PERSONAL SUBMISSION TO THE PRODUCTIVITY COMMISSION EARLY CHILDHOOD DEVELOPMENT WORKFORCE STUDY, DRAFT REPORT (JUNE 2011)

1.Introduction

In my humble opinion I would not have been able to work safely and professionally throughout the 21 years of my nursing career without the educational training in an Accredited Tertiary Educational Institution. I was fortunate to have had excellent Lecturers, teachers, instructors and mentors of the best caliber for whom my professional admiration does not cease. I am well aware of my professional boundaries and accountability, I do and must practice within these established standards that have been developed as science and technology evolved after the industrial revolution. Before this time we are all aware that disease was prevalent and there was high mortality. Public health was non-existent and people were lucky to live pass 65 yrs of age. In our days in Australia the "LUCKY" country as many call it (me included as I emigrated from a third world country when I was 21 years of age) we have an excellent health system second to none, our morbidity and mortality rates are low (except for the aboriginal population). Australia's life expectancy in 2009 was increased to 81.5 years Source: World Bank, World Development Indicators- 2009. This is the product of years of scientific and technological advances that go with been a rich developed country. However, there is much more to be done so that our Aboriginal and rural populations catch up with these benefits and when the whole country adopts the golden standards of Maternal/Family and Child Health Care.

2.Overview

My Submission is limited to Chapter 12 of the Early Childhood Development Draft Report, and the "Child Health Work Force".

My concerns are related to the recommendations 12.2 and 12.3 of the draft report regarding: A) the removal of midwifery as a qualification prerequisite of Maternal and Child Health Nurses or Family and Child Health Nurses. B) The questioning of the value of scholarships for nurses who are willing to take further studies to become competent practitioners.

Having been looking for employment in recent days in Queensland and New South Wales, I am very aware of the inequalities on qualifications and pay the same group of professionals get and the different array of terms by which they are identified. The adverts for some of the positions for Family and Child Health Nurses/Maternal and Child Health Nurses would say "Generalist Nurse" "Practice Nurse". Another would read "Baby Nurse", "Baby Whisperer" (I will not elaborate on all titles but will conclude that employers were looking for specialized nursing practitioners but were not willing to pay Nurses what they are worth, possibly because we are seen as having a "cushy job" and not "working hard as in the hospitals") I am sure there is not one university that offers extra qualification in those terms or anything similar. The "Baby nurse" is required in the pharmacies, I quote from the advert 'Your role will be to provide a professional and welcoming environment in which parents can seek advise and monitor their child's progress. You will be required to perform physical and developmental assessments on young children and help build upon our loyal client base through your exceptional customer service skills. You will also be required to recommend for purchase, where appropriate, products from our baby Range, including Baby formulae, nappies, medicines and baby accessories. Your friendly and trusting approach will enable you to develop a strong rapport with customers to observe and discuss the health and well being of mothers and their child. You will also be required to work in other areas of our busy pharmacy as needed. Experience in paediatrics and or other similar role would be highly regarded… have a passion for this work and are able to counsel customers in a timely and friendly manner we would love to hear from you!' this was an advert for a New South Wales pharmacy. The one for Malvern in Melbourne reads same in some parts; but it differs as they suppress the recommendations to purchase products. I quote "In this role you will have the fantastic opportunity to establish and develop a Baby Clinic and will be able to

assist in the pharmacy with other managed health programs. As a baby nurse…."(same as previous) the change is that they are not "required to recommend for purchase, where appropriate products…", such as formulae, medicines, etc. These advertisements only endorse what Commission is recommending: the downgrading of our professional educations and the low quality of health care delivery. There is conflict of interest for a person to work as a health professional and have at the same time the business hat on with certain targets that need to be met. The role of such a health professional would be biased to say the least and ethically and morally questionable. What would a child health nurse or baby nurse know (as opposed to a family and child health nurse or M+CHN with Midwifery qualifications and experience) about Breastfeeding and the research base benefits breastfeeding has on the overall health of the child, mother, family and society. Please read the submission from the Breastfeeding Association of Australia in response to the productivity commission 2008 available on this link http://www.breastfeeding.asn.au/advocacy/ABAProductivityCommissionsubmission20080807.pdf as a result of this submission we now have Breastfeeding friendly accredited hospitals, clinics, workplaces. After reading what the benefits and consequences of breastfeeding or not breastfeeding and consulting with the International Board of Certified Lactation Consultants (IBCLC) to enquire about the knowledge and studies required to become a Lactation consultant, I will recommend the productivity commission to investigate what Midwifery is; what the research results show in terms of the significance of education on this field. How education and training in and have impacted on the decrease of infant and maternal mortality and morbidity in the world.

