

### 3. Nurturing a healthy start to life

Key messages
<ul style="list-style-type: none"><li>• The early years provide the foundation for a person's health and wellbeing in life.</li></ul>
<ul style="list-style-type: none"><li>• Improving the health and wellbeing of children is important both because of the intrinsic value and because doing so will improve the health of the population as young people age into adulthood.</li></ul>
<ul style="list-style-type: none"><li>• Investments in early childhood development are among the most powerful that a nation can make.</li></ul>
<ul style="list-style-type: none"><li>• The health of Australian children has improved over the past few decades, but there are concerning levels of childhood mental health and socio-behavioural issues, and increases in chronic and complex diseases, obesity and physical inactivity. Furthermore, the health of Aboriginal and Torres Strait Islander children is still significantly poorer than that of other children.</li></ul>
<ul style="list-style-type: none"><li>• The health of mothers antenatally and postnatally – and even before conception – can significantly impact on a child's health. A strategy that fosters a healthy start for children must include improving the health of their mothers.</li></ul>
<ul style="list-style-type: none"><li>• Tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs. We acknowledge the need for such a comprehensive approach. Within the scope of this report we focus on the health system, while recognising the importance of its links to other systems that are essential to securing a healthy start for children, particularly quality early childhood education and care, family support and community services.</li></ul>
<ul style="list-style-type: none"><li>• The early childhood health system has a number of shortcomings that limit its effectiveness, including significant inequities in access to services (particularly for children in rural and remote areas) and fragmentation of service delivery. The system is not responsive to children with complex needs from vulnerable families, and often fails children with a disability or developmental concerns, who have to navigate a complex system and often experience long waiting times and poor continuity of care.</li></ul>
<ul style="list-style-type: none"><li>• There is also variable access across Australia to specialist teams for children with chronic or severe health conditions.</li></ul>

## Our reform directions

3.1 We propose an integrated strategy for the health system to nurture a healthy start to life for Australian children. The strategy has a focus on health promotion and prevention, better access to primary health care, and better access to and coordination of health and other services for children with chronic or severe health or developmental concerns.

3.2 We propose a strategy for a healthy start based on three building blocks:

- most importantly, a partnership with parents, supporting families – and extended families – in enhancing children’s health and wellbeing;
- a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school; and
- a child- and family-centred approach to shape the provision of health services around the health needs of children and their families. Under a ‘progressive universalism’ approach, there would be three levels of care: universal, targeted and intensive care.

3.3 We propose beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy.

3.4 In the antenatal period, in addition to good universal primary health care, we propose targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.

3.5 We propose that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life). The initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting.

3.6 We propose that, as part of its set of core services, where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services.

3.7 We propose that, where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.

3.8 We propose that all primary schools have access to a school nurse for promoting and monitoring children’s health, development and wellbeing, particularly through the important transition to primary school.

3.9 We propose that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure continuity of care and a comprehensive understanding of a child’s health needs. Families would have the opportunity to be enrolled with a primary health care service as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of a child and their family.

## 3.1 Defining and scoping a healthy start

The evidence is clear: the early years provide the foundations for a person's health and wellbeing in life. This includes developing sound physical and mental health as well as the cognitive, social and emotional skills needed to succeed in life. As noted in the landmark study, *From Neurons to Neighbourhoods: the Science of Early Childhood Development*:

*... virtually every aspect of early human development, from the brain's evolving circuitry to the child's capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning in the prenatal period and extending throughout the early childhood years.<sup>1</sup>*

With the multidimensional nature of health and wellbeing, nurturing a healthy start requires the involvement of a range of services and supports, including health and community services, and early childhood education and care. While acknowledging the relevance of this broader framework, the focus of this report is on the contribution of the health system to nurturing a healthy start to life.

