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beginnings:
Investing in
the early
years of life**

CAN THE *FAMILIES FIRST* INITIATIVE CONTRIBUTE TO REDUCING HEALTH INEQUALITIES?

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This article describes the ways in which *Families First*—a coordinated strategy of the NSW Government that has increased the effectiveness of early intervention and prevention services in helping families to raise healthy and well adjusted children—can contribute to reducing health inequalities.

CHILD HEALTH INEQUALITY TODAY

Inequality of health outcomes continues to be a major (and potentially reversible) feature of the health of Australia's children. The health of children is particularly sensitive to their socioeconomic environment. This environment can diminish the potential of 'reactive' or 'clinical' services to reduce health inequalities in children.

In spite of this, there has been progress in reducing some health inequalities over the past century. In 1970, the gap in infant mortality between Aboriginal and non-Aboriginal children was approximately four-fold. In 1998 this gap had reduced to approximately three-fold, but there has been little change over the last decade. Almost every health indicator related to children and youth continues to reveal a significant gap between the Aboriginal and non-Aboriginal populations.¹ However, in Australia, there is a dearth of health outcomes data for children and youth by other indicators of disadvantage such as family income, occupation of parent(s), and income distribution.

There are abundant data indicating the relationship between socioeconomic inequality and poor health outcomes; and of growing income inequality in Australia.² For example, the share of equivalent gross household income received by the bottom 10 per cent of Australians decreased from 7.44 per cent in 1986 to 7.35 per cent in 1996; and that received by the top 10 per cent increased from 13.7 per cent in 1986 to 14.96 per cent in 1996; also, there has been an increase in child poverty in Australia.^{3,4} Similar trends towards growing inequality have been even more clearly established between the developed and developing worlds. In the face of this, at best, unchanging income inequality—or, more probably, growing income inequality—how likely is it that the strategies underpinning *Families First* can reduce health and social inequalities?

It is also worth recalling that serious health inequalities can persist (and even widen) in spite of the implementation

of 'effective' interventions as these may produce improvements in the average rates of problems or diseases, but result in a widening of the gap between the upper and lower social strata.^{5,6,7}

WHAT IS *FAMILIES FIRST*?

Families First is a coordinated strategy of the NSW Government to increase the effectiveness of early intervention and prevention services in helping families to raise healthy, well adjusted children. The NSW Government has committed \$54.2 million to implement the strategy in all areas of NSW over a four-year period.⁸

The implementation of *Families First* is the combined responsibility of a number of NSW government agencies (the area health services; the Department of Community Services; the Department of Ageing, Disability and Home Care; the Department of Education and Training; the Department of Housing; and the Department of Health) and non-government agencies funded by the NSW Government.

The main objectives of the *Families First* strategy are to:

- help children grow to their full potential; support parents in enhancing parenting skills and to have a sense of control over their lives; support those who are expecting or caring for babies, infants, and young children up to eight years of age; and assist families who require extra support;
- help communities build and sustain networks to support families through strengthening the connections between communities and families.

These objectives will be met through a combination of universal and targeted services:

- a universal home visiting program that also concentrates services to vulnerable and disadvantaged families;
- extra support to families with specific health and social problems; for example: mental health, substance abuse, social isolation, financial stress, homelessness, etc;
- a coordinated network of services linking all sectors relevant to the health and social wellbeing of families with young children;
- community capacity building and community development programs targeting disadvantaged communities, using the *Schools as Community Centres* and other models.

These strategies are supported by research indicating that early intervention services and community capacity building programs can produce a sustained improvement in children's health, education, and welfare.^{9,10,11,12} There

is also evidence that early intervention services have the greatest impact when they are capable of addressing a broad range of issues and are provided as part of a coordinated network.^{13,14}

THE LINKAGES BETWEEN *FAMILIES FIRST* AND THE PROBLEM OF INEQUALITY

How much potential do the strategies underpinning *Families First* have for reducing inequalities of health outcomes? Which particular components of *Families First* are more likely to be effective?