In this submission I would like to express my objection to the title of Child Health Nurses for our workforce because in this Title inherently excludes the mother and a family as fundamental part of the process of healthy development of a child who eventually will be part productive society as an adult.

It is common knowledge that of all created species we are the most dependent on nurturing from the time of birth in order to survive. We need to be connected to a family and in particular to the biological mother as many research findings can demonstrate (unable to provide quotations for this statement due to the lack

of time and resources at hand) Child health without a family is non existent in other words excluding the family and the mother from the subject at stake leads to the conclusion this title is politically incorrect. It alienates the core structure (mother and the family) on which a child thrives and develops from. It is unrealistic in terms of variables that contribute to help and nurture a newborn, infant, child, teenager until she or he reaches the final stage of development: adulthood. Once the cycle is complete it commences again, based on role modeling provided in the family, experience and education; the replication of the process again in a successful and optimal manner depends very much on the supports (health care and social environments) provided through the journey of life.

I would like the Commission to examine the title they have chosen to describe our work force (CHILD HEALTH NURSE) thus, I am aware that Victoria is the only state that has Midwifery as a compulsory prerequisite to undertake further education on Family and Child Health Nursing and has chosen to identify our workforce with a title that is inclusive of the Mother for various fundamental reasons. I personally can identify several reasons:

All starts with being a Midwife I will quote from the English dictionary what the meaning of this word is so that it clarifies why we need midwifery and Maternal and child Health together in our tertiary educated workforce. '**mid·wife** (mdwf)

n. pl. **mid·wives** (-wvz)

1. A person, usually a woman, who is trained to assist women in childbirth. Also called regionally *granny*, *granny woman*.
2. One who assists in or takes a part in bringing about a result: "In the Renaissance, artists and writers start to serve as midwives of fame" (Carlin Romano).

tr.v. mid·wifed or mid·wived (-wvd), mid·wif·ing or mid·wiv·ing (-wvng), mid·wifes or mid·wives (-wvz)

1. To assist in the birth of (a baby).
2. To assist in bringing forth or about

[Middle English midwif : probably mid, *with* (from Old English; see me-[2] in Indo-European roots) + wif, *woman* (from Old English wf).]

Word History: The word *midwife* is the sort of word whose etymology seems perfectly clear until one tries to figure it out. *Wife* would seem to refer to the woman giving birth, who is usually a wife, but *mid* ? A knowledge of older senses of words helps us with this puzzle. *Wife* in its earlier history meant "woman," as it still did when the compound *midwife* was formed in Middle English (first recorded around 1300). *Mid* is probably a preposition, meaning "together with." Thus a *midwife* was literally a "with woman" or "a woman who assists other women in childbirth." Even though obstetrics has been rather resistant to midwifery until fairly recently, the etymology of *obstetric* is rather similar, going back to the Latin word *obstetrx,* "a midwife," from the verb *obstre,* "to stand in front of," and the feminine suffix *-trx;* the *obstetrx* would thus literally stand in front of the baby.

Another definition of midwife is:

midwife [ˈmɪdˌwaɪf]

n pl **-wives** [-ˌwaɪvz]

(Medicine / Gynaecology & Obstetrics) a person qualified to deliver babies and to care for women before, during, and after childbirth

[from Old English *mid* with + *wif* woman]

These definitions seem to have been consistent through the ages despite of all advances in science and technology. The reason for this may be well explained by the fact the process of natural childbirth has not changed and is basically something we cannot alter unless we want things "the complicated way" and create more health care issues in our society and add to the cost of Health Care and Professional Indemnity.