■ The evidence is clear: the early years provide the foundations for a person's health and wellbeing in life

## 3.2 Building on our strengths

Australia is fortunate in having a universal health system that provides the foundation for a strategy for nurturing a healthy start to life. Health services are uniquely placed to influence children's outcomes in early childhood for several reasons:

- (Almost) all children have a contact with the health system at birth when initial health and parenting issues can be identified and addressed.
- Almost universally, the first contact that children have with the government service system is with health services.
- In addition, most women access health services in the antenatal period, providing a 'window of opportunity' to positively influence maternal health, nutrition and behaviour when women are most receptive.
- Health practitioners are generally welcomed by parents who see them as having a legitimate role and skills to provide support through pregnancy and child growth and development. This can be particularly valuable in providing assistance with parenting skills and behaviour and when working with vulnerable families.<sup>2</sup>
- Children and their families generally have regular contact with health services in the very early years, although access is poorer for disadvantaged families. This provides an ongoing opportunity to monitor and influence the child's health and development in the vital years before they reach the two other significant universal programs – early childhood education and care services, and schooling.

As emphasised by the Victorian Maternal and Child Health Special Interest Group:

*MCHS [Maternal and Child Health Service] is at the forefront in providing health education messages that ultimately improve the health outcomes of those families through universal and early contact. The maternal and child health service has an uptake of 97 per cent of all families that are referred to them after the birth of their child. No other health profession has such immediate and ongoing contact with a public health focus and ideal opportunities for health prevention and promotion activities.<sup>3</sup>*

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1 J Shonkoff and D Phillips (2000), *From Neurons to Neighborhoods: The Science of Early Childhood Development* (National Academy Press: Washington DC).

2 D Olds, I Sadler and H Kitzman (2007), 'Programs for parents of infants and toddlers: recent evidence from randomised trials', *Journal of Child Psychology and Psychiatry* (48): 355–391.

3 Victorian Maternal & Child Health Nurses Special Interest Group (2008), Submission 188 to the National Health and Hospitals Reform Commission.

Primary health services for children have traditionally been focused on developmental checks to identify problems, vaccinations and seeing sick children. While nurturing a healthy start must certainly include these activities, the evidence on the importance of early childhood argues for health services to be also involved in 'well' care that extends beyond physical health and includes the many dimensions of wellbeing.

## 3.3 Identifying the case for change

### 3.3.1 Valuing early childhood

*The political approach will not change (including how spending is determined) unless we are able to change the discourse around children.<sup>4</sup>*

The importance of early childhood – including the antenatal period and the period from birth to eight years of age – is based on four key arguments.

First, childhood health and the uterine environment have a lasting impact on health and socio-economic status throughout life. Many adult health conditions – including major public health problems such as obesity, heart disease, diabetes and mental health problems – have their origins in childhood health conditions.<sup>5</sup>

Second, brain development in early childhood provides the foundation for lifelong wellbeing. Brain development is fastest and the brain most malleable during the first three years of life. Cognitive, emotional and social capabilities are all inextricably linked in brain development.<sup>6</sup>

Third, acting early has the best results. Early identification and intervention can prevent entirely or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions.<sup>7</sup> For children at risk of poor outcomes, it is much more cost-effective to intervene in early childhood to prevent problems from developing and compounding than trying to 'fix' the problems later.<sup>8</sup>

Fourth, disadvantage begins early but can be ameliorated (at least in part) through quality antenatal and early childhood health, community and education services. For children without adequate stimulation, or who are exposed to unhealthy levels of stress in early childhood, disparities in learning and abilities appear within the first 18 months of life and generally persist into the school years and beyond.<sup>9</sup> The early childhood period provides a valuable opportunity to provide services that address factors of disadvantage before they are cemented in the next generation.

Investments in early childhood development are among the most powerful that a nation can make

■ Investments in early childhood development are among the most powerful that a nation can make. They enable more children to grow into healthy adults who can make a positive social and economic contribution to society and reduce the escalating chronic disease burdens in adults. They can also be a powerful force for equity, with interventions having the largest effects on the

4 Participant (5 August 2008), National Health and Hospitals Reform Commission special interest forum on early start to life in Sydney.