Two of the overseas programs whose design underpin *Families First* (the Prenatal–Early Infancy Project and the High–Scope Perry Preschool Project) have demonstrated that the greatest benefit accrues to children in families at greatest social disadvantage.^{9,10} These findings suggest significantly better prospects for the reduction of health inequalities through *Families First* than through conventional service-based initiatives.^{9,15}

A number of randomised controlled trials of home visiting programs delivered to disadvantaged and vulnerable families predominantly in the USA,¹⁶ but also in Australia,¹⁷ have demonstrated positive health and social outcomes for children and mothers. These have included:

- reduced rates of smoking in pregnancy, hypertension of pregnancy, low birth-weight, preterm babies, child abuse, accidental injury, behavioural problems, high risk behaviours among adolescents, running away from home, delinquency, and mothers' dependency on welfare;
- increased rates of breastfeeding and immunisation, and better use of health services.

The data are less clear regarding the impact of a universally offered home visiting program with a concentration of services on the vulnerable and disadvantaged.

Intuitively, one would expect even better outcomes because the whole socioeconomic gradient is addressed and thereby potentially influencing greater numbers of children and families. However, there is some evidence that indicates that one home visit may be of little or no benefit.¹⁸ There are also data indicating that the proportion of children living in relative poverty in the USA is greater;¹⁹ and, in general, outcomes for the disadvantaged in the USA are worse than in Australia. Therefore, the degree of benefit observed in home visiting studies in the USA may be attenuated in the less-extreme Australian context. Although the funding currently provided to implement *Families First* is significant, it may yet prove insufficient to provide the levels of home visiting required to make a difference. For example, the Central Sydney Area Health Service would require an additional recurrent allocation of \$1.2 million per year to implement a universal home visiting program to the level indicated by effective programs, with resources focused on vulnerable and disadvantaged families.

Joint planning of services and preventative programs, which have been very successful in the Central Sydney Area Health Service as a means of addressing health inequities, has also not formally been evaluated. However, since health outcomes have multiple determinants, and approximately 70 per cent of which are not related to traditional health services,²⁰ the potential to further reduce health inequities is significant through joint planning with housing, education and community services, and other relevant agencies, including non-government agencies.

There is indirect evidence that community capacity building, and improving levels of social capital, have the potential to significantly improve not only child health outcomes but also adult health outcomes. There is a strong association between levels of social capital and total mortality rates; infant mortality rates; and deaths from cardiovascular disease, stroke, cancer, and homicide.^{21,22} Improving children's and young people's perception of connectedness with their family and schools has also been demonstrated to be associated with reduced risk taking behaviours and better mental health outcomes among adolescents.²³

POTENTIAL CONTRIBUTION OF *FAMILIES FIRST* TO REDUCING HEALTH INEQUALITIES

There is a growing body of evidence about the relative contributions of healthcare services, and of social and economic determinants of health, to measures of health outcome (such as mortality rates). It indicates that the contributions may be different at different ages, with socioeconomic factors having a greater effect at younger ages.^{24,25}

Considering the importance of programs that address social and economic determinants to population health outcomes in children, *Families First* has the potential to significantly affect brain development in the early years of children's lives. Home visiting has been shown to decrease smoking rates in pregnancy in disadvantaged women; decrease rates of low birth-weight and preterm babies; increase rates of breastfeeding and the duration of breastfeeding; and improve education outcomes.^{9,15} Provision of books, reading support programs, and transition to school programs for disadvantaged children, have been shown to improve readiness to start school.^{26,27} Community capacity building programs such as the *Schools as Community Centres* program have improved social capital and empowered families in disadvantaged communities.²⁸ Taken together, these kinds of strategies—which form the basis of *Families First*—have the potential to start to break the cycle of poverty, vulnerability, and disadvantage for this cohort of children and their families; and to begin to reduce health inequalities.

There is also compelling evidence that cognitive function in adulthood is dependent on parents' socioeconomic circumstances (and parents' level of education).²⁹ This

suggests that the health, developmental, and social benefits of the strategies underpinning *Families First* are likely to extend into adulthood—something confirmed in some studies.^{9,10}

POTENTIAL LIMITATIONS OF FAMILIES FIRST

There are a number of possible risks to the likelihood that *Families First* will achieve improvements in health outcomes and reductions in health inequalities.

