relevant images, Aboriginal voice-overs and guided self-reflection to support conversations about social and emotional wellbeing, strengths and support needs during pregnancy and early parenting.[103]

Families from CALD backgrounds face additional barriers such as language differences, unfamiliarity with the health system, and inconsistent access to interpreters. Interpreting services are not routinely built into antenatal or child health consultations, and written information is often provided only in English.[104] [105] Bicultural or bilingual Child and Family Health services and early-parenting programs exist in some areas but remain patchy and receive only short-term funding.[106] As a result, research suggests that children from CALD backgrounds are more likely to have higher developmental vulnerability but poorer access to culturally-appropriate developmental support, increasing the risk that developmental concerns go undetected.[107]

Cultural safety must go beyond workforce training, and be embedded in the system through governance, representation, tools, funding and accountability. Some national frameworks are in place to guide culturally safe practice within mainstream settings but their implementation remains uneven across services and jurisdictions.[108] While the Australian Institute of Health and Welfare's Cultural Safety Monitoring Framework supports oversight for services providing for Aboriginal and Torres Strait Islander families, significant data gaps persist, particularly in mainstream maternity services.[109] No equivalent framework exists for CALD populations, further limiting system visibility and accountability.[110] Embedding cultural safety within best-practice guidelines and mandatory standards for safe, high-quality clinical care has the potential to shift health and development outcomes, improving access to the care that families really need and timely escalation to further interventions where necessary. Building cultural safety is also a matter of shared governance and representation. When Aboriginal, Torres Strait Islander, and multicultural communities co-design and lead local health strategies, families are more likely to see themselves reflected in care, trust practitioners, and engage earlier. Without this trust, integration efforts falter: referrals are declined, appointments are missed, and early intervention opportunities are lost.

4. SERVICES ARE NOT CONSISTENTLY INCLUSIVE OF CHILDREN WITH DEVELOPMENTAL SUPPORT NEEDS AND DIVERSE FAMILIES

The child and family health service system does not consistently engage children with developmental support needs and their families in an inclusive and accessible way. Many families face barriers to recognising, raising and responding to developmental concerns, limiting early engagement with support.

Developmental concerns are not always identified early. Evidence from the *Thriving Kids* Advisory Group highlights that developmental delay is not always identified early, and that families often struggle to access support when concerns first arise. Many parents lack access to clear, accessible information about child development and may not recognise early signs of developmental difference, while stigma and fear can further delay help-seeking.

Families can struggle to have concerns heard and acted on. Stakeholders highlighted that even when concerns are identified, families can face barriers navigating the system and accessing appropriate support. Some families report that concerns are dismissed or not taken seriously, while others experience long delays in accessing assessment or support. These experiences reduce confidence in the system and can discourage continued engagement.

Diagnosis-based pathways can delay support and medicalise developmental differences. This structure of support pathways can further limit inclusion. Currently, families are often required to enter formal, diagnosis-based pathways to access support, creating a more medicalised experience of care. As highlighted in CPD's consultations on foundational supports and inclusion,[111] reliance on diagnosis can delay access to support, particularly for children with emerging or lower-level needs, and can frame developmental differences through a clinical lens rather than as part of the natural diversity of child development. One alternative is reflected in the *Thriving Kids* model, which creates an approach which does not require diagnosis for children, parents, carers and kin to receive support.[112] Rather, functional assessment of support needs is proposed to match the child and their family with the appropriate level of support.[113]

Services are not always flexible enough to respond to diverse family circumstances. Families have a wide range of needs and experiences, including single parent families, young parents, LGBTQIA+ families, neurodiverse families, families with disability, Aboriginal and Torres Strait Islander families, culturally and linguistically diverse (CALD) families, and recently arrived migrant or refugee families. Inclusion is therefore not only about identifying developmental concerns, but about whether services are flexible enough to make families feel safe, respected and able to participate.

The workforce needs stronger support to deliver inclusive, relational and non-stigmatising care. Ensuring that all families feel confident that the system is designed for them is dependent upon inclusive, continuous and relational care delivered by a workforce that is equipped with the training and knowledge to respond to different families' needs. As highlighted through submissions to the *Thriving Kids* Initiative Inquiry, professionals across the child and family health service system report needing stronger skills in early identification, relational practice, and inclusive approaches to supporting children with developmental concerns and their families.[114] When the workforce is not equipped to deliver culturally safe, trauma-informed and non-stigmatising care, families' trust is eroded and continued engagement with the child and family health service system is put at risk.

Ultimately, it is not simply the availability of services, but whether they are inclusive, accessible and responsive to families' needs that determines whether concerns are identified early, families remain engaged, and support is accessed at the right time.