5 N Halfon, H DuPlessis and M Inkelas (2007), 'Transforming the US child health system', *Health Affairs* 26 (2); and Early Child Development Knowledge Network of the Commission on Social Determinants of Health (2007), *Early child development: a powerful equalizer, Final Report* (World Health Organization: Geneva).

6 Centre on the Developing Child at Harvard University (2007), *A science-based framework for early childhood policy: using evidence to improve outcomes in learning, behaviour, and health for vulnerable children*, at: <http://www.developingchild.harvard.edu>

7 J Shonkoff and S Meisels (2000), *Handbook of Early Childhood Intervention* (Cambridge University Press: Cambridge).

8 National Scientific Council on the Developing Child (2007), *The Science of Early Childhood Development*, at: <http://www.developingchild.net>

9 National Scientific Council on the Developing Child (2007), *The Science of Early Childhood Development*, at: <http://www.developingchild.net>

most disadvantaged children.<sup>10</sup> This was a strong message to the Commission from consultations and submissions:

*The early years are the most critical time in terms of the largest gains to be made in the overall health and wellbeing of an individual. Those that are given the opportunity to grow and develop in a loving and nurturing environment will ultimately have the best intellectual, emotional and health outcomes.<sup>11</sup>*

### 3.3.2 Improving the health of Australian children

This section looks at key indicators of children's health (summarised in Figure 3.1).

In general, the health of Australian children has improved over the past few decades, but we lag behind other OECD countries in a number of important areas. Importantly, the health of Aboriginal and Torres Strait Islander children is significantly poorer than that of other Australian children. A recent assessment concluded:

*While many of the key indicators of child health and wellbeing are improving, there are rising rates of childhood mental health and socio-behavioural issues, chronic complex diseases such as diabetes is on the increase, and childhood obesity and physical inactivity are increasing. There is no improvement in the rates of prematurity and low birth weight. Many experts now predict that this generation could have a lower life expectancy than their parents.<sup>12</sup>*

The health of young children is very dependent on the health, including mental health, of their parents, and particularly of their mothers. The health of mothers antenatally and postnatally – and even before conception – can significantly impact on a child's health. A strategy that fosters a healthy start for children must include improving the health of their mothers. Key considerations include:

- While maternal deaths occur infrequently in Australia, maternal mortality rates for Aboriginal and Torres Strait Islander women are more than three times as high as for other women, and women living in rural and remote areas also experience higher rates of maternal death.<sup>13</sup>
- A significant minority of women report smoking during pregnancy and rates of alcohol consumption during pregnancy by Australian women are high.<sup>14</sup>
- Depression affects around 15 per cent of all women during the perinatal period, impacting on the health and wellbeing of mother and child.<sup>15</sup>
- While teenage fertility is falling, rates are substantially higher for Aboriginal and Torres Strait Islander women (five times higher) and for those living outside major cities.<sup>16</sup>

■ A strategy that fosters a healthy start for children must include improving the health of their mothers

10 Commission on Social Determinants of Health (2008), Closing the gap in a generation: Health equity through action on the social determinants of health, Final Report (World Health Organization: Geneva).

11 Victorian Maternal & Child Health Nurses Special Interest Group (2008), Submission 188 to the National Health and Hospitals Reform Commission.

12 Australian Research Alliance for Children and Youth (2008), 'National health strategy must start with children', Submission to the Australian Government's Australia 2020 Summit.

13 Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare, Canberra).

14 Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at [www.health.gov.au](http://www.health.gov.au)

15 Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at [www.health.gov.au](http://www.health.gov.au)

16 Australian Institute of Health and Welfare (2008), Making Progress: The health, development and wellbeing of Australia's children and young people (Australian Institute of Health and Welfare: Canberra).

