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Early Childhood Development Workforce Study

Productivity Commission

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To Whom It May Concern

My Name is Nola Bales and I have practised as a maternal and child health nurse (MCHN) in Victoria for the past 10 years. The majority of my practice has been in a rural setting. I graduated as a Registered Nurse Division 1 in 1984 from Epworth Hospital in Melbourne and worked in both metropolitan and rural settings. I left the hospital setting to work as a District nurse in 1986 but returned to St Georges Hospital in 1989 to complete my Midwifery training. After moving to Sydney I worked as a general nurse and a midwife and then returned to study. I completed my Post Graduate Diploma of Community Health majoring in Child and Family Health in 2000. On returning to Melbourne I worked casually at an Early Parenting Centre until my additional qualification in MCH was placed on the Nurses Board of Victoria Register and I could work as a Maternal and Child Health Nurse. I gained employment in a rural setting and have subsequently completed lactation education and achieved IBCLC certification in 2006 and recently recertified in 2011.

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

I am particularly concerned about recommendations 12.3 and 12.2 of the Draft report regarding removal of midwifery as a qualification prerequisite for MCH

nurses, and questioning the value of scholarships for the MCH programs of study.

The midwifery qualification is an integral part of MCH nursing and it is vital it remain. I would use my midwifery skills on a daily basis just as I use my general nursing skills. My Midwifery education and experience is also the basis for my knowledge of human lactation and enabled me to achieve my IBCLC. The MCH qualification is the overarching education which links these two bodies of knowledge together. This enables me to have a full understanding of the health and wellbeing of the infant; the needs and care of the mother in the ante/postnatal period and beyond; and the general health of the entire family. A single consultation with a client can encompass infant health wellbeing and development, infant feeding/lactation, maternal health and her adaptation to parenthood, the health and wellbeing of other members of the family as well as the social and emotional needs of families in the context of their community. The relationship we build with a family over the 6 or more years we are involved with their lives can make MCH the key primary care giver for this family.

The Draft report claims that having midwifery as a required qualification is unnecessary and an impediment to recruiting nurses to the field. However of the submissions used to support this inference the City of Geelong (sub.20) listed issues such as the loss of salary benefits enjoyed in the acute setting for example salary sacrifice, loss of entitlements and penalty rates as major deterrents. The CCCH submission (sub.81) made one comment and that was based on anecdotal reports only. The draft report also states that higher qualifications mean higher salaries but this is obviously not the case when Victorian nurses are not the highest paid. It is ironic that in other areas of the draft report where the focus is Child Care and Early Childhood Education the recommendations are for higher qualifications and higher salaries to attract quality staff. There is also a suggestion to assist 3 year qualified staff to add on to their qualifications, and yet it questions the value of the scholarship scheme for nurses and seems to recommend lesser qualifications and for less cost. There is also a suggestion that lesser qualified nurses such as practice nurses or health workers could be trained to provide child health care. Whilst I value the work practice nurses do in the general practice setting I am concerned that

they are seen as an alternative to MCHN. There is an inconsistency in the levels of education and qualifications with both Registered and Enrolled nurses working as practice nurses. Their scope of practice is hugely varied from MCH. The reason we have and need our current standard of qualifications is that we work autonomously , we carry our own client load and make decisions every day on what actions are required to give this child and family the best possible outcome for their health, well being and development. The service is divided in to the Key Ages and Stages framework, and a flexible component. The flexible component is used for additional home visits or centre visits as needed, visits to childcare centres/kindergartens if parents request, groups, community strengthening activities etc. This gives us the ability to accommodate those families who need extra care and support, whilst meeting with other families for timely child health checks.

I understand that Victoria's exacting qualification standard can be a problem when transferring from state to state. When I returned to Victoria from New South Wales I had to wait a lengthy period of time for my UTS course to be reviewed as comparable with that of Victoria's. To get my registration I had to complete some extra clinical practice, but I saw this as more a reflection on the lower standards in other states than an issue with Victorias MCH service. Unfortunately when national registration occurred APRHA decided to down grade our registration and have declined to offer Victorian MCHN the recognition which we once had. The recommendation in the draft regarding Midwifery is a further erosion of our speciality. The Victorian MCH service has put a lot of time, effort and money into providing a comprehensive and evidence based service for the families of Victoria. Clients can feel confident that whichever centre they attend in Victoria they will find a nurse with the same standard of qualifications and knowledge and will be offered the same high quality of service and that is integral in a universal service.

I am concerned at the limited consultation undertaken by the Productivity Commission with Victorian Nurses. As the Victorian System is viewed as the benchmark in Australia I was surprised that the Commission has not held Public Sittings with Victorian MCH Nurses. To help the Commission understand the many strengths of the Victorian Framework I would be grateful if the Commission would meet with me and other MCH nursing colleagues.