Australian Nursing Federation (Victorian Branch)

Submission to the *Productivity Commission - Early Childhood Development Workforce - Draft Research Report (June 2011)*

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Section 1 Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional Organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.

The ANF (Victorian Branch) represents in excess of 61,000 nurses, midwives and personal care workers (the latter predominantly in the private residential aged care sector). Our members are employed in a wide range of enterprises in urban, rural and community care locations in both the public and private health and aged care sectors.

The core business for the ANF is the representation of the professional and industrial interests of our members and the professions of nursing and midwifery.

The ANF participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANF (Victorian Branch [Vic Branch]) is pleased to participate in the national consultation being undertaken by the Productivity Commission, Early Childhood Education and Development Workforce Study - and to provide comment on the *Early Childhood Development Workforce, Productivity Commission Draft Research Report (June 2011)* [the Draft Report] (Productivity Commission, 2011).

This submission should be read in conjunction with the initial and supplementary submissions of ANF Federal Office.

Our submission is limited to Chapter 12 of the Draft Report and confined to issues relevant to the Maternal and Child Health nursing workforce.

Section 2 Executive Summary

As recently observed by Emeritus Professor, Dorothy Scott, OAM,

> *The Victorian Maternal and Child Health Service is the envy of the rest of the country and well beyond the shores of this country, as some of us have long known…* (Spark and Cannon, 2011, page 7).

ANF (Vic Branch) agrees with this assessment and contends the high regard with which the Victorian maternal and child health (MCH) nursing service is widely held is in no small part attributable to the comprehensive educational preparation of Victorian MCH nurses. Far from being an optional extra, qualifications in midwifery, general nursing and maternal and child health post graduate programs of study, are the critical linchpin of the high quality Victorian MCH nursing service. Our submission argues strongly against weakening the strong educational platform that underpins Victorian MCH nursing practice, and contends removing midwifery as a qualification prerequisite for Victorian MCH nurses would severely disable the Victorian MCH nursing service – and in turn, reduce the quality of maternal and child health care provided to Victorian families.

Our submission is structured in order of each recommendation within Chapter 12 of the Draft Report.

ANF (Vic Branch) is an ardent supporter of ongoing research in the area of maternal and child health and nursing. As a starting point however, Section 4 of our submission encourages the Productivity Commission to give due regard to research that already exists in this area - and which already informs MCH nursing practice in Victoria. Contrary to the dire picture painted in the Draft Report, the Victorian MCH Nursing Framework does not operate in a "research vacuum", but is strongly informed by contemporary research and grounded in evidence based practice.

In assessing the cost effectiveness of investing in the educational preparation of Victorian MCH nurses, it is imperative to recognise that the first three years of a child's life is a critical period in a child's physical, social and emotional health - and that health outcomes during this time set the foundation for health outcomes into adulthood. This is a period when health services can make their most positive and enduring difference – but equally a time when children are at most significant risk. Our submission therefore urges a strong investment in the educational preparation of the MCH nursing workforce, so that high quality, preventative maternal and child health care can be provided to the community. ANF (Vic Branch) highlights that this will yield lifelong and society wide benefits – together reducing overall economic cost to government (Baldwin, 2001;Tomison and Poole, 2000; Commonwealth of Australia, 2009; Blakester, 2006; Government of Western Australia, 2006)

As outlined in Section 4 of our submission, ANF (Vic Branch) supports concerted and sustained retention and recruitment strategies to guard against the challenges of an ageing workforce, and to ensure that supply of suitably educated and qualified MCH nurses is adequate now - and into the future - to meet the increasing health care demands of a growing community.

As a key plank to ensuring ongoing supply of suitably qualified MCH nurses, ANF (Vic Branch) strongly supports an expansion in the number and quantum of existing scholarships for maternal and child health nursing post graduate programs of study. Section 5 of our submission details that these have been integral to reversing MCH workforce shortages in Victoria, and thus demonstrate the purported barriers to achieving a highly skilled educated MCH nursing workforce can be overcome.

The body of knowledge that Victorian MCH nurses enjoy as a consequence of holding qualifications in general nursing, midwifery and MCH post graduate programs of study, is integral to the practice of MCH nurses within each component of the Victorian MCH nursing service including: the universal and enhanced MCH nursing services and the MCH Line. Section 6 of our submission explains that reliance on this body of knowledge is not limited to the initial period of puerperium, but extends past the first year of life and beyond - because the Key Ages and Stages MCH Framework depends upon the expert clinical judgment of Victorian MCH nurses. This knowledge is also pivotal to MCH nurses practicing in rural locations where there is often reduced access to general medication practitioners and other health professionals.

At the same time, our submission highlights that maternal health and wellbeing has a critical influence on the health, wellbeing, development and safety of the child. Because of this, the Victorian MCH nursing framework has a strong focus on maternal health and wellbeing and therefore requires Victorian MCH nurse to have sound knowledge and professional skills in midwifery care.

Section 7 of our submission considers Draft Report recommendations 12.2 and 12.3 in the context of a National Framework and urges the Productivity Commission to take into account the workforce implications that arise from jurisdictional differences in MCH service delivery. Moreover, we highlight that any reform to maternal and child health must retain the robust qualifications requirements of Victorian MCH nurses, which are so fundamental to the integrity of the Victorian model of MCH care. ANF (Vic Branch) argues that any recommendations in respect of a national framework must be in step with the positive and exciting vision developed by both State and Commonwealth governments for early childhood development, as outlined in*: Investing in the Early years - A National Early Childhood Development Strategy, An Initiative of the Council of Australian Governments* [COAG] (Commonwealth of Australia, 2009) which recommends improving the quality and supply of the MCH workforce as a means to strengthen universal MCH nursing services, and thereby ensure every child has the best start in life.

ANF (Vic Branch) refutes the purported disadvantages identified within the Draft Report of requiring nurses to hold qualifications in midwifery, in additional to qualifications to general nursing and MCH post graduate programs of study. In section 8 of our submission, we argue that an investment in MCH nursing workforce brings lifelong - and far reaching health and society wide benefits, and makes unequivocal good economic sense. There is an increasing body of evidence to support that Victorian children enjoy better health outcomes than children in other states. This reality is reflected in the compelling and recently released *Headline Indictors for Children's Health, Development and Wellbeing, 2011* (Australian Institute of Health and Welfare, 2011) which shows that Victorian children are faring better than their interstate counterparts in four out of eleven headline indicators, and performing at levels either better than - or similar to - the national average in the remaining seven indicators. ANF (Vic Branch) contends that these measures – and the enviable MCH KAS participation rates and high of client satisfaction – are attributable to the quality of the Victorian MCH nursing workforce, and more particularly the robust qualification requirements of Victorian MCH nurses.

The strong educational platform enjoyed by Victorian MCH nurses enables them to provide a comprehensive MCH nursing service to Victorian families from birth to school age and thereby has several important inherent strengths, which have been largely ignored by the Draft Report. These include:

- Increased continuity of care
- Decreased fragmentation of care

- Improved opportunity to develop trusting client /practitioner relationships
- Increased focus on preventative care
- Increased capacity to provide timely care and make early interventions.

There is a plethora of research that supports these factors are pivotal to quality of care, and that they have far reaching and enduring health and society wide benefits. These benefits must feature heavily in any assessment of the Productivity Commission regarding the cost effectiveness of investing in the educational preparation of Victorian MCH nurses.

Whilst practice nurses possess a body of knowledge that is suitable for their area of practice, section 9 of our submission argues that this is entirely inadequate for the roles and responsibilities required of Victorian MCH nurses.

Section 10 of our submission recommends a range of enhanced retention and recruitment strategies to attract sufficient numbers of suitably qualified MCH nurses and health practitioners to practice in remote locations, and within Victoria.

The Victorian MCH nursing service provides comprehensive and high quality, preventative maternal and child health nursing care to Victorian families. ANF (Vic Branch) is pleased to submit the following recommendations that strengthen the highly regarded Victorian MCH nursing service - and which guard against its diminution.