5. SERVICE DESIGN SETTINGS CONSTRAIN SERVICE FLEXIBILITY, INVESTMENT IN PREVENTION AND CONTINUITY OF CARE

The system lacks the flexibility to respond to different levels of need. Across maternity, general practice, and Child and Family Health, funding, eligibility, and program design limit how support can scale as families' circumstances change. In contrast to progressive universalism, where a continuum of care flexes in intensity - most services are binary: standard or targeted, eligible or ineligible. This limits preventative support and engagement, weakens continuity of care and leaves families whose needs are emerging, complex or changing without the right level of support.

Services are not designed to scale as family needs change. Families' needs can change quickly across pregnancy, birth and early childhood, but the service system often offers either a standard universal appointment or targeted support for families who meet specific eligibility thresholds. This creates a gap for families whose needs are emerging, changing or not yet considered severe enough to qualify for additional support. For example, families experiencing financial stress, isolation, mild perinatal anxiety or early parenting concerns may need more than a standard appointment, but may not meet the criteria for enhanced or sustained programs. This limits the system's ability to provide early, proportionate support before challenges become more complex.

Funding settings do not give the time needed for preventative and relational care. A key reason GPs and allied health services struggle to adjust in intensity is that funding settings shape time, continuity and clinical judgement. When it comes to the antenatal care item, the MBS rewards throughput rather than continuity, providing the same rebate regardless of the length or complexity of a consultation. Standard 10-15 minute appointments are often insufficient for early pregnancy planning or child-development consultations that require 30-40 minutes for screening, education, and psychosocial assessment. Without funding for longer, relationship-based care, GPs and nurses must either shorten appointments or charge additional fees, both of which undermine preventive engagement.[115]

State funded Child and Family Health services face similar constraints. While intended to be universal, support can be limited to the schedule of development checks contained in the child health record, which varies widely across jurisdictions. Eligibility for enhanced or sustained nurse home visiting is narrowly defined, often limited to those meeting specific "vulnerability" criteria. Families whose needs fall just outside these categories, such as those experiencing financial stress, isolation, or mild perinatal anxiety, rarely receive additional support and thus miss out on critical prevention and early-intervention.

This lack of access to preventative and relational care is further undermined by fragmented appointment scheduling and disrupted continuity of care mean that families do not have the opportunity to build trust. In antenatal practice, women in hospital based clinics or shared models may face irregular appointment intervals, rotating providers and limited continuity of care, conditions that undermine the effectiveness of routine screening, relationship-building, and tailored health education. Although continuity of care models such as Midwifery Group Practice are associated with improved maternal and neonatal outcomes, greater satisfaction with care, and reduced intervention rates, they are not available to many families and remain inconsistently available across jurisdictions.[116]

Underfunding of Child and Family Health services further prevents the workforce from being able to deliver services according to need. Child and Family Health services are often funded at a fixed amount. This means that funding is not increased alongside increases in birth rates, with funding often stagnant for more than a decade. This results in a mismatch between supply and demand, an overworked workforce and reduced access to timely support for families.

Preventative support is not consistently resourced before needs escalate. While many practitioners, including child and family health nurses incorporate health promotion and early support into their work, system settings do not consistently enable a preventative approach. Funding models, short appointment windows and rigid program boundaries can limit practitioners' ability to exercise judgement, provide proactive follow-up, or offer more flexible, relational support. As a result, opportunities for early intervention are reduced, even where prevention is an explicit policy goal.

6. A LACK OF SYSTEM AND SERVICE INTEGRATION

Families often experience the child and family health service system as a series of disconnected encounters. Despite available guidance on best-practice antenatal, postnatal and child health pathways, there are few mechanisms that guarantee smooth transitions between them. Fragmented coordination, inconsistent referral systems and weak information sharing protocols mean that continuity of care depends largely on local practice and individual initiative rather than on system design.

Referral and handover processes between general practice, maternity, hospital and Child and Family Health services remain inconsistent across jurisdictions. Many families may miss out on further support after hospital discharge when birth notifications are delayed or manual referrals are not followed up. With the exception of Victoria and South Australia, where structured birth notifications trigger proactive outreach, referrals often rely on manual processes, local discretion, or parent-initiated contact. This approach disproportionately misses families with low health literacy, unstable housing, limited digital access or those who have had to travel from their community to give birth.

Funding models do not incentivise coordination with other services. Under the Medicare Benefits Schedule (MBS), general practice is funded almost exclusively for direct consultations, not for the coordination, communication, or follow-up that genuine integrated care requires. GPs are not remunerated for time spent liaising with hospitals, Child and Family Health service teams, or allied health providers. Meanwhile, the structure of MBS items provides no incentive for joint care planning or multidisciplinary collaboration. Similarly, state-funded Child and Family Health services operate within their own budgets and reporting systems, with limited resourcing for cross-sector engagement. As a result, integration often relies on individual goodwill rather than formalised structures or funding.