‘Shifting attention away from the population distribution of health, *health inequalities*, to the health of the poorest groups in society, *health poverty*, and to conditions that the poor tend to suffer from in isolation of the circumstances in which those conditions are suffered’ has not been shown to have had any beneficial impact on existing health inequalities.³⁰

Nor is it clear how much the socioeconomic distribution of risk factors explains the observed health inequalities, making it risky to base efforts to reduce health inequities on strategies that focus on risk factors.^{30,31,32}

If *Families First* focuses on strategies providing ‘reactive’ services to ‘high-risk’ families or individuals, rather than providing population-based preventative interventions, there can be little confidence from the evidence that the anticipated improvements in population-level child health outcomes will be achieved.^{33,34}

It is unclear from the evidence that targeting of services, such as the selection of geographically disadvantaged areas for community capacity building programs, will reduce existing health inequalities. Research from Glasgow, Scotland, concluded that selective targeting of resources on an area basis would miss more deprived people than it would include.³⁵ Such an analysis has not been done in NSW, but it is probable the same would apply. Furthermore, other determinants of health can all negate the potential benefits of *Families First*. These include: a world recession, or war; government policies that continue to contribute to widening the economic and social gap (such as retrogressive taxation and support of the privatisation of education and health systems); job insecurity; inappropriate design of public housing, which contributes to further erosion of social capital; tolerance by government and the community of discrimination and marginalisation based on gender, race, religion, and class; support of inequity as inevitable; and sustainability of the environment.

CONCLUSION

Families First has the potential to reduce inequalities in health outcomes in children, and so to contribute to breaking the cycle of poverty for disadvantaged children, their families, and the adults they will become. However, this initiative cannot succeed on its own; it must be supported by other political, economic, and social developments.

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CHILD HEALTH POLICY IN NSW: BUILDING ON A CENTURY OF CARE

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The NSW child health policy framework is informed by a long and successful history of providing health services to children and their families, as well as recent policy developments at the national level. This article describes the background to the development of the NSW child health policy, *The Start of Good Health: Improving the Health of Children in NSW*,¹ and provides information on NSW Health policy directions for child health.

COMMUNITY CHILD HEALTH SERVICES IN NSW: A HISTORY

The origin of community child health services in NSW is found in the infant welfare movement at the beginning of the 20th century. This movement was one of the most significant and successful public health initiatives, stemming from an awareness that children's health and welfare represented a particularly sensitive index of the wellbeing and progress of our society. At that time the issues were the high infant mortality rate associated with infectious disease and poor nutrition, and advocacy from mothers and grandmothers seeking support for the physical and nutritional needs of children. There was also recognition that poorer families could not afford medical advice for their children except in an emergency. The infant welfare movement played a major role in reducing the infant mortality rate, and led to the establishment of baby health services, which were the forerunner of our current child and family health services.

Early innovations in care

A study of these early services revealed considerable innovation in delivering flexible and responsive services to the community.² For example, in the early 20th century, trained health visitors were employed to visit, at home, the mothers of all new-born babies in the city of Sydney and surrounding industrial suburbs. These trained health visitors instructed mothers on proper feeding and hygienic care of their infants, and noted the living conditions for appropriate further action. Health visiting obtained dramatic results in reducing the infant mortality rate.

Another example of an innovative model of service delivery was found in the 1930s. A railway car was fitted as a travelling home for a nurse, with bedroom, bath, kitchenette with refrigeration, and with a large space furnished as a consulting room and clinic. The railway car travelled to rural centres, staying in each centre from two to ten days, as the work demanded. The service was

extended by using local transport to reach towns beyond the station. The establishment of these Travelling Baby Clinics ensured that children and families in rural and remote areas of NSW, who most needed the services, received them.²

Critical factors for success

The success of children's health services over the last century has been the result of a number of critical factors. These include:

- securing the support of the public
- establishing partnerships with the community
- understanding the causes of ill health
- emphasising prevention
- the ongoing dedication and commitment of staff
- the flexibility of services
- a capacity to respond to changing social circumstances.

These same factors remain central to future progress in child health.

During the last 25 years, the focus of children's health care shifted again, as it came to be recognised that child health can be profoundly affected by social and family changes and new technologies. Child health services responded to these societal changes by increasing the range of services offered, reorientation of existing services, and further specialisation. With components coming from different public health, community health and hospital sector perspectives, this has meant that services have become increasingly specialised and more disparate. This has often resulted in poor coordination and communication between services.