Section 3 Recommendations

ANF (Vic Branch) Recommendation 1

To ensure sufficient supply of suitably qualified and skilled MCH nurses, ANF (Vic Branch) recommends all levels of government implement a range of concerted recruitment and retention initiatives including:

- **Increasing the number of affordable re-entry and refresher programs for registered midwives and nurses who choose to re-enter the workforce**
- **Increasing the number and quantum of scholarships for MCH nurses wishing to undertake Post Graduate programs of Study**
- **Improving clinical supervision and mentoring for MCH nurses entering the field**
- **Providing opportunities for professional development**
- **Providing attractive and competitive salaries to MCH nurses**
- **Improving access to family friendly employment arrangements for MCH nurses with caring responsibilities or as a measure to support the ageing MCH nursing workforce**
- **Promoting a culture that values and respects the enormous wisdom of mature aged workers**
- **Reducing intensification of work for MCH nurses.**

ANF (Vic Branch) Recommendation 2

To ensure ongoing supply of appropriately qualified and professionally skilled MCH nurses, and thereby a high quality MCH workforce, ANF recommends that:

- **Draft Report Recommendation 12.2 be deleted**
- **Scholarship programs to support post graduate education for maternal and child health nurses be introduced across all jurisdictions and**
- **The quantum of scholarship funding provided to support post graduate education for maternal and child health nurses be increased and sufficient to significantly contribute to the cost of tertiary level of study, and to mitigate the increased travel costs that may arise for prospective MCH nurses in rural or remote locations.**

ANF (Vic Branch) Recommendation 3

To strengthen maternal and child health services and thereby improve the health outcomes of children, mothers and families, ANF (Vic Branch) recommends:

- **Draft Report Recommendation 12.3 be deleted**

- **The requirement be retained for MCH nurses practicing in Victoria to hold qualifications in midwifery in addition to general nursing and post graduate programs in maternal and child health nursing**

- **State and commonwealth governments continue to work in collaboration to improve the educational base of the MCH nursing workforce, as outlined in *Investing in the Early years- A National Early Childhood Development Strategy, An Initiative of the Council of Australian Governments* (Commonwealth of Australia, 2009)**

Recommendation 4

To improve the supply of suitably qualified and educated health practitioners to remote areas and thereby "Stop the Gap" of Aboriginal health disadvantage, ANF recommends:

- **Full scholarships be provided to nurses and midwives wishing to undertake post graduate maternal and child health programs of study and choosing to practice in remote locations**

- **Full scholarships be provided to Aboriginal health workers to upgrade their qualifications to undertake post graduate maternal and child health programs of study**

- **Accredited education and professional development in Aboriginal and Torres Strait Islander cultural awareness be provided to all health practitioners to ensure culturally competent MCH nursing care, and thereby increase engagement of MCH nursing services by mothers and families of Aboriginal and Torres Strait Islander descent**

- **A range of incentives be implemented to attract suitably qualified health practitioners to practice in remote areas including but not limited to:**

    - **Significantly improved salaries**

    - **Financial assistance to meet the costs of relocation and housing**

    - **Access to mentoring and professional support**

Recommendation 5

To help "Stop the Gap" of Aboriginal health disadvantage in Victoria, ANF recommends:

- **Funding to Aboriginal Managed Health services in Victoria be made recurrent and significantly increased**

- **MCH nurses employed within ACCHOs and the VAHS (and Midwives employed within the Koori Maternity Service) be provided wage parity to their colleagues employed in the public sector or the universal MCH nursing service**

- **Aboriginal Health Workers employed within these services receive competitive levels of remuneration**

- **Enhanced retention and recruitment initiatives (such as outlined in ANF (Vic Branch) Recommendation 4) be introduced to attract MCH nurses to practice in Aboriginal Managed Health Services**

Section 4 Draft Report Recommendation 12.1

4.1 Evidence Based Practice

ANF (Vic Branch) strongly supports robust and ongoing research in the area of maternal and child health and is therefore broadly supportive of Draft Report recommendation 12.1 which states:

> *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 for child health services, in particular to determine the optimal number and timing of child health checks* (Productivity Commission, 2011, page 223).

At the same time however, it is important that the Early Childhood Development Workforce Inquiry (the Inquiry) acknowledges and gives due regard to research that already exists in the area of maternal and child health care. In contrast to the dire picture painted in the Draft Report, we highlight that the world leading Victorian MCH nursing service (Edgecombe, 2009) is strongly informed by contemporary research and grounded in evidence based practice.

The *Maternal and Child Health Service Programs Standards* [the Standards] (DEECD, 2009) provide an evidence based framework for the provision of high quality MCH nursing care, which in turn is delivered by the MCH Key Ages and Stages (KAS) Framework. The KAS Framework provides a schedule of carefully timed consultations and identifies evidence based activities to be undertaken during these. Relevantly, the KAS Framework was developed by a group of experts in the field, who reviewed available evidence, research and concepts of best practice to determine the optimal number and timing of consultations within the KAS Framework (Colahan, 2011). This included review of findings and recommendations of a report prepared by the Centre for Community Child Health, for the National Health and Medical Research Council [NHMRC], titled *Child Health Screening and Surveillance, A Critical Review of the Evidence* (NHMRC, 2002) and enabled KAS consultations to be timed to coincide with key developmental stages, and to be guided by best practice.

The first stage of a 3 year *Evaluation of the Implementation of the MCH Key Ages and Stages Service Activity Framework* being undertaken by The Centre for Community Child Health outlines that:

> *The new Framework sets out new evidence based activities for each of the ten KAS visits with additional emphasis on health promotion across a range of domains that address both maternal and child health and wellbeing.*
>
> *This Framework includes:*
>
> - *Parents' Evaluation of Developmental Status (PEDS) as a primary developmental screening tool to engage parents in discussion about the development of their child*
> - *Brigance as a secondary developmental screen, used when concerns are identified through the PEDS*
> - *Provision of consistent, evidence based and relevant health promotion handouts, activities and messages at each of the KAS consultations*

- *Provision of consistent, evidence based and relevant interventions that includes a SIDS risk assessment, Quit smoking intervention, screening of maternal health and screening for the presence of family violence*

> *This framework is intended to be complemented by opportunistic activity by MCH nurses, on the basis of their clinical judgment, in response to other parental concerns and nurse observation* (DEECD, 2011, page 5).

Crucially, the KAS Framework provides monitoring and promotion of health and development, together with interventions that go to the core of factors identified within the *State of Victoria's Children Report 2006* (Department of Human Services, 2006) as making a real difference to children's health, wellbeing, learning, development and safety. Additionally, the KAS Framework identifies specific indicators that can be used to measure targeted outcomes of the service framework. (DEECD, 2009

With this in mind, ANF (Vic Branch) is alarmed at the assertion within the Draft Report that states:

> *in the absence of evidence that the reduction in the average number of child health checks delivered by some jurisdictions has had a negative impact on the health and development of children in those jurisdictions, there may be a case for reducing funding to universal child health services. This would in turn reduce demand for child health nurses* (Productivity Commission, 2011, 223).

This assertion is particularly concerning as it ignores research that already exists in the maternal and child health care field of practice, and appears to promote a lack of evidence as a sound platform from which to introduce significant change in the delivery of MCH services. Taylor (2008) argues that an *absence of evidence, is not evidence of absence* (page 121) and therefore we concur, not a strong base from which to advocate a reduction in the number of maternal and child health consultations - especially given these changes relate to preventative health care and interventions delivered during the most formative period of a child's life.

ANF (Vic Branch) strongly supports ongoing research in the maternal and child health space, however urge the Inquiry to amend Draft Report Recommendation 12.1 to reflect that evidence and research already informs Victorian MCH nursing practice.

4.2 Cost effectiveness

On this point, it is imperative that any assessment of the cost effectiveness of MCH nursing services recognise that the first 3 years of a child's life is a critical period in a child's physical, social and psychological development, and that health outcomes during these early years set the foundation for health outcomes and behaviour into adulthood. (Baldwin, 2001;Tomison and Poole, 2000). Further, these formative early years represent a sensitive period in different aspects of a child's development and when a child's brain is most malleable (Commonwealth of Australia, 2009).

Consequently, there is enormous opportunity for health and support services to make a very significant and positive difference during the first 3 years of life. Equally, this is a time when babies and young children are most vulnerable and at greatest risk of suffering enduring detrimental effects that can arise from a lack of preventative health care or early intervention.

Critically:

> *Children who have poor start in life are more likely to develop learning, behavioral or emotional problems which may have far reaching consequences throughout their lives and in turn, the lives of their children. These problems accrue to the whole society in the form of increased social inequity, reduced productivity and high costs associated with entrenched intergenerational disadvantage* (Commonwealth Government, 2009, page 6).

It is our view that significant priority must be placed on ensuring primary preventative health services such as maternal and child health services are well equipped to meet the needs of their communities. Research indicates that investment in these years' yield lifelong - and society wide benefits - and is greatly more cost effective than remedial interventions that may be required later in life as a consequence from a lack of accessible, affordable, timely and quality preventative health care.

We also acknowledge the work of Blakester (2006), who indicates that every dollar invested in the early years saves a further seventeen dollars being spent later in life. We request this fact be strongly considered by the Productivity Commission when making assessments regarding the cost effectiveness of MCH nursing services.

ANF (Vic Branch) argues that an investment in the educational preparation of MCH nurses makes good economic sense especially given the quality of a workforce, and more particularly the respective qualifications and professional skills held by that workforce, is a primary determinate in the quality of early childhood development services is the workforce (Commonwealth of Australia, 2009).

4.3 Supply and Demand

The Draft Report asserts:

> *Government Policy on universal child health services is the main driver of demand for child health services (Productivity Commission*, 2011, page 220).