**Figure 3.1: Although the health of children and mothers is improving, there are still areas of concern**

Areas of achievements	Areas of concern
Infant mortality rates have fallen	Higher rate of low birth weight for Aboriginal and Torres Strait Islander infants, and infants living in rural and remote areas and socio-economically disadvantaged areas
Gap in infant mortality rates for Aboriginal and Torres Strait Islander children is narrowing	Low rates of breastfeeding, particularly among younger women and women living in socio-economically disadvantaged areas
Immunisation coverage for 1 and 2 year olds is over 90 per cent	Infant mortality, rates of low birth weight, Type 1 diabetes and teenage fertility compare unfavourably with other OECD countries, particularly for Aboriginal and Torres Strait Islander children
Drop in asthma hospitalisation rate	Increase in Type 1 diabetes and in hospitalisation rate, particularly for Aboriginal and Torres Strait Islander children
Good dental health compared with other OECD countries	Decline in dental health since the mid-1990s
Fall in teenage fertility rate	Dental health is worse for Aboriginal and Torres Strait Islander children and children living in rural and remote areas and socio-economically disadvantaged areas
Decline in maternal mortality	Children's level of physical activity
	Obesity rates, which are higher for Aboriginal and Torres Strait Islander boys and children living in socio-economically disadvantaged areas
	Maternal mortality rates are higher for Aboriginal and Torres Strait Islander women and women living in rural and remote areas
	Smoking during pregnancy, which is particularly high for Aboriginal and Torres Strait Islander women and for young women
	High levels of alcohol consumption during pregnancy
	Antenatal and postnatal depression, which affect about 15 per cent of women

Source: Australian Institute of Health and Welfare (2008), Making progress: the health, development and wellbeing of Australia's children and young people (Australian Institute of Health and Welfare: Canberra) and Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at: [www.health.gov.au](http://www.health.gov.au)

### 3.3.3 Improving child health services

While Australia is fortunate in having a universal health system as the foundation of child health services, there are a number of shortcomings of the current early childhood health system that limit its effectiveness.

First, there are significant inequities in access to services for families living in rural and remote areas, Aboriginal and Torres Strait Islander families, and disadvantaged families. These families access early childhood health services (including antenatal care) later and less frequently than the rest of the population but their children are often most at risk of developing poor outcomes.<sup>17</sup>

Second, the early childhood health system is fragmented. As with many aspects of the Australian health system, child and maternity health services are a combination of Commonwealth, state and territory government and privately funded and delivered services. They are provided in multiple settings by a range of different health professionals. The universal services that are most commonly accessed are maternity services provided in hospitals (including antenatal care), general practice, midwifery, and maternal and child health services provided in the community. In addition, many women access specialist obstetric maternity services. These services generally operate as separate systems and there is no automatic information sharing between systems. For example, a general practitioner may not be aware of the care provided to a patient by a maternal and child health service, which could result in the provision of different or conflicting advice and some families falling between the gaps.

Third, the current system is particularly failing families with children with special needs, including children with a disability or a developmental delay. These families have to navigate not only universal services, but also specialist and allied health care. They often experience long waiting times for specialist and allied health services, especially in rural areas, and poor continuity of care (see Figure 3.2).

Finally, while across Australia there are community child and family health services, there are important differences among the states and territories, which result in variable access and service provision for families.<sup>18</sup>

■ The early childhood health system is fragmented

Figure 3.2: Childhood disease prevalence is increasing

*The Australian Paediatric Society notes:*

*There is increased complexity of care for children expected in local settings. Children with cerebral palsy are undergoing new surgical techniques. Children with complex cardiac surgery are being returned to their communities earlier and require frequent follow-up. Children with diabetes, Crohns disease, allergy and coeliac disease are increasing in number and methods of therapy are becoming more complex. Children with complex developmental disabilities and needs are surviving into adulthood with few facilities or services available to support them. Behaviour disorders and school learning issues such as attention deficit hyperactivity disorder have increased in prevalence and are almost exclusively managed by paediatricians in rural areas.*

*Currently in most rural settings with state government models it takes up to two years for assessment of a child suspected of having autism, up to six months to receive early intervention services for developmental disability and, in public hospitals, several years to have a regular general paediatric outpatient appointment. There is a demonstrable failure to maintain services for children in the Australian rural community.*

Source: Australian Paediatric Society (2008), Submission 479 to the National Health and Hospitals Reform Commission.