The last decade

A number of initiatives in the 1990s started a process of bringing together the wide range of health services for children and young people. The development of the national *Health Goals and Targets for Australian Children and Youth* (1992),³ represented the first step in determining, across Australia, common aims and objectives for the development and provision of child health and youth health services. Five key goals were established as a starting point for planning to improve the health outcomes for Australian children and young people. These were:

- reducing the frequency of preventable mortality;
- reducing the impact of disability, including reductions in the occurrence of new disability and in the impact of established disabilities;
- reducing the incidence of vaccine-preventable diseases;

- reducing the impact of conditions occurring in adulthood which have their early manifestations in childhood or adolescence;
- enhancing family and social functioning.

The Health of Young Australians: A National Health Policy for Children and Young People, the first statement of national child and youth health principles and policy directions, followed in 1995.⁴ This was accompanied by an action plan, *The National Health Plan for Young Australians*,⁵ which was endorsed by Australian Health Ministers in 1996.

MEASURING AND REPORTING ON THE HEALTH OF YOUNG AUSTRALIANS

An initiative that arose from the action plan was the development of a national information strategy for measuring and reporting on the health of young Australians. The Australian Institute of Health and Welfare (AIHW) was commissioned to develop this information framework to monitor the health of young Australians and to produce biennial reports on the health of children and young people. *The National Child Health Information Framework*, covers the main issues relevant to the 0–14 year age group, and forms the basis for monitoring and future reporting of child health information. The first national report on the health status of children in Australia was published by AIHW in 1998. *Australia's Children 1998: Their Health and Wellbeing*,⁶ provides comprehensive information from currently available sources of data on the health problems of children in Australia.

Health problems experienced by today's children reflect a complex interaction between children, their family, and their socioeconomic, political and cultural environments. Further coordination of activity across the health system—and more meaningful partnerships between health, education and welfare sectors—are needed if we are to maximise the opportunities to improve the health and wellbeing of children.

THE NSW CHILD HEALTH POLICY

In response to the national developments described above, and the need for increased collaboration between health and other sectors, NSW Health developed its first overarching child health policy. The child health policy *The Start of Good Health: Improving the Health of Children in NSW* was launched by the Minister for Health in October 1999.

The Start of Good Health policy provides a framework for the provision of services by NSW Health, for children 0–12 years, over the next five years. It brings together current knowledge of the health care needs of children in NSW, and identifies priorities and strategies for addressing those needs. It also acknowledges that children require

specifically-designed health care services to meet their needs at each stage of their development. It further recognises that health services must become more responsive to the needs of parents for support in the important job of caring for children. The poorer health outcomes of children from socioeconomically-disadvantaged families are highlighted, and the policy emphasises that health services must reach those with the greatest need.

The Start of Good Health identifies four goals for NSW Health. These are to:

- improve the health and wellbeing of children;
- improve the accessibility and appropriateness of health services for children;
- improve the quality of health services provided to children;
- promote partnerships within the health system and with other public and community-based agencies which impact on the health of children.

The NSW child health policy identifies and highlights examples of good practice and brings, within a single document, the range of initiatives aimed at improving the health of children. Priority health issues are identified, based on the *Health Goals and Targets for Australian Children and Youth*, and flexibility is promoted in the delivery of child health services, to include different settings such as family homes, child care centres, preschools and schools. Key interventions are identified for each developmental stage, which address a variety of health issues simultaneously and adopt a settings-based approach. The policy is also intended to assist in preparing the health system for the implementation of the Government's *Families First* strategy.

CONCLUSION

The directions of *The Start of Good Health* policy are supported by international research findings from the past three decades. This research has indicated that:

- early life experiences are vital to the growth and development of children;
- multiple health outcomes can result, for both parents and children, when parents have early support;
- prevention and early intervention services have the greatest effect on health, education and welfare when they cover a broad range of issues and are provided through a coordinated network.

The Start of Good Health draws on lessons from the past, recognises our achievements, and identifies directions for the future. *The Start of Good Health* provides the framework for reviewing and planning child health services in Area Health Services. It encourages active participation from all levels of NSW Health, and collaboration with other sectors,

to focus on promoting the health and wellbeing of children and their families in NSW.

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