Whilst it is technically correct that size and nature of an individual service determines the composition, education and skills of the workforce required to deliver that service, ANF (Vic Branch) contends government policy alone should not be considered the true driver of demand for maternal and child health services. We are alarmed at this superficial assessment and instead propose that demand for maternal and child health services is more accurately driven by the factors outlined in the initial submission to the Inquiry by the Australian Nursing Federation, Federal Office. Such factors include but are not limited to:

- Exponentially increasing birth rates within Victoria. For example, Victorian birth notifications increased from 63,622 between 2004 and 2005, to 73,827 between 2009 and 2010 (DEECD 2004 – 2005 and 2009 – 2010)

- Increased complexity in the care needs of child, mother and family care, and related increase in chronic disease (KPMG, 2006)

- Reduced length of maternity inpatient stay (Henderson, 2010)

- Increased community expectations regarding the quality of service provision

- The setting in which the services provided. E.g. rural location

- Changing community demographics including an increase in migrant families or persons of CALD backgrounds.

It is incumbent upon government to ensure that MCH services keep pace and match the demand caused by the factors above by ensuring the MCH nursing workforce is suitable educated, skilled and supplied in sufficient number to meet the health care demands of its community. As detailed in the ANF Federal Office submission to the Inquiry, this is achievable through a concerted and sustained approach to the attraction, retention and recruitment of suitably qualified and skilled MCH nurses.

ANF (Vic Branch) does not consider a reduction in service provision as implied within the Draft Report, as a satisfactory long term method of matching workforce supply to demand. Instead we encourage the Inquiry to make recommendations that improve the supply of suitably qualified MCH nurses and also guard against the challenges presented by the ageing of the MCH nursing workforce.

Recommendation 1

To ensure sufficient supply of suitably qualified and skilled MCH nurses, ANF (Vic Branch) recommends all levels of government implement a range of concerted recruitment and retention initiatives including:

- **Increasing the number of affordable re-entry and refresher programs for registered midwives and nurses who choose to re-enter the workforce**

- **Increasing the number and quantum of scholarships for MCH nurses wishing to undertake Post Graduate programs of Study**

- **Improving clinical supervision and mentoring for MCH nurses entering the field**

- **Providing opportunities for professional development**

- **Providing attractive and competitive salaries to MCH nurses**

- **Improving access to family friendly employment arrangements for MCH nurses with caring responsibilities or as a measure to support the ageing MCH nursing workforce**

- **Promoting a culture that values and respects the enormous wisdom of mature aged workers**

- **Reducing intensification of work for MCH nurses.**

Section 5 Training and Qualifications - Scholarships for Programs of Study - Draft Report Recommendation 12.2

As outlined in the ANF Federal Office submission to the Inquiry, provision of scholarships are successful in Victoria in attracting registered nurses and midwives to undertake MCH post graduate programs of study.

For this reason ANF (Vic Branch) is disturbed by Draft Recommendation 12.2 which states that:

> *Scholarships for postgraduate study in child health nursing may encourage a small number of additional nurses to obtain qualifications in child health or to practice in areas of high demand. The cost-effectiveness of scholarships as a method of achieving this goal should be assessed by governments before any expansion of scholarship programs* (Productivity Commission, 2011, page 229).

We are unable to determine the methodology underpinning this Draft Report recommendation or the assertion that the scholarship scheme:

> *Simply reduces the cost of obtaining scholarships for nurses who would have obtained them anyway* (Productivity Commission, 2011, page 229).

This assessment is at odds with initial submissions made to the Inquiry which instead provide consistent and emphatic support for the enormous value of the scholarship program. It is also inconsistent with recognition within the Draft Report, that the ability to attract and retain MCH nurses depends largely on the relative attractiveness of MCH nursing to other employment options.

Similarly, ANF (Vic Branch) does not consider a purported absence of research into the extent to which scholarships attract prospective MCH nurses to this field as a strong platform to advocate dilution of the scholarship program, and instead suggest the Inquiry consider the compelling field evidence that exists in Victoria on this matter.

At the same time, we are underwhelmed by the Draft Report suggestion:

> *that scholarships and other incentives should only be targeted to nurses who would otherwise be unwilling to practice in demonstrated areas of workforce shortage* (Productivity Commission, 2011, page 229).

We argue this is a reactive and short sighted approach to building MCH nursing workforce capacity, and contend such a measure may in fact increase areas of so called *unmet need,* because of the associated reduction in MCH nursing workforce numbers it would most likely cause. In forming this assessment, we remind the Inquiry that scholarships were first introduced in Victoria in response to disseminated MCH nursing shortages and not in response to small pockets of need. More crucially, these scholarships have proved an integral and spectacularly successful method of reversing MCH nursing shortages and provide unequivocal evidence that the purported *barriers* in achieving a highly skilled and educated MCH nursing workforce can be overcome.

In this context, ANF (Vic Branch) contends an expansion in the existing scholarship programs represents enormous value and benefit especially when considered in the knowledge that:

*A primary determinant of **quality** in early childhood development service is the workforce - their qualification levels and ongoing training*… (And)

The quality of the workforce is a key factor in achieving good outcomes for children... (Commonwealth of Australia, 2009, pages 20 and 8 respectively).

ANF (Vic Branch) Recommendation 2

To ensure ongoing supply of appropriately qualified and professionally skilled MCH nurses, and thereby a high quality MCH workforce, ANF recommends that:

- **Draft Report Recommendation 12.2 be deleted**

- **Scholarship programs to support post graduate education for maternal and child health nurses be introduced across all jurisdictions and**

- **The quantum of scholarship funding provided to support post graduate education for maternal and child health nurses be increased and sufficient to significantly contribute to the cost of tertiary level of study, and to mitigate the increased travel costs that may arise for prospective MCH nurses in rural or remote locations.**

Section 6 Training and Qualifications. Why must MCH nurses be qualified midwives? - Draft Report Recommendation 12.3

Whilst presiding over the current Victorian *Protecting Victoria's Vulnerable Children Inquiry*, Emeritus Professor, Dorothy Scott, OAM observed that

> *The Victorian Maternal and Child Health Service is the envy of the rest of the country and well beyond the shores of this country, as some of us have long known*… (Spark and Cannon, 2011, page 7)

ANF (Vic Branch) agrees with this assessment and contends the high regard with which the Victorian MCH nursing service is widely held is in no small part attributable to the comprehensive educational preparation of Victorian MCH nurses. Far from being an optional extra, qualifications in midwifery, general nursing and post graduate MCH programs of study are the critical linchpin of the high quality Victorian MCH nursing service.

For this reason, ANF (Vic Branch) is strongly opposed to Draft Recommendation 12.3 which states:

> *In order to reduce unnecessary obstacles to attracting new child health nurses, state 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* (Productivity Commission, 2011, page 231).

If implemented, Draft Recommendation 12.3 would remove the essential educational foundation that: underpins the Victorian MCH Nursing Service Framework set out below – and is integral to the practice of MCH nurses employed within the universal and enhanced maternal and child health nursing services and the MCH Line.

6.1 The Universal MCH nursing service

<u>Maternal and Child Health - Key Ages and Stages (KAS) Consultations</u>

Program Standard 1 of the *Maternal and Child Health Service Program Standards* [the Standards], requires that the Maternal and Child Health Service provide universal access to its services for Victorian children from birth to school age, their mothers and families (DEECD, 2009, page 15). Access is provided to Victorian Families through: the universal MCH nursing framework, via the 10 KAS Consultations; the MCH Line; and the Enhanced Nursing Service.

In contrast to other jurisdictions, access to the service is triggered by mandatory birth notifications, required under the *Child and Wellbeing and Safety Act 2005.* KAS consultations commence with an initial home visit. This home visit occurs within 2-7 days following birth and provides an important opportunity for the MCH nurse to comprehensively assess the health and wellbeing of the baby, mother and family within their home environment and to assess for risk factors. This is followed by regular, planned and scheduled consultations at 2 weeks, four weeks, eight weeks, four months, eight months, twelve months, eighteen months, two years and 3 and half years.

Because seven out of ten KAS consultations are provided in the first year of a child's life - and importantly, during the period when a child is at greatest risk of death (Commonwealth of Australia, 2009) - care is significantly focused on facilitating optimal neonatal and infant health and development,

together with providing support and interventions to maximise maternal health and wellbeing. Critically, provision of such care is unavoidably and heavily dependent on the body of knowledge obtained through successful completion of a suitable midwifery qualification. The reliance on this body of knowledge is not limited to the initial period of puerperium, but extends into the first year of life and beyond, because each of the ten KAS consultations is strongly reliant on the clinical judgment and expert assessment skills of Victorian MCH nurse. The dependence on the clinical expertise of MCH nurses throughout the KAS Framework further illustrates the vital need for Victorian MCH nurses to be qualified as midwives in addition to holding undergraduate qualifications in nursing and maternal and child health post graduate programs of study.