In Victoria it is known that maternal and Child Health Nurses continue with our professional duties of being "with woman". The succinct description of

what maternal and child health nurses do is in the definition by Collins dictionary 'a person qualified to deliver babies and to care for women before, during, and after childbirth.' (Colleagues from the midwifery course and I disputed the term "DELIVERY" because in it is inferred that babies are delivered? as opposed to a mother birthing a baby; it omits the fact that the mother is at the center of the action of giving birth) In the Collins definition a Midwife is '"with woman" before the birth, during birth and after childbirth'. So to us (Maternal and Child Health Nurses) in Victoria it is a logical prerequisite that Health professional dealing with Family and Child Health to be educated and trained as a midwife to have the scientific knowledge and skills basis from which to build form when practicing in the community. M+CH Nurses are semi-autonomous interdependent practitioner where she/he is expected to be able to make assessments of both the mother and baby's health/development and take decisions that will continue to promote the health and wellbeing of the mother and child and empower women to rear a family.

A person with a "GENERAL NURSING REGISTRATION" does not qualify to perform the duties of a Qualified Specialized Nurse unless she is being trained and supervised to do so. A general nurse does not have the skills to work safely in all the specialties of health. Having done Paediatrics at two major hospitals did not prepare me or provided me with knowledge and skills to perform the professional duties of a Maternal and Child Health. The model of care in the pediatric hospitals is based on the scientific model of illness therefore developmental assessments were not part of the care delivery from the newborn and children up to the age of 6years. I did use other skills I learned and were helpful to compliment and build on Maternal and Child Health assessments and tailor the nursing care needed.

In the same way, I would not expect an Ophthalmologist to be able to perform cardiac surgery there is Specialized Cardiac Surgeons to perform this duties; or a General Medical Practitioner to be able to take on the role of an Internal Medicine Specialist to deliver the care to Critically ill Clients who need to survive. If this was to be the case I am certain you as the reader of this document would not engage in health care activities being the recipient of the

assessment and treatments if the person performing this duties was not qualified to do so. Another example form a different workforce is to expect a graduated Primary School Teacher to perform the teaching role of a University Lecturer in an adult education role with added knowledge to be imparted. On the other hand to be able to take on kinder students or become a clinical teacher in a hospital. The teaching is an action used by every area of knowledge and expertise to emulate the imparted new knowledge whether this will be in cleaning, science schools, music schools, etc. It does not mean ONE SIZE FITS ALL. These are examples highlight why Education and regulation of practice is needed to avoid the detriment of Public Health and Safety. To down grade education and training for health professionals in general would contravene progress and advance in our developed society.

3. Draft Recommendation 12.2 regarding the value of continuing and expanding the scholarship program for MCH postgraduate programs of study.

I strongly support the provision of Scholarship programs for Studies in MCHN as this help a little with the burden of costs and or diminished pay depending of full time or part time modality undertaken. Although I have not been a recipient of this particular Scholarships I have benefited from my past studies when I did not incur in debts from HECS Fees when I completed the general Nursing registration course. When I decided to further my education in Acute Cardiovascular Nursing My employer paid HECS fees this was such a bonus because it saved me more than ten thousand dollars. In those two situations, I would have to miss out on further education, I was a new immigrant with limited English and at the bottom of the socio-economic scale. HECS-HELP loan was taken to study M+CHN which made it easier for me to have a full time year of studies rather than miss out all together from furthering my nursing career due to lack of income and expensive course fees.

4. Productivity Commission Consultation with stakeholders and Workforce they are reviewing.

There is an alarming level of concern from me as a M+CHN and other colleagues (I am not representing them in this submission) regarding the limited consultation undertaken by the Productivity commission with the Victorian Nurses, Service Stakeholders and Recipients. Our Service is widely considered the golden standard if we can aspire to such valuable comparison. Our service does have strengths and has been built on sound Education and Training from current research practice that keeps all stakeholders and users with actualized Health Care Delivery. In Recent years Australia experienced an increase in population from both immigration as well arguably the result of the Federal Government's Baby-bonus and some of the pro-fertility strategies from the Stated and Federal Governments. In Melbourne we experienced a marked increase in the birth rate and the services were tested with new pressures on a Workforce that has widespread issues such retention, aging practitioners, changes to the service, burn out and lack of job satisfaction to name a few. There is now more concern with key performance indicators (KIP's) as opposed to focus on community engagement that responds to the particular needs of communities in different socio-economic situations confronting some of the following problems:

1) Poverty due to gambling, jobs redundancies, long term unforeseen illness, accidents, chronic illness, work related accidents, marriage break-downs, Drug abuse, alcoholism, Low education and unemployment

2) Domestic Violence mostly experienced by Women by male perpetrators

3) Child Abuse

4) Poor Health

5) Mental illness due to previous list of problems and childhood abuse sustained by adults when they were young children.