17 Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at: [www.health.gov.au](http://www.health.gov.au)

18 Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

## 3.4 Creating a better future

Our life course approach to health seeks to promote the health and wellbeing of children, both because of the intrinsic value and because doing so will improve the health of the population as people age into adulthood.

Tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs

■ But creating a better health system to support a healthy start in life is complex because many of the key factors affecting children's health outcomes lie outside the health sector, including social, family, community, and economic influences which impact on children's development. As advocated by the Australian Research Alliance for Children and Youth, tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs (see Figure 3.3).

We acknowledge the need for such a comprehensive approach. Within the scope of this report, however, we focus on the health system, while recognising the importance of its links to other systems that are essential to securing a healthy start for children, particularly quality early childhood education and care, family support and community services.

Figure 3.3: A comprehensive approach to improving children's wellbeing is required

*The Australian Research Alliance for Children and Youth is advancing collaboration and evidence-based action to improve the wellbeing of children and young people. This bio-psycho-social model, which acknowledges multiple interacting influences on the growing child, supports a multi-systems approach to:*

- *ensuring healthy young families, by improving care during pregnancy and the postnatal period, promotion of health behaviours, early recognition of children at risk, and effective early intervention;*
- *securing early learning and care, by increasing access to quality early learning and care services, successful transitions to school and early identification and intervention of children at risk;*
- *supporting families and parents, by improving access to family support services, such as parenting education programs; assistance to achieve a better work/family balance; improved access to quality parenting information; and development of neighbourhood/social supports; and*
- *creating child-friendly communities, by fostering flexible and responsive services at the local level, creating better links and coordination among community services, reducing levels of family violence, community provision of children's activity, play and learning opportunities.*

Source: Australian Research Alliance for Children and Youth (2008), National health strategy must start with children, Submission to the Australian Government's Australia 2020 Summit.

### 3.4.1 Nurturing a healthy start to life

The case for change in Section 3.3 highlighted key areas for improvement in child and maternal health and in health services to nurture a healthy start in life. Addressing these areas would require a greater focus on health promotion and prevention, and better access to primary health care. Children with special needs would also require access to better coordinated primary health care, specialist care, allied health and other relevant services.

In this section, we outline a strategy for the health system for nurturing a healthy start to life for Australian children. We begin with an overview of the key concepts and then map the strategy in more detail.

### Reform direction 3.1

We propose an integrated strategy for the health system to nurture a healthy start to life for Australian children. The strategy has a focus on health promotion and prevention, better access to primary health care, and better access to and coordination of health and other services for children with chronic or severe health or developmental concerns.

We have based our strategy on three key concepts. First, and most importantly, the focus must be on partnering with parents, supporting families – and the extended family – in enhancing children’s health and wellbeing.

■ The focus must be on partnering with parents

Second, it is based on a life course approach which identifies what is needed at different stages of life to secure a healthy start for children.<sup>19</sup> Our strategy for nurturing a healthy start to life begins at pre-conception, and covers the antenatal and early childhood periods.

Third, consistent with our principles, we emphasise a people- and family-centred approach, with a ‘stepped care’ approach to service provision, which shapes health services around the health needs of individuals, their families and communities. To do this, we emphasise ‘progressive universalism’<sup>20</sup>, with three levels of care to reflect different levels of need of children and families.