Maternal health and wellbeing

Mothers can be the cornerstone of healthy families (Lawn, Tinker, Munjanja and Cousens, 2006). With this in mind, Program Standard 2 of the *Maternal and Child Health Service Program Standards* [the Standards] (DEECD, 2009) recognises the critical influence maternal health and wellbeing have on the health, wellbeing, development and safety of the child and requires that the Victorian MCH nursing service promotes:

> *optimal health and development outcomes for children from birth to school age through a focus on the child, mother and family* (page 20).

In achieving this focus, MCH nurses are required to monitor maternal health and wellbeing at each contact, and to provide care, assessment and interventions around any physical and emotional maternal health issues including:

- *Breastfeeding*
- *Incontinence*
- *Post natal depression*
- *Recovery following childbirth*
- *Adjustment to becoming a mother*
- *Family planning*
- *Partnerships relationship*
- *Management of tiredness and fatigue*
- *Other women's health issues (DEECD, 2011, page 25).*

Providing such a focus is inextricably reliant on MCH nurses having sound knowledge and professional skills in midwifery and further illustration that qualifications in midwifery are integral to Victorian MCH nursing practice.

The focus on maternal and child health and wellbeing as a core influence on a child's health, development and safety is also recognised in the *Competency Standards for the Maternal and Child Health Nurses in Victoria* developed by the Victorian Association of Maternal and Child Health Nurses [VAMCHN], ANF [Vic Branch] (2010), which require Victorian MCH nurses to:

- *Collect a comprehensive medical, obstetric and family history…*

- *Promote maternal physical and emotional health and wellbeing…*

- *Promote, protect and support breastfeeding, through providing support, education and referral to mothers…*

- *Promote appropriate nutrition through education and guidance on optimal nutrition…*

- *Facilitate community linkages and support, such as provided by new parent groups, to reduce social isolation and improve social connectedness…*

- *Promote effective and safe parenting styles and assists parents to understand the needs of their infant or child in relation to their child's stage of development…*

- *Promote the role of the family in the health and development of the child…*

- *Use clinical judgment and critical thinking…*

- *Assist parents to develop an understanding of the needs of the infant or child in relation to their development…*

- *Use evidence based tools to aid clinical judgment and decision making in the assessment of maternal wellbeing…*

- *Use a range of nursing and midwifery knowledge and skills to explore maternal health issues…*

- *Demonstrate an awareness of the importance of promoting the health and wellbeing of the mother…*

- *Explore the emotional health and wellbeing of the mother…* (Pages 13, 14 and 15).

The broad requirements outlined above are not exhaustive in terms of the comprehensive competencies required of Victorian MCH nurses. They do however amply demonstrate Victorian MCH nursing practice is not neatly limited to monitoring and intervening around the health and development of the child, but requires a focus on maternal health and wellbeing – together with viewing the child holistically and as part of a family.

On this point, ANF (Vic Branch) is concerned that that Draft Report has failed to grasp the critical role that mothers play in the health and wellbeing of their child, and therefore given inadequate regard to the related need to ensure that MCH nurses are educationally equipped to promote and maintain maternal health. Our concern that the Inquiry has so failed to understand the interconnectedness between maternal and family health and the wellbeing, safety and development of a child, is compounded by the repeated reference to maternal and child health nurses throughout the Draft Report as simply "child health nurses". The Victorian MCH nursing service is not a proxy community paediatric health care facility or a service for simply 'weighing and measuring babies'. Instead, it plays a crucial role in promoting and maintaining optimal health, development and wellbeing of neonates, babies, young children, whilst also promoting and intervening to ensure optimal health and wellbeing of mothers and families - upon whom a child's survival depends. In this context, it logically follows that the MCH nurses charged with delivering the Victorian MCH nursing service, must be educationally equipped with the body of knowledge and professional experience afforded to them by qualifications in midwifery, general nursing and post graduate MCH programs of study.

The extent to which the professional knowledge and expertise in midwifery is interwoven into the fabric of every day Victorian MCH nursing practice is also reinforced by the comments of MCH nurses who participated in a survey of 325 MCH nurses undertaken by ANF (Vic Branch) in 2008. The theme of these responses is encapsulated in the comments below:

> *A large part of the work MCH nurses do is to encourage and assist with breastfeeding infants. In order to increase the breastfeeding rates of infants which then is linked to increased population health, we need to be providing correct up to date information and support. Midwifery qualifications provide a sound background of knowledge and information of breastfeeding. Midwifery qualifications also ensures we have a thorough understanding of pregnancy, complications of same, different types of deliveries and complications of those and care required. Midwifery also provides a sound basis of neonatal conditions which allows us to provide appropriate care to those families with infants born with a congenital problem. The postnatal recovery period for women post-delivery can be enhanced by having midwifery knowledge to provide correct education and information. Overall midwifery provides a thorough basis for maternal and child health work particularly in the first few months and during pregnancies when we already have contact with families… (Participant number 133)*
>
> *It is essential that a maternal and child health nurse has midwifery skills in order to understand the physiological, social and emotional effects of pregnancy and birth on the mother and infant. There are many instances when a mother is discharged home from hospital that complications arise from the birthing process. These can be life threatening … (Participant number 95)*
>
> *I use midwifery in my practice every day. For example, today I saw a mother at the MCHC for a 2 week visit. She had cracked and bleeding nipples and had heavy PV (per vagina) loss. I was able to use my midwifery skills to teach her correct attachment and positioning while breast feeding and to assess her PV loss, which was heavier than what would be normally expected at this stage post-partum. This may be indicative of retained placenta or membranes or infection, so an appropriate referral was made for follow up (Participant number 68)*
>
> *Maternal and Child Health Nursing involves the mother and the child, as well as the extended family unit. It is essential to have a midwifery degree in order to understand the experience of the mother during the ante-natal period through to the delivery of the child, and then the ongoing post-natal period. In this timeframe, what may be termed as the 'normal' pregnancy and the 'normal' delivery and the non- complicated post-natal period in my view is extremely rare. There are many variations of what can be termed normal and what can be described as complications. It is therefore essential that the nurse has knowledge as well as experience obtained via general nursing and enhanced during midwifery, to understand and most importantly to recognise the variation of disease process often seen in the pregnant woman…. Following delivery, in an everyday clinical scenario, the knowledge of midwifery in everyday practice is essential for understanding the lived experience of the mother and providing appropriate clinical advice. Having a knowledge of medical/surgical /midwifery /neonatal / complications and their outcomes provides the way forward for both mother and child. Advice provided to the mother to enable her to care for her child as well as the health of herself and her family is very extensive and is evidence based. …Without the underpinning of General Nursing and midwifery, and a further prescriptive maternal & Child Health course, our mothers of the future will be severely short changed in the mediocre care that will be available to them. I ask the question 'Is this we want for the future of our Australian Families?' I think not (Participant number 29).*

6.2 Midwifery and the MCH Line

The MCH Line is an important component of the Victorian MCH nursing Framework receiving just over 102,000 calls in the 2009-2010 period (Crook, 2011). The service promotes maternal and child health and wellbeing by providing professional advice and support to parents in need, 24 hours a day, 365 days of the year.

As revealed below, queries to the MCH hotline predominantly relate to:

- Breastfeeding
- Nutritional queries
- Crying or unsettled infants
- Medical advice
- Maternal ill health
- Maternal depression
- Infant or child ill health or behaviours of concern
- Accidents
- Immunisation
- Families in crisis
- Emergency Formula provision

(The Maternal and Child Health Line Annual Report July 2000 to June 2001, unpublished).

ANF (Vic Branch) submits that the nature of these queries go to the heart of the knowledge and clinical experience gained through midwifery qualifications, and provide further illustration of the vital importance of midwifery qualifications to the Victorian MCH nursing service.

6.3 The Enhanced Maternal and Child Health Nursing Service - Vulnerable Families

The strong educational platform that qualifications in midwifery, general nursing and MCH post graduate programs of study provide to Victorian MCH nurses is of pivotal importance to the effectiveness of the Victorian Enhanced MCH nursing service (EMCH). The EMCH nursing service focuses on children, mothers and families who may have been identified at being at risk of poor health outcomes including risk of child neglect or abuse. This service is generally delivered in the family's home but can also be delivered within the MCH nursing centre. MCH nurses within the EMCH nursing service are often required to make difficult assessments of child, maternal and family health and wellbeing and to provide complex MCH nursing care, interventions and referrals.

Relevantly, the positive and enduring benefits to the health of and wellbeing of mothers, families and their young babies and children that flow from an in reach service provided by Maternal and Child

Health nurses with the appropriate educational underpinning, is also well documented in literature. In their article titled *Effects of Home Visits to Vulnerable Young Families* , Kearney, York and Deatrick, (2000) outline that:

> *Mothers' psychological status, including depression, anxiety, stability, psychological distress and perceived mastery, was positively affected by nurses home visiting in three of the 4 studies in which it was measured* (page 372).