Health and early education pathways are not integrated. ECEC settings, which often provide early opportunities to detect developmental concerns, are rarely linked to Child and Family Health services or general practice. Without integrated ways of working such as shared referral protocols, co-located services, or local communities of practice, families may move between health and education systems with little continuity or feedback. This weakens the opportunity for health and education to work together to support children and their families, providing holistic care and best-practice early intervention.

Digital systems are fragmented. The absence of shared digital systems further undermines integration. Pregnancy and child health records remain largely paper-based, vary across jurisdictions and are not consistently integrated with general practice, hospital systems or My Health Record. Where information is not shared in real time, care plans are often re-created at each transition, wasting resources and eroding trust. This creates particular challenges for children who have experienced significant change or disruption in their lives, such as those living in out of home care.

7. LOW PUBLIC AWARENESS AND KNOWLEDGE OF CHILD AND FAMILY HEALTH SERVICES

Families can only engage with services they know exist and understand how to access. For first time parents, knowing what services they are entitled to, which services are available and when they should engage is often unknown. The ability to find, interpret, and act on information, sometimes called *service literacy,* is shaped by language, digital access, education, and trust in institutions. Many families rely on friends, the internet, social media and increasing AI technologies to access information about the child and family health service system.

Public knowledge of Child and Family Health services remains particularly low compared with hospital-based maternity or care provided by GPs. Many parents do not understand the role of Child and Family Health services or when to re-engage after the early postnatal period. Websites, brochures, and referral instructions differ across and within state and territory systems, and self-referral options are not always obvious or user-friendly. Families with low health literacy, limited English, or unstable housing are least likely to navigate these systems successfully. Digital tools such as state health apps or My Health Record remain underused, and paper-based systems require families to physically carry records between providers, creating gaps when documents are lost or incomplete. While every state provides a child health record book and many issue a baby bundle with local service details, these resources rely on parents reading and interpreting written information without structured follow-up.

Knowledge challenges are also reinforced by the lack of consistent language around programs and eligibility. Similar services operate under different names across jurisdictions, (i.e.: *Child and Family Health Service* in New South Wales, *Maternal and Child Health* in Victoria and *Child Health and Parenting Service* in Tasmania), making it difficult for parents moving interstate or between health districts to know where to go. Even professionals report uncertainty about local referral processes, leading to missed or delayed handovers.

A lack of awareness around the role of Child and Family Health services also prevents many families from engaging with critical health and development checks. As with other appointment-based services, this model assumes that families have the time, transport, and confidence to attend, and that they feel culturally and emotionally safe engaging in these settings. Families might also feel that their children's health needs are already catered for by their GP and the value and importance of developmental checks and the unique care provided by a Child and Family Health service has not been made known to them. Other families simply do not see the value in attending Child and Family Health services, with one study of Australian parents identifying that 44.1% of parents of children under five did not attend appointments with their Child and Family Health service due to not perceiving a need, or otherwise identifying that services were unknown, inaccessible, or considered unsuitable.[117]

8. LIMITED DATA AND DIGITAL INFRASTRUCTURE LIMITS ENGAGEMENT AND SERVICE IMPROVEMENT

Australia's child and family health service system still relies heavily on paper-based records and manual communication, leaving families to carry responsibility for continuity. Across maternity, Child and Family Health services, and general practice, digital infrastructure remains fragmented and inconsistent, limiting timely coordination and system visibility.

There is limited digital infrastructure to support families during pregnancy and the transition to Child and Family Health services. During pregnancy, the Pregnancy Hand-Held Record remains the primary tool for sharing information between providers in most jurisdictions. Its format, name, and the point at which it is provided differ by state and territory. In some locations, the record is provided at the first general practice visit; in others, it is not issued until the hospital booking appointment, sometimes as late as 16–20 weeks' gestation. When care begins late or is fragmented between providers, critical information can be lost or duplicated.

The transition to Child and Family Health services faces the same problem. After birth, hospitals, GPs, and Child and Family Health services often rely on fax, email, or manual entry to notify each other of a birth or referral. Only two states have automated notification systems, and even these are not fully interoperable across services. As a result, families may never receive follow-up contact if a referral is missed, or may be contacted twice by different services unaware of each other's involvement. Proactive, systematised post-discharge follow-up can improve continuity between hospital and community-based care, with recent evidence finding that systematic planning of postpartum home visits prior to hospital discharge was associated with better outcomes for parent-child bonding.[118]

Digital infrastructure for child development monitoring is also limited. Each state maintains its own child health record, which varies in format and developmental check schedule. These books provide valuable guidance for families but are not integrated into electronic health systems, preventing providers from tracking developmental progress across time or location. In contrast, the Australian Immunisation Register offers a national model for real-time data sharing, population-level monitoring, and recall systems capabilities that remain absent in early development monitoring.