The first level is universal primary health care – the universal health services that address needs that all or most Australian children and families have to foster a healthy start in life. These services support families in enhancing their children’s health and wellbeing, while picking up problems and addressing them early. As emphasised by Professor Bryanne Barnett, Foundation Chair of Infant, Child and Adolescent Psychiatry at the University of New South Wales:

*Services must not be limited to high risk/needs groups only. Children in all socio-economic strata benefit from appropriate pregnancy and early childhood programs.<sup>21</sup>*

The second level is targeted care – health services designed for children or parents with identifiable risk factors, or children with early symptoms of disability or delayed developmental outcomes. The services would include paediatricians, allied health and family support, and would generally be provided upon referral from primary health care.

The third level is intensive care – services for children or parents in need of ongoing specialist attention for significant problems or vulnerabilities; for example, children with complex, chronic or severe health or developmental concerns. This level of care will often include a range of health and family support services. There would be a care coordinator attached to primary health care services to coordinate services for a child and their family in need of more intensive care.

19 N Halfon and M Hochstein (2002), ‘Life course health development: An integrated framework for developing health policy and research’, *Milbank Quarterly* 80(3): 433–79; and N Halfon, H DuPlessis and M Inkelas (2007), ‘Transforming the US Child Health System’, *Health Affairs* 26(2): 315–30.

20 J Barlow and colleagues (2008), *Health-led parenting interventions in pregnancy and early years*, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

21 B Barnett (2008), Submission 486 to the National Health and Hospitals Reform Commission.

## Reform direction 3.2

We propose a strategy for a healthy start based on three building blocks:

- most importantly, a partnership with parents, supporting families – and extended families – in enhancing children’s health and wellbeing;
- a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school; and
- a child- and family-centred approach to shape the provision of health services around the health needs of children and their families. Under a ‘progressive universalism’ approach there would be three levels of care: universal, targeted and intensive care.

### 3.4.2 Mapping the strategy

The strategy for a healthy start draws on two of our identified building blocks: a life course approach to understanding health needs, and the three levels of care that respond to the needs of children and families.

Our strategy for the health system to nurture a healthy start to life begins with pre-conception, and then covers the antenatal period and early childhood stage, from birth up until eight years of age. For all stages, the level of universal care includes effective health promotion and prevention, and primary health care services which encourage good nutrition, healthy lifestyles and a high level of health literacy for all Australians, as we discuss in Chapters 1 and 2.

It is essential that health services connect well with other services which are important for the health and wellbeing of children

■ The health system would also be linked with two other universal service systems essential to nurturing a healthy start – early childhood education and care, and primary school. While we do not discuss their roles in any detail here, we recognise that there is a shared responsibility for nurturing a healthy start. It is essential that health services connect well with other services which are important for the health and wellbeing of children. For most children, after the very early years, health services ‘pass the baton’ to the early childhood education and care and school sectors to take the (non-family) lead in advancing a child’s development and wellbeing.

#### *Pre-conception stage*

We begin our strategy for nurturing a healthy start with the pre-conception stage – the stage at which the health of Australia’s future mothers and fathers is formed. At a Special Interest Forum on a Healthy Start held by the Commission, we heard about the importance of healthy lifestyles for young people, both for their own health and for the health of their children for those who become parents.

For example, smoking cessation programs – which should begin before pregnancy – have been found to be the most effective intervention in reducing the risk of low birth weight:

*Preventing low birth weight will require a longitudinal and integrated strategy to promote optimal development of women’s reproductive health, not only during pregnancy, but over the life course.<sup>22</sup>*

Furthermore, a partner’s smoking status is a key determinant of a woman’s smoking during pregnancy, highlighting the importance of health promotion for all young people.<sup>23</sup>

22 J Barlow and colleagues (2008), Health-led parenting interventions in pregnancy and early years, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

23 J Barlow and colleagues (2008), Health-led parenting interventions in pregnancy and early years, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

Participants at the Special Interest Forum also raised particular concerns about alcohol consumption and the need for more responsible drinking among young people:

*Alcohol consumption among young people is increasing dramatically in all states. Particular increases have been identified in rural and indigenous communities, with corresponding increases in the number of children being born with foetal alcohol syndrome. The level of hazardous drinking has escalated over the last 30 years, with an increase since 1996 from 12 to 20 per cent. This has resulted in a need to proactively respond to the particular needs of this population cohort as it moves through the system.<sup>24</sup>*

At the pre-conception stage, in addition to health promotion and prevention, and primary health care services, the universal services would include sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy – for example, through programs to encourage better connection with school.