On this point, whilst we welcome that the Draft Report has acknowledged that:

> *home visiting programs have been shown to be associated with improvements in some child outcomes and in parenting skills among vulnerable families* (Productivity Commission, page 223);

we are underwhelmed by the absence of analysis within the Draft Report as to why these programs are effective. Crucially, research indicates the effectiveness of home visiting or in reach programs is improved where they are delivered by well qualified MCH practitioners (Olds, Robinson, Pettitt, Luckey, Holmberg, Ng, 2004; Commonwealth of Australia, 2009).

We also caution significance being placed the observation within the Draft Report that:

> *The number of families assisted by home visiting and other targeted child health services is relatively small*… (Page 223);

because funding for this service is restricted to children aged between 0 and 12 months of age, and allocated according to socioeconomic disadvantage – not client demand. Funding is in fact calculated using the Accessibility/Remoteness Index of Australia and the number of maximum tax benefit recipients with a child aged 0 – 6 years (DEECD, 2011). This creates a virtual capping of the number of families and children that are funded to receive enhanced MCH nursing care – and is therefore an inappropriate method to assess demand for this service.

Nonetheless, the EMCH nursing service plays a pivotal role in providing more intensive support to children, mothers and families. Their interventions range from improving protective factors and teaching lifelong parenting skills, to preventing and making early interventions around child abuse and neglect. The comprehensive qualification requirements of Victorian MCH nurses are pivotal to the success of this service. They underpin the often life changing and sometimes lifesaving interventions MCH nurses within this service provide, and are further illustration of the need to uphold the existing qualification requirements of Victorian MCH nurses.

6.4 The Flow on Effect- Midwifery and Early Parenting Centres - Vulnerable Families

Crucially, any strengths and weaknesses within the universal MCH services have direct consequences for other services within maternal and child health, because such services commonly rely on the clinical expertise and knowledge of the highly skilled MCH nurse workforce. For example, Early Parenting Centres (EPCs) that include Mercy Health O'Connell Family Centre, Queen Elizabeth Centre and Tweedle and Family Health perform a crucial function in promotion of maternal and child health, prevention and early identification of child abuse and neglect – amongst a range of other health and wellbeing issues These services provide practical support and education to parents who may have been identified as requiring more intensive support than provided under the universal MCH or enhanced nursing service. EPCs equip parents with lifelong skills and knowledge to become

competent and confident parents, who are able to provide love and care for their children and manage challenging behaviour more effectively. Importantly, EPCs make interventions that directly mitigate the likelihood of known risk factors of child abuse including:

- Low parental self esteem
- Lack of parenting skills or knowledge
- Stress
- Sleep deprivation
- Post natal depression
- Unreasonable high parental expectations regarding the developmental stages of their infant or child
- Inability or difficulty in breastfeeding, from escalating and otherwise leading to the incidence of child neglect or abuse.

The programs offered by Queen Elizabeth Centre are known to have demonstrable and measurable success in improving outcomes relating to maternal health, stress, depression and self-esteem as reported in the Evaluation of the Queen Elizabeth Centre's 5-day Residential Program which found that:

> *Symptoms of depression, anxiety and stress were all reduced after parents completed the program…and parental sense of efficacy and satisfaction increased over the measurement period, and improvements were seen in parent's caregiver behavior when interacting with their children* (Treyvaud, Rogers, Matthews and Seymour 2006, Page 5).

Similarly in the *Report to the Queen Elizabeth Center on the Evaluation of the Queen Elizabeth Day Stay Program for Mothers with Infants and Toddlers*, Hayes and Matthews report:

> *That mothers who attended the Queen Elizabeth Day Stay program reported improvement in their psychosocial wellbeing and parental satisfaction…(and) improvement in their child's problematic behavior , such as night walking, settling and behavioral difficulties, with decreases in problem behavior severity, and decreases in the frequency of occurrence of problem behavior. In contrast, there were no such improvements reported by the waitlist group over the same period of time and before attending the program* (2003, Page 8).

In summary, the services offered by early parenting centres can be pivotal in equipping parents with the lifelong requisite skills of parenting and in providing early intervention around the factors that are known to otherwise contribute to child abuse. The comprehensive knowledge base of Victorian MCH nurses in contributing to these outcomes should not be underestimated - and serves as another illustration of the enduring and far reaching benefits that flow from the comprehensive qualification requirements of Victorian MCH nurses.

6.5 MCH nursing in rural locations

The requirement to hold qualifications in general nursing, midwifery and a specialist post graduate qualification in maternal and child health is of paramount importance for MCH nurses working in rural locations throughout Victoria.

In regional and rural such locations, there is often reduced access to general medical practitioners or specialist medical and allied health services. This has implications for MCH nurses who, in addition to providing specialist MCH nursing care, are also often expected to assume a quasi-advanced generalist role (Hegney, McCarthy, Rogers-Clark and Gorman, 2002). Because MCH nurses working in rural locations have great diversity of practice, they require a broad and wide scope of clinical practice. This mandates that MCH nurses practicing in rural areas have a robust educational preparation, and is further illustration of the vital importance of MCH nurses holding qualifications in general nursing, midwifery and MCH post graduate programs of study.

Section 7 Discussion - Draft Recommendation 12.3

7.1 Midwifery and a National Approach to MCH nursing

The comprehensive knowledge base enjoyed by the Victorian MCH nurse workforce is integral to implementation of the Victorian MCH nursing service across Victoria. Conversely, diminution of this strong educational platform would severely disable the capacity of MCH nurses to deliver the Victorian MCH nursing framework safely and competently.

With this in mind, ANF (Vic Branch) considers Draft Recommendation 12.3 to be a destructively ill fitted and overly prescriptive attempt to achieve national consistency - and is entirely at odds with the overarching objectives of the national approach to maternal and child nursing espoused by Allen Consulting Group who caution:

> *A key objective of a national framework is to promote consistency in family health services across Australia**. However, this objective needs to be carefully balanced with the need to allow jurisdictions flexibility to deliver services in line with local needs. A national framework also needs to be able to take account of different service delivery and funding arrangements in jurisdictions…A key issue for this project is to understand where a consistent approach would deliver the most benefits*** (The Allen Consulting Group, 2009, page 39) and
>
> *There are many examples of high quality, evidence based universal child and family health services across the country…**This Framework by no means seeks to prescribe service delivery or restrict the flexibility of services to deliver innovative services**…For that reason the Framework operates at a high level, providing suggestions and support for evidence based practice…* (The Allen Consulting Group, 2009, page 57).

The ANF (Vic Branch) urges the Productivity Commission to take into account the workforce implications that arise from jurisdictional differences in service delivery. Moreover, we highlight that the Victoria model of MCH service delivery is highly regarded (Edgecombe, 2009) because the MCH nursing workforce holds qualifications in general nursing, midwifery and MCH post graduate programs of study – and therefore enjoys a strong and broad knowledge base. It is crucial that any reform to maternal and child health retain these fundamental qualifications for this group of health professionals.

Crucially, any recommendation by the Productivity Commission regarding a national framework must be in step with the positive and exciting vision developed by both State and Commonwealth governments for early childhood development, as outlined in*: Investing in the Early years - A National Early Childhood Development Strategy, An Initiative of the Council of Australian Governments* [COAG] (Commonwealth of Australia, 2009).

The *National Early Childhood Development Strategy* seeks to improve early childhood outcomes through implementation of:

> *National workforce initiatives to **improve the quality and supply** of the early childhood education and care workforce* (Commonwealth of Australia, 2009, page 5).

The National Early Childhood Development Strategy identifies that the **quality of the workforce** is a key factor to achieving good outcomes for children, and in turn, the quality of the workforce is significantly dependent upon the **level of qualifications and ongoing training** the workforce has.

This State and Commonwealth collaboration also identifies that:

> *There is good evidence that **quality** maternal child and family health, early childhood education and family support programs make a significant difference for improving outcomes for children* (Commonwealth of Australia, 2009, page 8).

With this in mind, *The National Early Child hood Development Strategy* identifies six areas of immediate action identified to achieve the vision that all children have the best start in life. These priority areas require State and Commonwealth governments to:

- ***Strengthen universal maternal, child and family health services***
- ***Support Vulnerable children***
- *Improve early childhood structure*
- *Build parent and community understanding of the importance of early childhood development*
- ***Strengthen workforce** across early childhood and family support services*
- *Build better information and a solid evidence base (*Commonwealth of Australia, 2009, page 23).

