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To Early Childhood Development Workforce Study, Productivity Commission

I am writing to express my concern with the recommendations in the Productivity Commission Early Childhood Development Workforce draft report (June 2011) with particular reference to Section 12.

I am a Maternal & Child Health (MCH) Nurse qualified and working within Victoria over the past 17 years. I have qualifications as a Registered Nurse, Registered Midwife and I have completed a Graduate Diploma in Family, Child and Community Health. I hold other relevant qualifications to the maternal and child health work role including family planning, positive parenting, accredited nurse immuniser and previously an International lactation consultant qualification for 10years. I currently hold a position as a clinical quality co-ordinator of maternal and child health and immunisation services in a large regional city. I outline below some of my major concerns with the draft recommendations (Sectioin 12) around the child health workforce.

1. I am concerned at the focus on cost saving rather than the quality and effectiveness of care to families and children in our communities. The suggestion of mobilising an increased number of workers on the premise of saving money and at the expense of well qualified, skilled, competent and professional nurses is not a desirable outcome for children or families. In Victoria we offer a MCH service with a high level of professional training, knowledge and skill where nurses are able to draw on a background of evidence-based competencies as they provide family centred practice that addresses many concerns relating to pregnancy, birthing and the post natal period. MCH Nurses are resourceful in assisting families to acquire evidence based information complemented by their training as a Registered Nurse, midwife and MCH nurse. Families today demand this level of expertise of health professionals as they sift through an overload of information on parenting, child rearing and health.
2. I welcome the recommendation of further work being undertaken to explore the outcomes for children related to the number and timing of child health developmental checks conducted Nationally and Internationally. This needs to be conducted with the focus on child outcomes rather than cost saving, and should commence with aiming for what works best to assist children in reaching their potential. This is in contrast to the suggestion that child health services will offer support to families raising children at a minimum level that the Government

can support financially. Research on timing and frequency of child visits needs to occur in the context of family focused nursing that also offers support to parents and other extended family members who are involved in the child's care. There needs to be a particular focus on care and support of maternal health and wellbeing and the frequency and timing of visits to offer this.

3. In relation to MCH scholarship programs, I am concerned the recommendation indicates financial restraint rather than the broad long term goal of growing a qualified and highly skilled professional workforce that can assist families. MCH Nurses largely operate as sole practitioners in their day to day work, and most remain in the child health field for the remainder of their working lives. There are significant costs involved in studying for two post-graduate degrees but in a stand alone context this appears short sighted. Where MCH nurses are supported by medical, allied health and welfare referral networks they can make a difference to the lives of families and children. Creating a spread across Australia of child health professionals with this skill and knowledge level would be a desired outcome and the beneficiaries would be the families in their care. MCH nurses should continue to have work opportunities for as close to retirement age as they desire as the expansive knowledge base in MCH is to be valued and grown.
4. I strongly disagree with the recommendation around removal of the midwifery qualification as a pre-requisite to working in child health. The midwifery qualification is complimentary to the role of a MCH nurse and adds significant depth and quality of the work in MCH. The quality and care given to families from child health nurses who work from this background has significant differences to those who do not. Large components of the child health visits in the early newborn period focus on the physical and emotional health of postnatal women where midwifery skills are drawn on to provide a higher level of intervention. This reflects in appropriate referrals and outcomes for families who see a child health nurse in Victoria. Day to day examples include palpation of a women's abdomen post-natally where there is concerns with abnormal birth recovery, management of breastfeeding difficulties including mastitis, blocked ducts, nipple trauma, establishing lactation following birth interventions, giving advice and referral around contraceptive concerns, discussing implications of difficult pregnancy and birthing on mother, relating birth complications to child health trajectory eg premature babes, drug use in pregnancy, special care nursery interventions.

   Mothers attending MCH in Victoria gain ante-natal advice and care during sibling consults from their MCH Nurse eg information around folate in pregnancy, implications of ante-natal screening tests, pre-pregnancy vaccination, care of mother in discussion of pregnancy related health issues such as pre eclampsia, ante-partum haemorrhage and infection.
5. I am concerned at the recommendation that other health workers could commence child health work in areas where there is a shortage of staff eg Practice Nurses. There are glaring differences in existing accreditations, educational standards, qualifications and training between MCH nurses and Practice Nurses. This suggestion underestimates the complexity and depth of the MCH role and the speciality links to pregnancy, birthing and the post-natal period. Why should families living remotely or in rural areas have less of a service for their children? This is not a logical conclusion if the focus is on an evidence-based health service to assist all children and families to achieve their potential, in particular the more vulnerable, such as Indigenous families

and children. Indigenous children have poorer outcomes at the current time – why are we offering a less trained, less professional workforce to these population groups where the health, welfare and child development scenarios are complex? Vulnerable families, including families who live in rural and remote areas deserve better.

6. The inquiry need to consider further quality of the evidence based framework model currently in place in Victoria, that requires all MCH nurses to have completed compulsory key training components eg SIDS, QUIT, Family Violence, and to work from a research base. The Victorian Key Ages & Stages model is beginning to report on measurable child health outcomes that specifically address the key headline indicators. There is not a comparable model being offered to families in other States where all MCH nurses offer a standardised, measurable range of nursing activities and health promotion with the families they see. Participation rates for children are the envy of interstate child health services, with 63% of 3-4yo remaining engaged in the service for child health checks. In the last five years this percentage has shown an increase in service use. In the first twelve months of life, over 80% of children are still attending the Victoria MCH service regularly. The support and benefits gained from the MCH nurse as cited by parents anecdotally outweigh what can be measured. There is evaluation reports available that give specific feedback on the Victorian MCH service. It is of concern that the workforce report has given little focus to the Victorian model who are leaders in this field in establishing and implementing this successful program change. There needs to be greater exploration prior to final recommendation.

In reviewing and creating a workforce report, positive outcomes for children and families must be protected and preserved by the recommendations. There needs to be further analysis of the possible impact of reducing currently required qualifications and offering families a workforce that have reduced background, knowledge and skill. To assume that a less qualified workforce would lead to the same child health outcomes that we currently experience in Victoria would be naive. I respectfully ask that you reconsider the draft recommendations.

Yours sincerely,

Bernadette Cavanagh