6) Grieving of mothers /families who have experienced sudden unexpected death/loss as a result of tragic circumstances such the Fires and flooding.

7) Unexpected and unwanted pregnancy, teenage pregnancy.

8) Developmental issues: autism, hearing deficits, language deficits, etc.

9) Behavioural problems

10) Continuous Chronic Illness of the premature babies and its sequela.

11) Post natal depression.

12) Compromised parenting capacity due to intellectual disability among other circumstances.

13) Language Barriers, Culture shock in new immigrants, Discrimination issues.

These are some of the community's issues that we Maternal and Child Health Nurses face on an every day basis in our practice. The Key visits and developmental checks are only one aspect of what we do. I believe that Maternal and Child Health Nurses in Victoria are in a position to help the community through their complex problems due to the comprehensive tertiary education training and continual updating of our practice. Maternal and Child Health Nurses/Family and Child Health Nurses have been Educated and Trained to provide Health physical and emotional assessments, provide individuals with self help strategies and referral to appropriate agencies. Having stated the obvious, health professionals in the rural and remote communities do not have as much of the resources available in the metropolitan communities and yet they have far more complex issues. These communities keep on being missed as they may be deemed as a minority.

I would like to question how the commission has arrived to the recommendation that education of Maternal and Child Health Nurses/Family and Child Health Nurses need their education and training down graded on the face of all complex issues. With the advancements of knowledge and technology specialized health disciplines compliment one another; they interrelate and draw from expert knowledge but they cannot become one these specific disciplines are as follows: Community health, Primary and Family health, Midwifery and Breastfeeding.

There is an startling assertion being made in paragraph last paragraph of section 12.2 this reads:

Quote:

‘Child health nurses are trained in health promotion and preventive care and generally have experience in delivering such care in a community setting. Many nurses with child health qualifications work as practice nurses, mainly because, until quite recently, certificates and diplomas in child health nursing were some of the few qualifications that equipped nurses to work in community settings (Parker et al. 2009)

Initiatives to encourage general practices to employ practice nurses, such as the Practice Incentives Program (Medicare Australia 2010), are therefore likely to increase demand for child health nurses, at least in the short term. As graduates of the recently developed practice nursing courses increase in number, demand for child health nurses in general practice is likely to fall. 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.’

In this paragraph is it difficult to ascertain where this information came from, as it is not been cross-referenced with statistics from the Universities and employers alike.

I would be refreshing to be informed what is the basis of this statement and where is this interchange of practice nurses and child health nurses taking place because the paragraph does not provide any more information. In my recent working experience I had to resign to my job for personal reasons and applied to several practice nurse roles, keeping in mind that these roles are not interchangeable and that I would be expected to practice outside the scope of my expertise possibly compromising my professional boundaries. However, because I needed a job to get by economically, I did apply with the startling revelation that the jobs were later given to general RNDIV1 or RNDIV2, as they are cheaper labor. None of the employers offered employment, when I rung them to follow up on the application some stated that they extensive education and training was excellent but “unfortunately I was overqualified for the job” in other words paying the rates Maternal and Child Health Nurses as per award was not an option. This is a recent experience that happened in Melbourne. I would like to request references that will sustain and explain the assertions/statements

quoted above so that I can understand the scope of your investigations, research and basis for the recommendations needed to be implement to improve our service.

On the other hand I would kindly request your commission to provided me with the academic programs for both for Maternal and Child Health Nurses/Family Nurses or as you have chosen to name them Child Health Nurses so that I can see the similarities and differences in their educational training. In My humble opinion and as having accumulated 21 years of experience working as a nurse, Practice Nurses and Maternal and Child Health Nurses can support, one another but ultimately what each discipline is set up to do is inherently different except for using same nursing processes. It needs to be clearly established that both roles deal with a wide scope of information and skills where practice boundaries need to be clearly determined to protect the workforce from malpractice, burn out and lack of job satisfaction and legal indemnity issues. One discipline cannot supplement the other without damaging the philosophical and ethical governances of that particular health discipline been diminished. Often this situation is best described by the old say… "Jack of all trades, Master of None".