ANF (Vic Branch) does not support that the reduction in the comprehensive educational platform of MCH nurses that would occur as consequence of Draft Report Recommendation 12.3, can reasonably be considered a measure to strengthen our world class MCH nursing service, or a means to improve the quality or supply of the Victorian MCH nursing workforce. Instead, this recommendation presents as the antitheses to the vision and action plan for MCH nursing services endorsed by COAG in 2009, as outlined in *Investing in the Early years- A National Early Childhood Development Strategy, An Initiative of the Council of Australian Governments* (Commonwealth of Australia, 2009).

7.2 Professional Scope of Practice

The proposed removal of midwifery qualifications as a prerequisite for Victorian MCH nurses also poses significant doubt regarding their ability to practice in accordance with the Professional Codes, Standard's and Guidelines established by the Australian Nursing and Midwifery Council and the Nursing and Midwifery Board of Australia, and required of them under the *Health Practitioner Regulation National Law (Victoria) Act 2009.*

The Australian Nursing and Midwifery Council (ANMC) *Code of Professional Conduct for Nurses in Australia* requires that:

> *nurses practise in a safe and competent manner* [(and that)]
>
> *nurses are aware that undertaking activities not within their scopes of practice may compromise the safety of persons in their care. These scopes of practice are based on each nurse's education, knowledge, competency, extent of experience and lawful authority* (Australian Nursing and Midwifery Council [ANMC], page 2).

The removal of the current requirement for MCH nurses in Victoria to hold qualifications in midwifery in addition to general nursing and a post graduate MCH qualification would ostensibly require Victorian MCH nurses to undertake employment to practice in areas of responsibility for which they are not educationally prepared. Such a development clearly fails to the public and may place these nurses in a professional quandary that is at odds with their professional obligations to practice in accordance with the Professional Standards, Codes and Guidelines set out within the *Health Practitioner Regulation National Law (Victoria) Act 2009.*

Section 8 Discussion – The purported disadvantages *of requiring MCH nurses to hold qualifications in midwifery*

ANF (Vic Branch) notes that the Draft Report has indicated:

> *there are a number of important disadvantages of requiring child health nurses to have qualifications in midwifery* (Productivity Commission, page 230, 2011).

As will be explored in the remainder of this section, we do not concur with this assessment.

8.1 The costs of obtaining qualifications

ANF (Vic Branch) refutes the assertion within the Draft Report that:

> *the time and cost of obtaining qualifications in nursing midwifery and in child health nursing could reduce the number of potential entrants to the filed contributing to workforce shortages in some areas* (Productivity Commission, 2011, page 230).

We cannot find the methodology relied upon by the Productivity Commission in forming this view, nor evidence relied upon to support this assumption.

Further we understand that RMIT and La Trobe Universities - who provide post graduate nursing qualifications in maternal and child health nursing - experience strong demand from midwives and registered nurses to undertake their respective MCH post graduate programs of study, (Ridgway, 2011; Associate Prof Shahwan-AKL, 2011). Notwithstanding the critical importance that scholarships play in attracting potential entrants to Victorian MCH post graduate programs of study, the success that RMIT and La Trobe Universities enjoy in attracting prospective students demonstrates that the requirement to be a registered midwife and registered nurse is not an impediment to the number of potential entrants to MCH nursing in Victoria, but rather an asset.

At the same time, we do not accept submission 81 from Centre for Community and Child Health gives any credence to the proposed deskilling of the maternal and child health nursing workforce espoused in the Draft Report. On the contrary, submission 81 strongly supports the importance of ensuring the early childhood development workforce is appropriately educated and skilled stating that:

> *Lessons from Toronto First Duty in Canada have found that when integrated teams of qualified staff share spaces and resources and work together to plan programs for children and families, the learning environment is strengthened and program quality is improved …The link between program quality and outcomes for children is now well established….*
>
> *Early childhood is a unique period influenced by neurological research; psychology; community health; and more recently, early childhood pedagogy. It is important that training content reflects this complexity and enables practitioners to become highly skilled. In order to be recognised for the unique contribution it makes to childhood learning and development**, it is vital that the qualification standards of the workforce be raised** (Pages 2 and 3).*

Finally, even if one was to accept that such qualifications presented challenges for ensuring adequate numbers of MCH nurses, we submit that focus must reasonably be on how to mitigate such challenges to ensure supply of appropriately skilled MCH nurses is sufficient to meet demand. *The Maternal and*

Child Health Nursing Service Workforce Strategy, January 2004 (Department of Human Services, 2004) provides guidance on how this can be achieved and is an example of how government can implement successful strategies to attract and retain sufficient numbers of MCH nurses. This document outlines four key strategy areas including:

1. *Recruitment and re-entry strategies aimed at improving the supply of local government MCH nurses. Key areas for action include the development of scholarship programs, re-entry courses, university open day programs, and marketing programs aimed at stimulating interest in the profession.*

2. *Retention strategies aimed at providing options for improving the retention of local government MCH nurses including improvement in clinical supervision, and the development of preceptor roles and models to manage competing work demands.*

3. *Labour market strategies aimed at stimulating the supply of local government MCH nurses over the long term. Key areas for action include the review of the range and extent of services performed by MCH nurses in the local government MCH service, career path development, and ensuring provision for adequate education places*

4. *Service provision strategies aimed at introducing aspects of the recently developed Children First policy (Page 5).*

The field evidence in Victoria demonstrates that these strategies are spectacularly successful and we therefore urge the Productivity Commission to adopt such measures as a means to strengthen the MCH nursing Workforce.

8.2 Recompense for additional qualifications

The Draft Report outlines that:

> *workers with additional qualifications require recompense for those qualifications in the form of higher wages as can be seen in the relatively high wages paid to child health nurses in Victoria* (Productivity Commission, 2011, page 230).

ANF (Vic Branch) argues this is a flawed foundation upon which to contend the qualifications requirements of MCH nurses should be diluted, and is in direct conflict with acknowledgment within the Draft Report that provision of competitive and adequate remuneration is critical to the attraction and retention of MCH nurses.

On this point, we note the Draft Report has identified:

> *The **ability to recruit and retain nurses to child health services depends on the attractiveness of employment in those services, compared to nurses' other employment options. While this is largely determined by the remuneration** and conditions offered to child health nurses, other factors also contribute to making child health nursing attractive to many potential workforce entrants. For instance, professional autonomy and the ability to establish relationships with families contribute to the desirability of working in child health (Productivity Commission, 2011, page 225).*

Similarly, we note that the *Centre for Community and Child Health* has highlighted that:

> *Given our understanding that in the early years all education is care and all care is educational, it is imperative to* ***develop equivalent remuneration and conditions that are determined by qualification,*** *rather than setting, in order to enhance the capacity for innovation and flexibility that meets the needs of families and children …(Submission 81, page 4).*

Whilst naturally supportive of improved salaries for all MCH nurses in Victoria, we also note that Table 12 of the Draft Report (Productivity Commission, page 226) provides little support for the notion that the robust qualification prerequisites of Victorian MCH nurses has led to unreasonable or excessive wage growth in this sector. On the contrary, Victorian MCH nurses are ranked a modest third in respect to their interstate counterparts. Given this, and the connection between adequate and competitive levels of remuneration and the attraction and retention of MCH nurses, ANF (Vic Branch) contends a reduction in MCH nurse remuneration through removal of the MCH nurse qualification requirements, cannot logically be argued as a means to ensure adequate supply of the MCH nursing workforce.

8.3 Restriction of Movements

ANF (Vic Branch) is unable to identify the methodology supporting the Draft Report assertion:

> *that these requirements restrict movement of nurses between jurisdictions* (Productivity Commission, 2011, page 231).

We observe the submission from the Australian College of Children's and Young People's Nurses (submission 45) is devoid of any evidence or detail to support that this is a significant issue obstructing supply of the Victorian MCH nurse workforce.

ANF (Vic Branch) does not accept that this purported problem is of sufficient size and scope as to justify upheaval the high quality MCH nursing service Framework - and contends that quality care and protection of the public must take precedence over the personal relocation desires of nurses and midwives from other jurisdictions.

8.4 Health Outcomes - The Evidence

ANF is particularly concerned with the assertion in the Draft Report that suggests:

> *The Commission was not told of, nor could it find, any evidence to suggest that Victorian children have better health outcomes than their counterparts in other states as a result of being seen by more highly qualified child health nurses. If the additional qualification requirements did indeed contribute to child health outcomes, it could be expected that some evidence to this effect would be available. In light of these factors, the Commission considers that there is little justification for requiring child health nurses to hold qualifications in midwifery* (Productivity Commission, 2011, page 231).

We contend this assessment is unsupported by the facts and unhelpfully skewed by the startling absence of discussion, documentation - or acknowledgment - of existing evidence pointing towards improved health outcomes for Victorian Children, and the far reaching and enduring benefits that flow from comprehensive educational requirements of Victorian MCH nurses.