Efforts to modernise digital systems have begun, but remain partial. The National Children's Digital Health Collaborative developed a harmonised national data model and piloted a digital child health record in New South Wales in 2020–21, yet no national rollout has followed. In June 2026, Victoria announced the digitisation of their child health record, to be available via app.[119] The 2026-2027 Federal Budget includes funding for a National Digital Child Health Record in My Health Record, alongside supports for parents, carers and kin of children with developmental concerns or autism. These are important first steps towards better data infrastructure. However the scope, timing and functionality of the national rollout are still unclear. Currently, My Health Record offers only limited maternity and child health functionality, with low uptake among clinicians and families.

Current data systems also provide limited insight into how families actually use and experience the child and family health service system. There is very little publicly available, consistent data on service uptake, frequency of engagement and continuity of care over time throughout the first 2000 days. This lack of visibility constrains system design and improvement. Without reliable data on who is accessing services, when contact drops off, or which families are missing out altogether, policymakers and service planners are unable to assess whether universal services are functioning as intended or to target reforms where they are most needed.

9. A LACK OF NATIONAL OVERSIGHT PREVENTS CONSISTENCY IN QUALITY AND INVESTMENT

System governance and professional guidance for the workforces that support the health and development of families across the first 2000 days is fragmented. This reflects Australia's divided responsibility for child and family health between the Commonwealth, states and territories, and local government.

This split in responsibilities has produced parallel systems that rarely align around shared outcomes, service planning, workforce expectations, data collection or accountability. For children and families, this means that access to high quality and best-practice care is not universal. It is instead dependent upon geography.

National governance, reporting and performance frameworks are needed to support governments to elevate child and family health as a policy priority. Stakeholders noted that national direction is useful not only for consistency, but also for visibility and prioritisation. Where there are nationally reported indicators or benchmarks, service gaps become more visible and governments have a clearer basis for tracking progress. This can help elevate child and family health within government decision-making and support states and territories to make the case for investment in workforce, service access, quality improvement and system reform.

The lack of a shared performance framework for child and family health across the first 2000 days means that state and territory governments are not held to the same performance standards. While some data is collected through existing reporting arrangements, there is no shared national performance framework that links child and family health policy goals to consistent indicators, benchmarks and reporting across antenatal care, postnatal care and developmental monitoring. This makes it difficult to track whether families are receiving nationally consistent, timely, high-quality and culturally safe care across the full pathway. Jurisdictions are not held to consistent benchmarks, making it difficult to ensure equity or drive continuous improvement across the system nationally.[120]

There is currently no dedicated national forum or governance mechanism that covers the whole child and family health service system. While individual service systems have their own policy, clinical and funding arrangements, there is no coordinated mechanism for bringing together levels of government to consider how antenatal care, postnatal care, Child and Family Health services, general practice, monitoring, development and disability supports through *Thriving Kids* and the NDIS, and related supports connect as one seamless pathway for children and families. This limits the ability to identify gaps between service systems, align reform efforts and build shared accountability for access, quality, continuity and outcomes across the first 2000 days.

Such an approach could better support consistent service planning within each state and territory across the first 2000 days, guiding where models of care should be located, prioritised or expanded based on population need. The lack of national planning limits the ability to scale best-practice models or address gaps in care, particularly in continuity-based or culturally safe services. Without joint planning infrastructure, efforts to improve equity and access remain fragmented.[121]

Consistent application of best-practice guidelines across jurisdictions requires national oversight.

Clinical guidelines set standards for best practice, but many are not yet tied to funding or policy. Across the services and workforces that make up the child and family health service system, various professional guidelines, frameworks and standards of practice outline best practice in delivering care to families and children. Typically they are evidence-based, provide recommendations for treatment and are professionally endorsed by scientific, peak and professional bodies.

Some sets of guidelines, such as those supporting maternity care,[122] are underpinned by strong professional and scientific endorsement, are continuously reviewed and updated, provide specific recommendations guiding service delivery, set national benchmarks for high quality clinical care, are directly tied to funding and hospital accreditation and are linked to national outcomes reporting. This makes them highly effective in setting a national clinical standard and driving quality improvement.

Professional guidance across other parts of the child and family health service system varies in authority, evidence base, update cycles and links to funding or accountability. **Appendix 4** summarises key policy levers shaping practice across the three transitions, highlighting differences in endorsement, evidence base, clinical utility and system integration. This variation means that even where guidance exists, it does not always translate into consistently planned, funded or delivered services.

Developmental monitoring is a clear example of inconsistent guidance and weak implementation levers requiring national coordination. In contrast to the well-established clinical framework that guides maternity care, eleven different sets of guidelines for Child and Family Health services have been developed to try and drive national consistency in developmental monitoring, but none provide explicit clinical guidance or are connected to professional accreditation, formal policy, service design settings or funding streams.[123] While there is overlap in terminology and recommended tools, it results in significant clinical variation in practice, inconsistent delivery of care and an inability to track the performance of systems.[124] As outlined in **Appendix 4**, these instruments vary in their purpose, authority and connection to implementation levers.

