SUBMISSION:

Productivity Commission, Early Childhood Development Workforce

Fionnuala Tate: Maternal and Child Health Nurse, City of Kingston.

I have worked as a Maternal and Child Health Nurse since 1989. I have practised as an MCH Nurse in the following areas:

- Phillip Island Shire and Bass Coast Shire in country Victoria - 1987-1989
- in a remote area of the Eastern Highlands of Papua New Guinea - 1990-1992
- Teaching the care of young children at Footscray College of Tafe using my Maternal and Child Health qualifications - 1992-1995

In metropolitan Melbourne

- Kensington – Altona St Maternal and Child Health Centre where 99% of my practice was with high needs families living in the High Rise Ministry of Housing flats - 1995-1997
- Break for Maternity leave
- North Melbourne – Abbotsford Street Maternal and Child Health Centre, once again 50% of families where 'high needs families' – 1999-2001
- Enhanced Maternal and Child Health Service for the City of Kingston – 2001-2007
- Working in the universal service from 2007 to the present for the City of Kingston.

I am registered as a midwife and nurse with the Australian Health Practitioner Regulation Authority. My Nursing Education is as follows:

- Registered General Nurse, Ireland 1978
- Midwifery Nursing Scotland 1979
- Diploma of Applied Science in Community Health Nursing (Maternal and Child Health) Australia 1987
- Graduate Diploma of Education, University of Melbourne 1996

Having read the report I have grave concerns with a number of points. My submission is strictly limited to Chapter 12 of the Early Childhood Development Draft Report regarding the removal of midwifery as a qualification prerequisite for MCH nurses. I would also like to highlight the need for the ongoing support of the Scholarship for MCH programs of study. I have a firm belief that both of these two points are integral to the ongoing support of a service that would have to be close to 'best practice' in a global sense.

Unlike the Draft report, I, like the World Health Organisation will be continuing to include 'Maternal' when referring to Maternal and Child Health and not 'Child Health Nurse'. It was a pity that the Draft

Report was been unable to identify the critical link between 'maternal' and 'child'. Every MCH Nurse both in ACT and Victoria will categorically say that while their 'name' is Maternal and Child Health they deliver a service that is all-inclusive of family health.

Draft Recommendation 12.1

To ensure the cost effectiveness of child health services and better inform consideration of future child health workforce needs, state and territory governments should seek to improve the evidence base of child health services, in particular to determine the optimal number and timing of child health checks.

Victorian Early Years Learning and Developmental Framework (for all children from Biirth to 8 years)is evidence based. The framework allows for anticipatory guidance at the well researched Key Ages and Stages. It states the following:

"Maternal and Child Health Services deliver a **universal** health service **free** of charge for all **Victorian families** with children from birth to six years. The service **supports** families and their children in the areas of **parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning.** The Universal Maternal and Child Health Service consists of the Key Ages and Stages Consultations and a flexible service component. It also includes an enhanced service which provides a more **intensive** level of **support** for **children, mothers and families** at risk of poor health and wellbeing outcomes, in particular where multiple risk factors for poor outcomes are present."

Children learn in the context of their families and families are the primary influence on children's learning and development. **Professionals too, play a role in advancing children's learning and development.** Professionals engage in family-centred practice by respecting the pivotal role of families in children's lives.
Maternal and Child Health Nurses:
• use families' understanding of their children to support shared decision-making about each child's learning and development
• create a welcoming and culturally inclusive environment where all families are encouraged to participate in and contribute to children's learning and development experiences
• actively engage families and children in planning children's learning and development
• provide feedback to families on their children's learning and information about how families can further advance children's learning and development at home and in the community

Draft Recommendation 12.3

In order to reduce unnecessary obstacles to attracting new child health nurses, sate and territory governments should not require child health nurses to have qualifications in midwifery in addition to their qualifications in nursing and in child health.

I am vehemently opposed to such a recommendation. The need for midwifery as a prerequisite to obtaining a MCH Nursing qualification is paramount to maintaining a service 'second to none' in both the developed and the developing world. It is more important than ever, that both general nursing and midwifery qualifications remain a prerequisite for obtaining entry into MCH study

program. Both these qualifications have given me a critical body of knowledge, confidence and invaluable professional skills to allow me to deliver a service that meets the needs of clients in 2011 and as we approach 2030 with both the Federal and State governments intention to increase our population.