Before exploring these critical points, it is important to acknowledge that measurement of child health outcomes is a complex matter. The Allen Consulting Group has identified that deficiencies exist in data a collection and that the related ability to measure outcomes is limited in some jurisdictions. At the same time a number of commentators including Schmied, Homer, Kemp, Thomas, Fowler and Kruske, (2008) and The Allen Consulting Group, (2009) highlight there is some disagreement regarding what should be considered headline indicators of child health - and recognition that the effect of some early childhood interventions may not be apparent or measurable until adulthood

8.4.1 Australian Institute of health and Welfare (AIHW) Headline Indictors

Despite these challenges however, the somewhat compelling and recently released *Headline Indictors for Children's Health, Development and Wellbeing, 2011* (Australian Institute of Health and Welfare, 2011) indicates that Victorian children are faring better than their interstate counterparts in four out of eleven headline indicators, and performing at levels either better than - or similar to - the national average in the remaining seven indicators. For example:

Developmental Vulnerability

Proportionally, the percentage of Victorian children (20.3 percent) who were developmentally vulnerable on one or more domains of the AEDI (percent) is lowest than in any other state and is significantly less than the national average of 23.5 percent

Literacy

The proportion of Grade 5 Victorian Children achieving at or above national minimum standards for reading is higher than any in other state (94.2 percent compared to the national average of 91.7 percent)

Numeracy

The proportion of Grade 5 Victorian Children achieving at or above national minimum standards for numeracy (percent) is higher than any in other state (95.5 percent compared to the national average of 94.2 percent)

Death rates due to injury

Child death rates in Victoria are the second lowest in Australia with 4.4 deaths per 1000,000 children, compared to 5.8 per 100, 000 nationally

Infant Mortality

Mortality rates for Victorian infants less than one year of age (deaths per 1,000 live births) are the second lowest of any other state (3.8 percent compared to the national average of 4.2 percent)

Child Abuse and Neglect

The rate of Victorian children aged 0-12 years who were the subject of a child protection substantiation of a notification received in a given year is the third lowest (5.9 per 1,000 children) and significantly lower than the national average of 6.9 per 1,000 children

Low birth weight, Immunisation, Dental health and Obesity

Statistics relating to birth weight immunisation, dental health and obesity indicate that Victorian children at similar levels to the national average (Australian Institute of Health and Welfare [AIHW], 2011, page 14)

At the same time this important report has identified:

- *The critical importance of strengthening the foundation of health in the prenatal and early childhood periods and identified that doing so may have long lasting positive effects; and*

- *That there is good evidence to support that early intervention and prevention in the areas of maternal and child family health can improve outcomes for children* (AIHW, 2011, page 1).

In this context, the statistics pointing to improved health outcomes for Victorian Children should - in no small part - be attributed to the high quality Victorian MCH nursing service, and moreover the comprehensive educational qualifications of the Victorian MCH nursing workforce who deliver this service.

8.4.2 Participation rates-the Victorian MCH nursing service

The Victorian MCH nursing service experiences enviable client participation rates and engagement as evident in the 2009 – 2010 Key Ages and Stages participation rates below:

- 99.8 % Home Consultation
- 96.6% 2 weeks
- 95.4% 4 weeks
- 94.7% 8 weeks
- 91.5% 4 months
- 82.7 8 months
- 80.3 12 Months
- 71.6 18 months
- 69.1 2 years; and
- 63.1% 3.5 years

(Maternal and Child Health Services Annual Report, 2009- 2010, Statewide DEECD, 2010).

Additionally, as outlined in the recent report titled *Maternal and Child Health Service, Achievements Since 2000:*

> *Participation rates have increased in the last 4 years. In 2006–2007 the participation rates were 69.1% at 18 months, 64.8% at 2 years and 57.8% at 3.5 years compared with 2003/04 where the participation rates were 63.9% at 18 months, 58.4% at 2 years and 50.3% at 3.5 years* (DEECD, 2010, page 2).

We contend that these enviable participation rates should be given special attention by the Inquiry, particularly given The Allen Consulting Group has recommended in respect of determining health outcomes that:

> *A first step would be to determine the current performance of services, particularly in access and participation to establish a benchmark from which to measure progress under a national framework. This process would also assist in developing an understanding of the level of change required in each jurisdiction to achieve a truly universal service for all children in line with the vision for a national framework*…(2009, page 48).

We also note that Schmied et al (2008) observed the Victorian MCH nursing service has been:

> *Found to be accessible and acceptable to most parents and families and mothers reported that they were provided with high quality information, education and support* (2008, page 19).

ANF (Vic Branch) submits that the enviable MCH service client participation rates are no accident. Instead, these are significantly attributable to the sound educational platform Victorian MCH nurses enjoy as a consequence of their qualifications in midwifery general nursing and post graduate MCH programs of study.

8.4.4 Levels of Client Satisfaction

In an evaluation undertaken by KPMG into the Victorian MCH nursing Service, it was found that:

> *Clients of the service display high levels of satisfaction (in excess of 95% of clients are satisfied with the service) with the service and endorse all components and aspects of the service* (KPMG, 2006, page 3).

Victorian families are overwhelming positive about the MCH nursing service and in particular the support provided by Victorian MCH nurses (DEECD, 2011). The relevance of these high levels of satisfaction should not be underestimated, and are further indication that the robust qualification requirements of Victorian MCH nurses make a positive difference to the quality of the service they provide.

8.4.5 Breastfeeding rates

The Victorian Breastfeeding rates expressed as a percentage (includes exclusive and partial breastfeeding) are as follows:

ANY	1999/00	2000/01	2001/02	2002/03	2003/04
Discharge	81.64	83.59	83.41	83.63	83.9
2 Weeks	76.98	78.16	78.36	77.94	81.4
3 months	58.26	59.16	58.59	57.65	57.72
6 months	44.59	45.19	44.09	43.14	43.9

ANY	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Discharge	84.2	85.3	85.3	86.1	86.1	86.6
2 Weeks	77.7	80.2	79.7	80.8	80.8	81.1
3 months	58.8	60.1	60.4	61.2	61.2	61.2
6 months	46.7	45.9	46	46.9	46.9	45.6

(Ormston, 2011)

ANF (Vic Branch) submits that the steadily increasing breastfeeding rates in Victoria can in part be attributed to the high quality MCH nursing service and provide a further reminder of the critical importance of midwifery qualifications to Victorian MCH nurses.

8.5 Benefits versus Cost

In the Draft Report, it is asserted that:

> *While the costs of the additional qualification requirements are considerable, the benefits are both diffuse and uncertain (Productivity Commission, 2011, page 231).*

ANF (Vic Branch) strongly rejects this proposition and contends the assessment is unhelpfully imbalanced because the Draft Report has largely ignored the significant and far reaching benefits that flow from the robust qualification requirements of Victorian MCH nurses. These include but are not limited to:

Improved continuity of care and decreased fragmentation of care

The broad scope of practice of enjoyed by Victorian MCH nurses equips them to provide care to babies, young children, mothers and families from as early as 24 hours after birth, through puerperium and into early childhood. This reality enables greater continuity of care than exists in other jurisdictions throughout Australia, whilst also reducing fragmentation of care. In contrast to other jurisdictions where primary care of the mother and baby can be divided or splintered amongst different health practitioners, Victorian MCH nurses are the metaphorical "one stop shop" for primary maternal and child health care.

More timely care

In turn, the broad scope of practice enjoyed by Victorian MCH nurses enables them to provide timely health assessments and interventions. This can also reduce the need for clients to seek help with other health practitioners that may instead prove time-consuming, difficult or result in additional expense to clients and or government. The importance of providing care and interventions in a timely manner is well recognised for its multifaceted and lifelong benefits (Caldwell, 1992).

Trusting relationships

At the same time, because Victorian MCH nurses are educationally able to commence their care giving relationship with babies, mothers and families at such an early stage, they are also very well positioned to develop trusting relationships with their clients. Trusting relationships are critical to effective maternal and child health practice (Schmied et al, 2008; Briggs, 2007, Centre for Community Health, 2010), and illustrate a further advantage of requiring MCH nurses to be qualified as midwives, nurses and to have successfully completed post graduate MCH programs of study.

Increased focus on prevention

The KAS framework enables a strong focus on preventive health care and early intervention. This is afforded by the intensive nature of the service when compared to other jurisdictions where consultations are offered in a less structured way and where there is greater reliance on opportunistic care. This is an important strength of the Victorian MCH nursing service, particularly given the plethora of research highlighting the importance of prevention and early intervention in respect of averting human misery, child abuse and neglect - and the associated long term cost savings.

The material traversed in sections 7 and 8 of this submission demonstrates the critical need for Victorian MCH nurses to hold qualifications in general nursing, midwifery and post graduate programs in maternal and child health nursing. The knowledge and professional skills gained through these are integral to Victorian MCH nursing practice and implementation of the highly regarded Victorian MCH nursing service framework. At the same time, there are significant and enduring benefits arising from the strong educational platform underpinning Victorian MCH nursing practice, which far outweigh the costs of requiring MCH nurses to hold qualifications in general nursing, midwifery and MCH post graduate programs of study.