A national approach is needed to consolidate one practice guideline as has already been achieved for maternity care. This would hold state and territory Child and Family Health services to clinical best practice benchmarks and allow for better planning and funding for these benchmarks to be achieved.

Done correctly, national oversight has the potential to formalise best practice and minimum standards of care that are delivered within a progressively universal child and family health service system, while preserving local adaptability and variation. Health services for children and families in the early years need to be adapted to local community needs, workforce availability, geography and existing service systems. However, without clearer national expectations, families can receive different levels of access, quality and continuity depending on where they live. Stakeholders emphasised the need for national consistency through shared principles, minimum standards, entitlements, indicators and reporting, while retaining flexibility for local and place-based delivery.

10. SOCIAL DETERMINANTS ARE NOT CONSISTENTLY BUILT INTO CARE PATHWAYS

Australia's child and family health service system is not designed to respond effectively to the social conditions that shape families' lives or to comprehensively support the whole family in their context. The birth of children represents a significant adjustment in families lives, with increased financial strain and responsibility. It can also lead to an increase in pre-existing risk factors such as domestic and family violence.

Housing stability, nutrition, income, transport, income and employment conditions, the mental and physical health of parents and caregivers and social support networks all influence whether families can attend appointments, follow guidance, and sustain engagement with services. However, these realities are rarely considered in service design, eligibility criteria or care pathways. There is also little attention given to the needs of fathers and other caregivers.

Social determinants are not consistently factored into service design and delivery. Health services often treat social determinants as external to their remit, focusing primarily on clinical presentations rather than the structural conditions that drive them. While the evidence linking social conditions to health and development outcomes is well established, these factors are insufficiently accounted for in system design. As a result, responses are often fragmented, reactive, and limited in scope. Development checks in general practice and Child and Family Health services rarely have the funding or capacity to respond to broader social factors such as housing instability, food insecurity, or parental mental health, even though these are strong predictors of early developmental vulnerability.

Parenting support is also not consistently treated as a core part of health in the early years. While many services provide advice or reassurance, government have not systematically invested in parenting support as a universal, non-stigmatising and preventative service offer. This leaves many families without practical support for the everyday challenges of caring for babies and young children, including sleep, feeding, behaviour, parent-child relationships and parental confidence.

While some services screen for social risk factors, identification does not always lead to support. Perinatal care typically includes clinical measures and risk screening for mental health, domestic and family violence, smoking and alcohol use, and family and domestic violence exposure.[125] However, support where risks are identified is limited and variable. For example, the cessation of the National Perinatal Depression Initiative in 2015 saw a significant reduction in the availability of perinatal mental health screening and counselling services.

Screening and referral pathways are not always suitable or effective for all families. Even when screening is available, it does not address the full spectrum of conditions that shape wellbeing in pregnancy and early childhood, and may not lead to appropriate support. Risk screening can be ineffective or unsafe for Aboriginal women who require culturally safe and Aboriginal-led service models to disclose risk factors without fear of prejudice.[126] The Baby Coming You Ready screening and assessment tool is one innovation that takes a strengths-based, trauma-informed approach to perinatal assessment and follow up specifically for Aboriginal women, creating a safer and more effective means of identifying and responding to risks in the perinatal period.

However, effective programs show that services can respond to social determinants when the right pathways are in place. The Healthier Wealthier Families pilot study created a systematic referral pathway between the Child and Family Health service and community-based financial counselling for families experiencing financial hardship.[127] Trialled across Victoria and New South Wales in low socioeconomic communities, participating families gained access to an average additional income from government entitlements of $6504 annually, with families reporting a significant impact on reduced stress, increased financial literacy and overall wellbeing.[128]

Creating a future child and family health service system that supports all children and families to thrive

Australia's universal public health system is premised on the widely held value that everyone should have equitable access to high-quality care, regardless of circumstance, with the social and economic returns on investment well worth the investment made in such a system.

The child and family health service system is currently the only universal system engaging children and families from pregnancy through to school entry. It is the first point of engagement for families and the existing infrastructure must be leveraged to ensure that wellbeing and outcomes for all families are maximised throughout the early years.

However, the substantial barriers outlined in this report show that many children and families are excluded from the significant lifelong benefits that a truly progressively universal child and family health service system can provide: providing access to critical early intervention for developmental delay, supporting parent and caregiver wellbeing and offering more intensive support where needed. These are foundational to child and family wellbeing and guarantee the best possible outcomes for children and families in the early years.