A sound medical knowledge base is required to deal with a number of medical conditions when a woman becomes pregnant. It would be a perfect world if all women who became pregnant went into their pregnancy without medical conditions. Take for example, diabetes, cardiac conditions, anaemia, more currently Vit D deficiency, renal disease, tuberculosis, urinary tract infections, women born with differing physical abilities and those acquired disabilities to name but a few. As MCH Nurse we deal with these conditions on a daily bases both with the mother, father, their infant and children. In my present centre of employment, I am supporting a young mother whose partner has just been admitted to the Transplant Plant Program at Monash Medical Centre. He is currently on dialyses. Another mother, older primigravida and Type 1 Diabetic. A 10 month baby died last October from a Mitochondria sequencing disorder. This baby's mother has just given birth to her second baby. The knowledge needed to support and guide practice is only acquired from having general nursing qualifications.

In building upon the knowledge and skills studied at an undergraduate level, midwifery is an integral body of knowledge that is necessary for the cementing together of both General and midwifery.

I will provide information in support of the above statement that will demonstrate the need to maintain midwifery as a vital qualification and prerequisite for MCH study program.

Each year, according to the WHO, ill-health as a result of pregnancy is experienced **(sometimes permanently)** by more than 20 million women around the world. Furthermore, the "lives of eight million women are threatened, and more than 500,000 women are estimated to have died in 1995 as a result of causes related to pregnancy and childbirth". Reproductive Health and Research Publications: Making Pregnancy Safer". World Health Organization Regional Office for South-East Asia. 2009. http://www.searo.who.int/EN/Section13/Section36/Section129/Section396_1450.htm. Retrieved 7 December 2009

Pregnancy poses varying levels of **health risk for women**, depending on their medical profile before pregnancy as was mentioned above.

The following are some of the complaints that may occur during and/or **after pregnancy** due to the many changes which pregnancy causes in a woman's body:

- Anaemia
- Back pain
- Carpal tunnel syndrome
- Constipation
- Regurgitation, heartburn, and nausea.
- Gastroesophageal Reflux Disease
- Haemorrhoids.
- Pelvic girdle pain. PGP disorder is complex and multi-factorial and likely to be represented by a series of sub-groups with different underlying pain drivers from peripheral or central nervous system altered laxity/stiffness of muscles, laxity to

injury of tendinous/ligamentous structures to 'mal-adaptive' body mechanics. Musculo-Skeletal Mechanics involved in gait and weightbearing activities can be mild to grossly impaired. PGP can begin peri or postpartum. There is pain, instability or dysfunction in the symphysis pubis and/or sacroiliac joints.

- Postpartum depression
- Postpartum psychosis
- Urinary tract infection
- Varicose veins

I can keep going one example after another. I hope you can start to visualise the importance of a sound knowledge base which cannot be obtained without the prerequisite of the both the Bachelor of Nursing and midwifery qualifications particularly as McGraw-Hill Concise Dictionary of Modern Medicine defines the **postnatal** period as the, 'Neonatology *adjective* After birth Pertaining to events occurring after birth, usually **within 1 year of childbirth** (McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.)

I believe knowledge of the conditions and management of the above particularly if experienced by a mother after 28 days postpartum or while pregnant with second or subsequent children while attending the MCH service is only gained from having obtained Midwifery qualifications and the knowledge essential to daily practice and delivery of a quality service.

The high quality professionalism of the Maternal and Child Health service and the excellent standard which it has attained throughout the years, dictates an equally highly standard of nursing qualification requirements. It is quintessential that those wishing to work as Maternal and Child Health Nurses need to undertake Bachelor of Nursing, Midwifery and to undertake MCH post graduate program of study. Possessing these qualifications should **not** be seen as a negative barrier to MCH nursing but rather the cornerstone of providing quality MCH nursing care.

Draft recommendation 12.4

Trainnig and Scholarships for postgraduate training.

I believe I have covered the necessity for training in the previous point 12.3 but I would like to comment on the Draft's report on scholarships. As a working mother today with a mortgage to pay, if I was interested in obtaining my Post Graduate in MCH Nursing, I can honestly say that I would not have been in a financial position to pay $15,000. There are no guarantees that a person will be eligible for Government scholarships or HECS. A Scholarship provided from a Local Government Authority would be of assistance financially. However it also gives a clear message of support to the student demonstrating confidence in the candidate and subsequently inspiring confidence. It offers support and the student is mentored into the workforce diminishing the impact of working as a 'sole practioner'.

12.4, P230, it dismays me that the report is very negative and cannot put forward a balanced opinion and strive for the implementation of 'best practice' rather than the negativity of what it costs to pay MCH Nurses due to their high qualifications.