Recommendation 3

To strengthen maternal and child health services and thereby improve the health outcomes of children, mothers and families, ANF (Vic Branch) recommends:

- **Draft Report Recommendation 12.3 be deleted**

- **The requirement be retained for MCH nurses practicing in Victoria to hold qualifications in midwifery in addition to general nursing and post graduate programs in maternal and child health nursing**

- **State and commonwealth governments continue to work in collaboration to improve the educational base of the MCH nursing workforce, as outlined in *Investing in the Early years- A National Early Childhood Development Strategy, An Initiative of the Council of Australian Governments* (Commonwealth of Australia, 2009).**

Section 9.0 Practice Nurses

Whilst ANF (Vic Branch) values the role practice nurses play in the general practice setting, we are concerned at the suggestion within the Draft Report that:

> *The substantial number of child health nurses working in general practice could therefore be thought of as a reserve pool of child health nurses, who may return to child health over time…* (Page 225)

ANF (Vic Branch) does not accept that practice nurses are a suitable substitution for MCH nurses, as is implied by this statement. In forming this view, we highlight that practice nurses enjoy an entirely different educational preparation and scope of practice than MCH nurses. Whilst this educational platform is suitable for their defined practice nurse role, it is does not adequately equip them to undertake the roles, functions and responsibilities required of MCH nurses and which are relevant to the specialist MCH nursing setting. As illustration of this we note that:

- Practice nurses have varying levels of educational preparation, with only 40% holding a post graduate certificate and 21% possessing a post graduate diploma (Australian Practice Nurses Association, [APMA], 2011)

- The practice nurse workforce is comprised of enrolled nurses, (9%), registered nurses (78%), midwives (7%) and nurse practitioners (less than 1%) (APNA, 2011).

At the same time:

- 28% of practice nurses have never undertaken an antenatal check (APNA, 2011); and,

- 15% of practice nurses have never undertaken a child health assessment (APNA, 2011).

With such assessments comprising the core business of maternal and child health - and only 7% of the practice nurse workforce comprised of registered as midwives, and therefore educationally prepared to provide maternal and neonatal care in the puerperium period - the substitution of MCH nurses with practice nurses does not strike ANF (Vic Branch) as a valid, warranted or desirable early childhood development workforce initiative

At the same time we note that Victorian Families are voting with their feet on this issue. Participation rates for the *Healthy Kids Check* undertaken within the general practice general is approximately 7% (Raitman, 2011) and is therefore a faction of the 63.1% (DEECD, 2009 - 2010) participation rates enjoyed under the 'equivalent' KAS three and half year old consultation provided as part of the universal maternal and child health service.

Section 10 Remote Area Nursing - Aboriginal Health - Draft Report Recommendation 12.4

ANF (Vic Branch) supports the role of Aboriginal Health Workers (AHW) as an important adjunct and support to suitably qualified nurses and midwives. We further support competency based education and preparation for Aboriginal Health Workers, that is conducted in the vocational sector to a level appropriate to articulation and credit transfer to other nursing and midwifery programs. Nurses and midwives can delegate activities to Aboriginal Health Workers having regarded to: the degree of educational preparation of the AHW; their demonstrated competence; the acuity of the client and in the context of where the care is being provided.

Whilst we acknowledge the provision of maternal and child health services to remote communities has significant challenges, ANF (Vic Branch) does not consider the suggested 20 hour *Healthy Kids Education Package Training Package* is adequate to enable Aboriginal Health Workers to provide care to children aged from birth to 5 years, nor the solution to overcoming these challenges.

To ensure that every Aboriginal child - irrespective of their geographical location - has access to quality maternal and child health care, ANF (Vic Branch) argues concerted and sustained strategies must be implemented to enable adequate supply of suitably qualified MCH nurses to these areas. These may include the strategies outlined in Recommendation 1 of this submission, together with targeted and enhanced incentives to attract qualified MCH nurses to practice in remote areas.

Recommendation 4

To improve the supply of suitably qualified and educated health practitioners to remote areas and thereby "Stop the Gap" of Aboriginal health disadvantage, ANF recommends:

- **Full scholarships be provided to nurses and midwives wishing to undertake post graduate maternal and child health programs of study and choosing to practice in remote locations**

- **Full scholarships be provided to Aboriginal health workers to upgrade their qualifications to undertake post graduate maternal and child health programs of study**

- **Accredited education and professional development in Aboriginal and Torres Strait Islander cultural awareness be provided to all health practitioners to ensure culturally competent MCH nursing care, and thereby increase engagement of MCH nursing services by mothers and families of Aboriginal and Torres Strait Islander descent**

- **A range of incentives be implemented to attract suitably qualified health practitioners to practice in remote areas including but not limited to:**

    - **Significantly improved salaries**

    - **Financial assistance to meet the costs of relocation and housing**

    - **Access to mentoring and professional support**

We also urge the Inquiry to consider provision of maternal and child health care to persons of Aboriginal descent in a wider context, including additional measures to support Aboriginal Managed Health Care services in Victoria including:

- The Koori Maternity Service
- The Victorian Aboriginal Health Service (VAHS) in Fitzroy which employees on full time MCH nurse
- Aboriginal Community Controlled Health Organisation (ACCHO) in 10 sites across Victoria
- Mainstream MCH nursing services via the KAS Framework

(http://www.health.vic.gov.au/maternitycare/progs.htm#koori last accessed 3/05/11).

The role of these services is to provide women and families of Aboriginal or Torres Strait Islander descent access to timely and professional midwifery and maternal and child health care and services. Critical to the effectiveness of such services is that they are culturally appropriate and delivered in a manner that facilitates maximum engagement and utilisation by Aboriginal or Torres Strait Islander women and their families.

The services provided by ACCHOs are generally delivered by a combination of MCH nurses and aboriginal health workers. The services often contain a very practical element of support and assistance to mothers of Aboriginal or Torres Strait Islander descent. They provide a professional component of care together with practical support measures, such as providing transport to assist mothers and parents are able to attend appointments and utilise required support services. Such a combination of support is crucial to ensuring mothers and families of Aboriginal or Torres Strait Islander descent have access to - and moreover utilise - professional support and assistance in all aspects of parenting and care of their young infants and children.

This is particularly important given Victorian Aboriginal children can experience greater challenges from within their families compared to non-Aboriginal families, and that they live in homes where there is more likely to be risk factors of child abuse or neglect such as:

- Sole parent families
- High levels of parental unemployment
- High proportion of expenditure on housing
- Greater levels of poverty
- Greater levels of family stress as result of mental illness, serious physical illness, alcohol and drug related problems.

The Department of Education and Early Childhood Development Victoria (2009) report titled *The State of Victoria's Children 2009. Aboriginal children and young people in Victoria,* also identifies that Aboriginal children remain overrepresented in child investigations and placements and underrepresented in usage of universal and secondary support services.

ANF (Vic Branch) concurs with our colleagues from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) that additional and ongoing funding must be guaranteed to these services so that they can attract sufficient supply of suitably qualified MCH nurses. For example, MCH nurses employed within Aboriginal Managed health Services are commonly remunerated at levels significantly lower than MCH nurses employed within the mainstream universal MCH nursing service (Nicole Huxley, CEO VACCHO, personal contact 8/05/11).

Recommendation 5

To help "Stop the Gap" of Aboriginal health disadvantage in Victoria, ANF recommends:

- **Funding to Aboriginal Managed Health services in Victoria be made recurrent and significantly increased**

- **MCH nurses employed within ACCHOs and the VAHS (and Midwives employed within the Koori Maternity Service) be provided wage parity to their colleagues employed in the public sector or the universal MCH nursing service**

- **Aboriginal Health Workers employed within these services receive competitive levels of remuneration**

- **Enhanced retention and recruitment initiatives (such as outlined in ANF (Vic Branch) Recommendation 4) be introduced to attract MCH nurses to practice in Aboriginal Managed Health Services**

Section 11 Conclusion

If we value our children, we must cherish their parents (John Bowlby)

The highly regarded Victorian MCH service provides high quality, comprehensive preventative primary health care to children, mothers and families in the community. The expert care and interventions provided by MCH nurses have far reaching, lifelong and society wide benefits. They reduce the overall health care cost to government, through a focus on health promotion, prevention and early intervention. Crucially, these benefits are achievable because of the robust educational preparation of Victorian MCH nurses - and are inextricably linked to the requirement for them to hold qualifications in general nursing, midwifery and MCH post graduate programs of study.

With this in mind, we urge the Inquiry to make recommendations that strengthen – rather than weaken - the quality of the MCH workforce, and thereby allow Victorian MCH nurses to continue improving the health outcomes for Victorian children, mothers and families.

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