CPD's subsequent recommendations report will lay out how we can build from the system architecture we have now, to ensure an integrated, consistent and equitable health system for all children and families in the future. By improving early engagement, strengthening continuity of care across all three transitions, and making developmental monitoring reliable and culturally safe, developmental delay and other inequities can be identified and addressed at the earliest point. This is needed well before children reach ECEC or school, where the impacts of disadvantage will begin to compound over time. Strengthening this foundation is critical to achieve the vision set in the *Starting Better Guarantee* and for reforms such as *Thriving Kids* and Universal ECEC to achieve their goals and maximise the social and economic return on investment.

Appendices

APPENDIX 1: OVERVIEW OF MAJOR ANTENATAL CARE MODELS (ORDERED BY PREVALENCE)

Model	Description	Continuity of care provided	Availability of service model
Public Hospital Midwifery-led Care	Standard antenatal care provided through hospital-based midwifery clinics. Often delivered by rotating midwives.	**Low-moderate**	Most common model nationally. Universally available in principle, but women in rural, remote, and some outer urban areas may need to travel significant distances to access services.[129]
GP Shared Care	The woman alternates care between her GP and hospital maternity services.	**Moderate**	Formally structured and widely available in SA and VIC, where accredited programs, clinical guidelines, and hospital coordination are in place. Also available in NSW, ACT, and TAS through locally managed arrangements. In QLD and WA, shared care occurs in some regions but lacks a statewide framework or GP accreditation system, leading to more variable access and implementation. NT information is limited, and shared care is likely informal or ad hoc.
Midwifery Group Practice/ Caseload Midwifery	Care by one known midwife or small team across pregnancy, birth and postpartum.	**High**	Available and relatively well established in SA and QLD, particularly in major metropolitan centres. Expanding in NSW, VIC, and ACT. More limited in NT, TAS, and rural or remote areas of WA, where access is often restricted by workforce and service capacity.
Private Obstetric Care	Ongoing antenatal care from a private obstetrician, typically with hospital birth.	**High (with obstetrician)**	Available with private health insurance/self-funded. Most common in metropolitan areas.
Community-Based Midwifery Models (incl. ACCHOs and Midwifery Group Practice Hubs)	Midwifery care delivered outside hospital settings, including Aboriginal Community Controlled Health Services (ACCHOs), birth centres, community midwifery programs, and Queensland's Midwifery Group Practice hubs. These models emphasise cultural safety, continuity, and accessible, place-based care.	**High (relational and/or cultural continuity)**	Regionally available. ACCHOs are strongest in QLD, NT, and NSW. Queensland's publicly funded Midwifery Group Practice hubs are expanding and offer continuity-based care for priority populations in community settings. Other community midwifery programs exist in WA, VIC, and NSW, but availability remains limited and uneven.

APPENDIX 2: HANDOVER PROCESS FROM HOSPITAL BASED POSTNATAL CARE TO COMMUNITY BASED CHILD AND FAMILY HEALTH SERVICES BY JURISDICTION.

NSW	In New South Wales, the intended postnatal pathway includes a sequence of early contacts designed to support the transition from hospital to home. Midwives are typically expected to provide an initial home visit within one to two weeks after discharge. For women who have had longer hospital stays, additional postnatal care at home may be offered by hospital-based midwives until the baby is 14 days old. However, the availability of this extended support varies across hospitals and is not universally provided.[130] Following discharge, hospitals are expected to initiate a referral by sending the family's contact details to the local Child and Family Health service. A nurse then contacts the family directly to arrange a home visit in the early weeks after birth. This visit includes development checks for the baby and facilitates connection to further Child and Family Health services. While this system is designed to ensure continuity of care, the consistency and timeliness of follow-up are shaped by local workforce availability and system coordination.
VIC	In Victoria, postnatal follow-up is primarily delivered through the Maternal and Child Health (MCH) Service, a long-standing, universal program provided by local governments under state policy. The pathway is initiated through a birth notification from the hospital to the local council, which triggers proactive outreach from the MCH service. A Maternal and Child Health nurse then contacts the family to arrange and conduct the first home visit, typically within the first week after birth.[131] This initial visit forms the foundation for ongoing developmental monitoring and parenting support through the early years. During the first visit, the MCH nurse provides information about the nearest MCH centre, outlines the schedule of future visits, and explains how to contact the service for support at any time.[132] MCH centres are located in local communities and funded jointly by state and local governments. They may be managed by local councils, health services, or Aboriginal Community Controlled Organisations, depending on local arrangements. Where a child, parent, or carer is identified on the birth notice as Aboriginal or Torres Strait Islander, the MCH service provides information about culturally specific MCH options available in the area.
QLD	There is no system-wide infrastructure to ensure continuity between hospital care and community-based services. Postnatal follow-up often relies on a mix of midwifery-led outreach (e.g. via early discharge support programs in hospitals like Royal Brisbane & Women's Hospital), general practice involvement, and parent-initiated contact with Queensland Health child health clinics.[133] Midwives may conduct home visits or call post-discharge, especially where continuity of midwifery care has been provided. However, Queensland clinical guidelines only advise that midwives at discharge assess whether a GP has been identified and, with consent, refer the mother to relevant services such as child health, this is not a mandated or automated referral.[47] Families are typically encouraged to see a GP at 5–7 days post-birth, or to attend community child health clinics that offer drop-in's for newborns or scheduled support for feeding, sleep, and maternal wellbeing.