Remuneration 12.2

According to the table supplied P226, Victorian Maternal and Child Health Nurse are the 3rd highest paid nationally. The table fails to take into consideration that in other States nurses are Government paid. This allows for Salary Sacrificing which is not portrayed accurately in the table allowing for overall greater benefits/remuneration.

12.4 Planning and supporting the child health workforce of the future;

75% of Maternal and Child Health Nurse when qualify apply and are successful in obtaining work, the remainder reconsider! Why! An area not addressed as to 'why there is a poor uptake' into MCH Nursing either to study or work in the field after graduating, is not about the need for the extra qualifications required to practice in Victoria but the discrepancy in pay from the Public Hospital and Local Government. Nurses are reluctant to forfeit their Long Service Leave entitlements and lose out on loading pay for working public holidays and weekends but this was not mentioned in the report. A midwife in Victoria can earn up to $600 for working a Sunday afternoon shift. There are longer Annual Leave entitlements in the Public Hospital system than Local Government.

Additional Comments:

Child Health Nurses in Queensland no longer require Midwifery qualification this has resulted in the dissemination of the service and young inexperienced single certificate nurses been sent to the more vulnerable families both in urban areas and remote rural communities. This is not what we want to see happen in Victoria. These families should have access to appropriately qualified clinician.

The Draft report fails to address the proposed increase in Australia's population either on the State or Federal level. Our population could well double by the 2050s.

The ABS On 21 August 2011 at 06:54:56 PM (Canberra time), the resident population of Australia is projected to be:

22,684,874

This projection is based on the estimated resident population at **31 December 2010** and assumes growth since then of:

- one births every 1 minute and 46 seconds,
- one death every 3 minutes and 40 seconds ,
- a net gain of one international migration every 3 minute and 05 seconds , leading to
- an overall total population increase of one person every 1 minute and 37 seconds .

These assumptions are consistent with figures released in Australian Demographic Statistics, December Quarter 2010 (cat. no. 3101.0).

We are already experiencing a diverse range of ethnicity, cultures, languages and practices. Cultural competence relies on a strong foundation of knowledge about other cultures. Clinicians need to assess and be aware of the cultural, ethnic, and socioeconomic factors that influence the

experience of **pregnancy, birth, and parenting beyond**. These clients should have access to the highest qualified nurses that the

Victoria legislation has that all Birth Notices are sent to the Local Government Authority area where the patient resides. As a result 98% of all families are engaged at least once with the service. This needs to be considered 'best practice' and recognised for its effectiveness and not deemed as unnecessary.

- This report was written by Educators with no input from individual MCH Nurses. Is it fair to draft a report without intimate knowledge of the service? Will this mean that MCH Nurses will be asked to Draft a Productivity report on Teachers – I think not.
- P222, The Federal Government have introduced a voluntary 4 yr old check and are planning on linking paying of the Family Tax Benefit Part A supplement conditional on parents attending for their child's four-year -old check. Why is the 'wheel been reinvented'? I believe that the National target for 3.5yr old health checks is 10% and the uptake is 14%. **Victoria's figures demonstrate the uptake is 63%** but the report failed to comment on this.
- The uptake for 4-5yr old health check done by Gp's is very low. This is done by Practice Nurses – research in 2006 showed that the majority of Practice Nurses had one one qualification. In the case where there was more than one qualification the second was Midwifery.

I am disappointed that the Draft Report has not identified the numerious strengths of the Victorian MCH Nurses Framework such as:

- The comprehensive educational requirements of Victorian MCH Nurses enable Victorian MCH nurse to provide comprehensive care to mothers, families and children as clients of the service. This contrasts with the fragmented approach to service delivery in other states that rely upon many different health professionals to provide Care.
- The Maternal and Child Health Service offers anticipatory guidance in many areas of children's health, well being, nutrition, behaviour etc to all parents
- The universal framework is founded upon the evidence based Key Ages and Stages Framework.
- Families utilising the service report very high levels of satisfaction demonstrated in the high levels of attendance.
- Participation rates for KAS are high – see link below http://www.education.vic.gov.au/ecsmanagement/matchildhealth/policyreports/default.htm
- The Victorian Framework provides continuity of care for families from birth to 8 years. As a result the framework facilitates the development of trusting relationships between mother, families and the MCH nurse from birth onwards.
- The Victorian framework is structured and well support by DEECD

I thank the commission for considering my submission. I hope that the strengths of the Victorian MCH nursing service can be adopted by other states and that the recommendations in the Draft report are not imposed. If the recommendations were to be adopted it would reduce and diminish the quality of the Victorian MCH nursing service and lower the service to the standard of the lowest common denominator nationally instead of lifting it to the highest standard available nationally.