I would like to be reassured that Tertiary institutions will not provide new educational training where there is no limited scope of practice or professional expertise by which the professional practitioner is accountable because this will contribute to nurses vulnerability to malpractice, wrong assessments, nursing diagnosis and interventions which will lead to more professional indemnity problems.

There are important differences between the educational preparation and scope of practice nurses versus that of Maternal and child health nurses. For example:

a) The education of practice nurses is not standardized or accredited.

b) The practice nurse workforce is comprised of registered Division one and two

c) Whilst some practice nurses are involved in immunization, they have limited education, preparation that does not equip them with the

knowledge required of MCHN in providing care to maternal emotional needs, health family needs and development of young children.

5.Inconsistenscies in the draft report

There are a number of inconsistencies throughout the draft report.

For example on page 230 of the draft report it is identified that the time and cost of obtaining qualifications in nursing, midwifery and Maternal and child health nursing could reduce the number of potential entrants to the field…. and workers with additional qualifications require recompense for those additional qualifications in the form of higher wages, as can be seen in the relatively high wage paid to child health nurses in Victoria.

This statement is in direct conflict with other statements throughout the draft report including:

-Page 225 The ability to recruit and retain nurses to child health services depends on the attractiveness of employment in those services, compared to nurses with other employment options.

The Commission has been unable to provide any evidence to suggest that Victorian Children have better health outcomes than their counterparts in other states as a result receiving services by highly competent health professionals. If there is a comparison I believe the Victorian framework is singular and none of the other frameworks can provide similar information because none of the state services are alike. I would respectfully suggest to the Productivity commission to take the opportunity to bring the Family and Child Health Framework to as a universal service in all other States where progress is taken to improve the services that have struggled to achieve the same benefits most Victorian Families enjoy.

6. Draft recommendation 12.3 Pertaining the Removal of the Midwifery training, General Nursing education as a qualification prerequisite to

become a Maternal and Child Health Nurse of Family and Child Health Nurse.

I am strongly opposed to the removal of the midwifery qualification and general nursing training (just in case the new practice nurse courses have not included this part of the training and get into a direct entry as they did with the new Midwifery educational training) I believe every course I have done in my nursing career gave me the basis to build new skills and knowledge needed to practice as a Maternal and Child Health Nurse. An example as to how Midwifery has build on maternal and child health is the post acute or puerperal period women go through after the baby is born. In third word countries there is high mortality for Womb infections, Post partum hemorrhage and its consequences. M+CHN are skilled on how to monitor maternal post partum health in terms of possible infections and/or anemia which impacts on breastfeeding and consequently the health of the mother and baby.

Another example: The emotional health of the women related to the consequences of the birth. The health professional needs to assess if the birth was assisted, normal vaginal birth, planned or emergency Caesarean Section or if the pregnancy was unplanned. The interventions experienced by the woman may interfere with emotional attachment of baby and lactation process. The issues surrounding each birth could potentially contribute to postnatal depression in women (there is extensive research on this topic but unable to provide any references due to time constraints) If I had no midwifery training I would be oblivious to the woman's health care needs and attribute her problems to other wrongly asserted causes. In the long term the woman would be left with an emotional scar; she will continue to blame herself for not being a "good mother" in her own eyes, her family and the practitioner who ignores that the symptoms are related to antenatal, partum and post partum health issues.

The requirement of midwifery been a prerequisite has not been a barrier to me and in my practice people love it when I have told them of my Midwifery qualifications they have stated they feel reassured. Some have commented that they could not wait to get out of the hospital because they felt disconcerted with the level of experience and knowledge provided to them during their stay

because they know maternal and child health nurses have a lot of experience and have a wealth of relevant information to share with them.

Even though in Victoria Maternal and Child Health Nursing is possibly excluding the father. I have never heard any of the fathers comment on feeling excluded from the service. Some of them have mentioned it is good "You know about women business" We encourage participation of fathers, I have noted that they are already aware what we do is being "with woman". I have felt respected and welcomed, well received by the fathers with whom I had the pleasure to meet during my years of practice as a M+CHN.

Finally, I would like to thank the Commission for considering my observations and comments. My dream is that Australia develops a Maternal and child health framework that will be governed by uniform high standard regulations across the country where Rural and Aboriginal communities would enjoy and engage in the same way the metropolitan communities do.