SA	In South Australia, midwives complete discharge documentation in hospital and issue the My Health and Development Record ('Blue Book'), which includes information on child health checks and immunisation. Families are informed that they will be contacted by Child and Family Health Services (CaFHS) as part of the Universal Home Visiting Program, which aims to provide a home visit by a CaFHS nurse within the first two weeks after birth.[134] CaFHS nurses provide support with infant feeding, settling, sleep, and parenting, alongside health and developmental checks. In cases where infants are identified as high risk, referrals can be made, with consent, to the two-year sustained home visiting program. Home-based postnatal care may also be delivered by a Midwifery Group ractice or hospital-based midwives, depending on the local model. The overall system provides a structured framework for continuity, but delivery may vary by geography and workforce availability.
WA	In WA, early postnatal follow-up in the home may be provided by hospital-based midwives through the Visiting Midwifery Service (VMS) for women discharged early, though this service is not universally available across the state. In other regions, community Child Health Nurses deliver follow-up care, usually beginning with a home or clinic visit within 10 to 14 days of birth. Hospitals are expected to notify the WA Child and Adolescent Health Service (CAHS) upon discharge, but this process doesn't appear systematised across all facilities, which could lead to variation in follow-up coordination.[135]
Tas	In Tasmania, women who received care through a Midwifery Group Practice model may receive postnatal home visits via the Extended Midwifery Service (EMS), which provides home visits to eligible families. After this period, the intention is that care transitions to the Child Health and Parenting Service (CHaPS), which delivers universal Child and Family Health services for children aged 0–5 years. CHaPS offers a combination of home visits, centre-based care, parenting support, and developmental health checks. However, there is no published clinical guidance at the state level outlining whether hospital-based midwives are expected to initiate referral to CHaPS. While both health professionals and parents can refer, and parents are encouraged to contact CHaPS directly, the absence of a visible structured or automated transition process may result in inconsistencies in access and follow-up, particularly in areas where families may not be aware of available services.[136]
NT	In the Northern Territory, women who receive public maternity care are routinely offered home visits by domiciliary midwives, commencing from 24 hours after birth. These midwives provide postnatal care focused on breastfeeding support, maternal recovery, and newborn wellbeing, with the frequency of visits tailored to each family's needs. Once the domiciliary midwifery service concludes, follow-up care is accessed through community health centres, where child health nurses or general nurses provide ongoing monitoring and support. There doesn't appear to be a system-wide digital birth notification or automatic transition to Child and Family Health services. Instead, families are advised to book a 6-week postnatal check with a GP or community health clinic, and follow-up is generally parent-initiated.[137]
ACT	In the Australian Capital Territory (ACT), women who give birth in public hospitals are supported by the Midcall program, which provides up to seven days of home-based midwifery care after discharge. Following the Midcall phase, responsibility for ongoing developmental monitoring and parenting support transitions to the ACT's Maternal and Child Health (MACH) service. MACH nurses, who are registered nurses and/or midwives with additional qualifications in child and family health, offer a universal home visit shortly after birth, followed by scheduled health and development checks at key milestones from birth to five years of age. These visits include growth measurement, feeding and parenting support, maternal wellbeing screening, and early identification of any developmental concerns. Appointments can take place at home or at community clinics across Canberra, and are supported by new parent groups, breastfeeding services, and parenting information sessions. Families can self-refer to MACH at any time, and follow-up is supported by reminder systems and centralised booking lines.[138]

APPENDIX 3: RECOMMENDED UNIVERSAL CHILD DEVELOPMENT CHECKS BY JURISDICTION – PER CHILD HEALTH BOOK

	NSW Blue Book	VIC Green Book[139]	Qld Red Book	SA Blue Book	WA Purple Book	TAS Blue Book	NT Yellow Book	ACT
1	1-4 wks	Home Visit	0-4 wks	1-4 wks (in home)	0-14 days	2 wks	10 days	1-4 wks
2	6-8 wks	2 wks	6-8 wks	2 wks (GP)[140]	8 wks	4 wks	4 wks	6-8 wks
3	6 mo	4 wks	4 mo	6 wks (GP)	4 mo	6 wks (GP)	8 wks	4 mo
4	12 mo	8 wks	6 mo	8 wks	12-18 mo	8 wks	4 mo	6 mo
5	18 mo	4 months	12 mo	6-9 mo	2-3 years	6 mo	6 mo	12 mo
6	2 yrs	8 months	18 mo	12 mo	School entry health assessment	12 mo	9 mo	18 mo
7	3 yrs	1 yr	2.5-3.5 yrs	18-24 mo		18 mo	12 mo	2 yrs
8	4 yrs	18 mo	4-5 yrs	3 yrs		2 yrs	18 mo	3 yrs
9		2 yrs		4-5 yrs		4 yrs	2 yrs	4 yrs or before starting school
10		3.5 yrs					2.5 yrs	
11							3 yrs	
12							3.5 yrs	
13							4 yrs	
14							4.5 yrs	

