My name is Maria McKinnon, and I am a newly qualified Victorian Maternal and Child Health nurse (MCHN) providing casual relief over three Victorian councils, being Kingston, Glen Eira and Bayside since completing my studies in 2010 at Latrobe University. The purpose of this submission is to respond to the Productivity Commissions, Early Childhood Development Workforce Study, which contains inconsistencies, lack of evidence, inadequate consultation with Victorian stakeholders and some disturbing recommendations.

Primarily, I hold grave concerns over recommendation 12.3, astounding me that the removal of the midwifery qualification as a prerequisite for practicing as a MCH nurse could even be contemplated. My initial opinion is qualitative, largely based on my own experience, as I find myself providing information and recommendations based on my knowledge gained in midwifery, NOT general nursing. To take this one step further, I was fortunate to work at Melbourne's Royal Children's Hospital as a general nurse for over a year, yet still the value of my midwifery experience and knowledge vastly surpasses my paediatric experience. Whats more, I do not look upon midwifery as an obstacle as suggested in draft recommendation 12.3, but as a valuable asset to the provision of a well rounded maternal and health care service.

An overwhelming example of this is of course through the provision of breast feeding support. This type of knowledge requires a massive amount of clinical experience to perfect and enable the gained appreciation of the psychological impact that breast feeding can have on maternal well being. One could elaborate further on this, as we consider the long term benefits from successful breast feeding that impact on both the individual infant, and community. Examples of this are allergies, eczema, immunological benefits, future cardiovascular health, diabetes and obesity.

The provision of MCH care based on general nursing AND midwifery knowledge is also essential when you consider the beaurocratic practice of discharging postnatal women back into the community, only two days after delivery. This is further complicated by a society that is geologically widespread, based on more nuclear and single parent families, with an upward trend in medical problems, multiple births, caesarean sections and maternal age. (http://www.aifs.gov.au/growingup/pubs/asr/2010/asr2010.pdf) It is pertinent that our service includes "Maternal" in the title, with midwifery care that the MCH nurse provides after hospital discharge supporting the adjustment to parenthood, reiterating education received, early identification of post natal issues as well as close monitoring of the infant.

This support influences the uptake of the Victorian MCH service, which proudly outshines the participation rates of any other Australian state. This participation continues to surpass other states right up to the 63.1% attendance at the 3.5/4yo universal 'Healthy Kids Check' consultation.
(http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/mch/report10annual.pdf)

This continued participation is reflective of the excellent program that Victoria provides. Despite the draft recommendations inferring that the timing and optimal number of child health checks is ad hoc and not based on evidence (draft recommendation 12.2), the Victorian service has made purposeful changes in the last few years to ensure that the service they provide IS evidence based, timing the '10 Key Ages and Stages' visits to coincide with recognized developmental milestones. This structured Victorian framework is well supported by the Department of Education and Early Child Development (DEECD).

What is really disappointing, is the lack of consultation and representation of Victorian MCH nurses in the Draft report which has relied only on statistics provided by MAV, and one a salary concern raised in Geelong. Victoria is undeniably recognized as the benchmark in provision of MCH services, Yet, they have the audacity to claim in draft recommendation

12.1 that '*the Commission was not of, nor could find, any evidence to suggest that Victorian Children have better outcomes than their counterparts in other states as a result of being seen by more highly qualified child health nurse.* '(page 231) Families using the Victorian MCH service report very high levels of satisfaction of the services. A service that goes beyond surveillance, and incorporates reassurance, anticipatory guidance and health promotion, all of which are difficult to quantify in data analysis. Instead of stating that only 1132 clients accessed the Victorian Enhanced Maternal and Child Health Service in 2010, why not state that Victoria has a 99.8% participation rate for the first home visit? Even Aboriginal and Torres Strait Islanders, an identified vulnerable population, produced a 94.3% participation at the Home Visit, and still maintained 43.8% participation at the 3.5yo consultation.(http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/mch/report10annual.pdf) Again, participation rates support the many strengths of the Victorian Maternal and Child Health service, a service actually provided by paediatricians in the United States!

Furthermore, the notion that *other child health nurses working in general practice could therefore be thought as a reserve pool of child health nurses....(page 225)* draft recommendation 12.4, has been shown unsuccessful, when one looks at the uptake of the 4yo healthy child check which I recall to be approximately 16% (DoHA 2010). It is amusing that the data is inflated purely due to the influence of the Victorian MCH 3.5yo attendance of 63.1%. Discussion with my Victorian based GP brother (Peter Shanley), enlightened me to how this program is not financial for the GP clinic, and thus performed by the practice nurse. His wife who works for him as a practice nurse has attended some study, but when last discussed had only had the opportunity to perform the consult twice, once being for a friend purely for practice. She stated that she is not confident in this role via lack of knowledge and experience. Moreover, the education of practice nurses is not standardized or accredited.

This inadequate experience and training is further exemplified in the proposed '*Healthy Under 5 Kids Education Package*,' that suggests that an online 20 hour self directed package (equivalent to less than three days training) can result in experienced practitioners (page 234). This effort by the Australian Government is a bandaid token to provide extremely basic care and immunization cover to remote and vulnerable communities that struggle to attract qualified staff. Although such an effort can be applauded due to the basic necessity of improvement, comparing quality MCH services such as in Victoria, against subservient ones, devalues the intention of providing high standard Maternal and Child Health services to the people of Australia.

Many inconsistencies existed in the report in relation to recruiting nurses to study MCH. (page 225, 229, 230) As a mother, my income as a part time midwife alone did not justify paying for a course that ultimately would pay less than what I already earned, once you take away the weekend penalties and salary sacrifice opportunities. Therefore the provision of a scholarship provided by Kingston council, was definitely the impedance for me in taking up a student role again, having practiced midwifery and had three children over the 16 years preceding this. I strongly support the provision of these scholarships questioned in recommendation 12.2, and would propose that maybe NSW and other states would still hold midwifery as a required qualification, had they had the insight to promote such a program.

Finally, suggesting on page 230 of the draft report t*hat additional qualifications require recompense for those additional qualifications in the form of higher wages, as can be seen in the relatively high wages paid to child health nurses in Victoria,* is a joke that I do not find amusing. When compared to the other Australian states (page 226), Victorian MCH nurses receive the third highest pay rate, which does not take into account salary packaging which the privatized council employed Victorian MCH nurses are not privy to. When compared to other careers, a minimum of 5 years study and countless years of experience, our pay is appalling.

I thank the Commission for considering my comments above, and welcome the Commission in meeting with myself and other MCH nursing colleagues. I hope that the strengths and qualities of the Victorian MCH nursing service instead of being overlooked, can be adopted by other states, and the the recommendations in the draft are not imposed that reduce and diminish the quality of the Victorian MCH nursing service.

Regards

Maria McKinnon