Submission to Productivity Commission re Early Childhood Development Workforce Draft Report

1.Introduction:

My name is Maureen Cormican and I have practised as Maternal and Child Health Nurse Victoria for 32 years. The majority of my practice has been in rural areas apart from the last 4 years in the metropolitan area.

I am a registered nurse and midwife with the Australian Health Practitioner Regulation Authority. I completed my Division 1 nurse training at Mooroopna and District Base Hospital (Victoria) in 1968, my Midwifery training was completed at the Queen Victoria Hospital (Tasmania) in 1972. My Maternal and Child Health training was completed at the Queen Elizabeth Hospital in 1979. Additionally I have completed a Graduate Diploma in Community Health in 1994 at Deakin University. As a Maternal and Child health Nurse who strives to provide the most accurate current information to clients, I also attend frequent additional conferences and seminars which serve to enhance my practice. Some of these are provided by the State Government (DEECD), some by my employer and others through external organisations such as the Australian Breastfeeding Association.

2. Overview:

My submission is limited to Chapter 12 of the Early Childhood Draft Report and the Child Health Workforce.

I am particularly concerned with recommendations 12.2 and 12.3 of the Draft Report regarding:

1. The removal of midwifery as a prerequisite qualification for MCH nurses in addition to
2. Questioning the value of scholarships for MCH study programs.

3.Draft recommendation 12.2

I strongly support the ongoing provision of scholarships for MCH post graduate study programs. The provision of scholarships by many Victorian Councils has been very successful in attracting potential MCH nurses and helping to maintain appropriate staffing levels. This means that more clients are able to be seen and assessed by the evidenced based Key Ages and Stages Framework (KAS). Participation rates for KAS are high in Victoria, thus providing a continuity of care for families from birth to 4 years. The rates vary from 99.8% for the initial home visit following discharge from hospital to 63% at the 3.5 year assessment. *(Maternal & Child Health Services Annual Report 2009-2010, Page 10 of 21).*

The KAS framework facilitates an ongoing and trusting relationship between families and the MCH nurse from birth onwards through regular consultation and assessment at particular stages of a child's development. The 10 key visits are viewed as essential and evidenced based; the periodic assessments are valuable in identifying children with a condition that requires intervention but also children who may benefit from secondary prevention activities.

4. Draft recommendation 12.3

I am strongly opposed to the removal of Midwifery as a prerequisite qualification for MCH nurses. The requirement to have midwifery qualifications has not been a barrier for me; rather it enhances my practice by providing an indispensable area of knowledge. Having this qualification enables me to discuss with authority and empathy the client's birthing experience in the postnatal period. It also enables me to discuss and encourage such things as breastfeeding, pelvic floor exercises, and emotional health while providing holistic family centred care to families.

Breastfeeding has been proven to enhance the health and development of children as well as helping to restore mothers to their pre-pregnancy state. The knowledge gained through having Midwifery qualification assists in providing assistance to mothers to feed as long as possible; an example is by providing increased immunity through breastfeeding there is decreased cost to the community with less time having to be spent in hospitals.

The care of the mother in the postnatal period includes physical issues such as care of the perineum after episiotomies and tears, pelvic floor exercises and general advice regarding her own health; for example, if the recommended pelvic floor exercises are not done, the woman will more than likely require surgery and physiotherapy at a later time to correct continence problems.

The emotional health of mothers has been proven to be related to the emotional health and development of babies and young children; when children are not given the emotional support and stimulation that is required for their normal development, there is an increased cost to the community in having to provide early intervention education to enable these children to develop to their optimum potential. Post natal depression is a condition that is always present in the immediate time after delivery; the addition study of midwifery provides me with the necessary knowledge and understanding to assist mothers at this time.

I am also concerned at the apparent inadequate training by some states regarding child health; as MCH in Victoria we are able to provide health education and promotion to all children 0-6 years. Our specialised knowledge in child development, for example, assists in early recognition of conditions such as Autism, Development Dysplasia of Hip, speech delays. The training that I have had in Child Health enables me to recognise and refer for specialised treatments. Early recognition and treatment of such issues results in less community costs at a later date.

5. Consultation

The Victorian MCH service is widely considered to be the gold standard in Australia and has much strength. I am concerned that the Productivity Commission has had only limited consultation with Victorian nurses. In order for the commission to fully understand the numerous strengths of the Victorian MCH service, I would be grateful if the Commission would meet with me and other MCH nursing colleagues.

6. Conclusion

I would like to thank the Commission for reflecting on my comments above. I am hoping that the widespread strengths of the Victorian MCH nursing service will be desired by other states and that the quality of the Victorian Service will not be diminished.

Sincerely,

Maureen Cormican