APPENDIX 4: COMPARISON OF KEY POLICY AND PROFESSIONAL GUIDANCE FRAMEWORKS MAPPED ACROSS CPDS THREE KEY TRANSITIONS (NON-EXHAUSTIVE)

	Transition 1	Transition 1&2		Transition 3	
Framework	**Royal Australian College of General Practitioners (RACGP) Preventative Activities Guidelines**	**Maternity Care Guidelines (Living Evidence for Australian Pregnancy and Postnatal Care)**	**MCaFHNA National Standards of Practice**	**National Framework for Universal Child & Family Health Services**	**National Guidelines for including mental health and wellbeing in early childhood health checks**
Authority & Endorsement	Strong Professional Authority: Issued by the RACGP.	Strong Scientific & Professional Authority: Endorsed by the NHMRC (scientific) and peak professional colleges (Australian College of Midwives).	Professional Authority: Issued by the peak professional body for Child and Family Health Nurses.	Political Authority: Based on inter-governmental agreement, reflecting a shared policy goal.	Political Authority: Drafted by the National Mental Health Commission on request from the Dept of Health, Disability and Ageing. Informed by Advisory Group but not formally endorsed.
Evidence Mode/ Update Cycle	Periodic Review Cycle: The RACGP guidelines are updated every few years, not continuously.	"Living Evidence" Model (LEAPP): Continuously updated as new high-quality research emerges. The ACM guidelines are reviewed periodically (e.g., the 4th edition in March 2025).	Periodic Professional Review: The standards are reviewed and updated by the professional body on a periodic basis, not continuously.	Static / Infrequent Political Review: As a high-level policy document, it is not designed for regular updates and would only be reviewed if there is a major new political agreement.	First introduced in 2024, no date or timeline set for review.
Clinical Utility	High: A practical guide defining best practice for GPs.	High: A specific, evidence-based "how-to" manual for clinicians, directly applicable to daily practice and risk management.	Moderate (for professional guidance): Defines the scope, principles, and values of the nursing specialty.	Low (for clinicians): An aspirational "what-to-do" document for policymakers.	Moderate (for professional guidance): Provides clear and specific recommendations but requires state govt action.

	Transition 1	Transition 1&2	Transition 3		
System & Vision Utility	High: Sets the professional standard and vision for preventative care in the primary care sector.	High: Sets the national benchmark for high quality clinical care, used for system planning and quality improvement.	Moderate: Sets the vision of the nursing specialty, including standards to guide practice, education and research.	High: Its core purpose is to establish the national vision, principles, and scope for the entire service system.	High: Clear, evidence-based benchmark for holistic approach to development checks, available to states and territories to use.
System Integration & Funding Link	Direct but Misaligned: Directly linked to MBS item numbers, but the fee-for-service model creates a financial barrier to implementation.	Strong: Informs services funded by hospital budgets and is a core requirement for hospital accreditation (NSQHS). Aligned to MBS items.	None: The standards are separate from the state and territory funding models.	None: Relies entirely on discretionary state and territory budgets.	None: Recommendations and advice for state and territory policymakers only.
Data, Accountability & Reporting Mechanisms	Moderate: Professional accountability (AHPRA) Voluntary practice accreditation Financial Medicare audits	Indirect but Effective: National outcome reporting (AIHW) Mandatory hospital accreditation Professional accountability (AHPRA)	Professional Accountability: Provides a benchmark for individual nursing practice. Lacks any system-level reporting.	Very Weak / Non-Existent: No national reporting framework. National performance indicators are not reported on	None: no data, accountability or reporting mechanism.
Overall Impact & Effectiveness	Effective in defining best practice, but its impact is hampered by a misaligned funding model.	Highly Effective in setting a national clinical standard and driving quality improvement.	Effective in defining professional identity, but ineffective in driving system-wide consistency.	Ineffective in driving national consistency. It remains a static statement of shared goals.	Effective in setting benchmark for evidence-based, best practice development checks but ineffective in driving uptake.

Endnotes

1 Recently expanded eligibility for MBS bulk billing incentives are designed to support GPs to bulk bill Medicare-eligible patients, with a goal of hitting 90% bulk-billed services by 2030.

2 Medicare eligibility is determined by the Commonwealth, but the ACT and Queensland Governments require possession of a Medicare card as a requirement to access state funded Child and Family Health Services.

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