### Reform direction 3.3

We propose beginning the strategy for nurturing a healthy start to life at pre-conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy.

### Antenatal stage

Universal primary health care services provide care for most women in the antenatal stage. Usually, women will have their pregnancy confirmed by a general practitioner or other primary health care worker, who can then link women to a midwife or obstetrician for management of the pregnancy and birth.

For women with special needs or at risk, there would be services provided through targeted care, such as home visits for very young, first-time mothers or women with substance abuse problems. As noted at the Special Interest Forum on a Healthy Start:

*Pregnancy provides a good opportunity for mothers to make behavioural changes if they are given appropriate supports.<sup>25</sup>*

The Commonwealth Government is currently undertaking a separate review of maternity services, which covers antenatal services, childbirth, and postnatal services up to six weeks after birth.<sup>26</sup> The review is due to report on ways to improve maternity services in December 2008, and we will take account of its findings in our final report due in June 2009.

### Reform direction 3.4

In the antenatal period, in addition to good universal primary health care, we propose targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.

24 Participant (5 August 2008), National Health and Hospitals Reform Commission special interest forum on early start to life in Sydney.

25 Participant (5 August 2008), National Health and Hospitals Reform Commission special interest forum on early start to life in Sydney.

26 Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at: [www.health.gov.au](http://www.health.gov.au)

## Early childhood stage

As noted earlier, while across Australia there are community child and family health services which focus on the early years of life, there are important differences among the states and territories which result in variable access and service provision for families. These include:

- different schedules of contact visits across varied ages;
- different assessment and monitoring activities;
- varying emphasis across the domains of child physical health, child development, child social and emotional wellbeing, parental wellbeing and family functioning;
- different approaches to primary prevention strategies; and
- different approaches to interventions in response to identified issues.<sup>27</sup>

The universal child and family health services would provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring during early childhood

■ While allowing for local responsiveness, under our strategy for nurturing a healthy start to life the universal child and family health services would provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring during early childhood.<sup>28</sup> The schedule would cover the period from between birth to eight years of age, reflecting the critical early childhood period, and seeing children through the important transition to primary school. The schedule could be provided by a range of health professionals, including general practitioners, child and family health services, and school nurses.

An evidence-based schedule of contacts would be designed that allows for the delivery of core services to children and families at age-appropriate times. A list of the core services and activities to be provided under the schedule of contacts is at Figure 3.4.

**Figure 3.4: The following are core services for children and families to be provided by child and family health services from birth to eight years of age**

Core services	Activities
<i>Monitoring of child health, development and wellbeing</i>	<i>Health monitoring, including physical health and growth</i>
	<i>Monitoring of child development, which is particularly important for the early identification of children with developmental delay, and provision of/referral to early intervention services</i>
	<i>Monitoring of a child's socio-emotional wellbeing and parent-child attachment</i>
<i>Early identification of family risk and need</i>	<i>Comprehensive assessment of risk and protective factors for a child's development, including parent, child, family and community factors</i>
	<i>Maternal health (including mental health) screening</i>
	<i>Identification of family support needs across multiple domains (for example, health and housing)</i>
	<i>Identification of risk of child abuse and neglect</i>

27 Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

28 This section draws on a recent review of best practice universal family and child health services undertaken to develop a draft national framework for child and family health services for the Australian Health Ministers' Advisory Council. The (draft) National Framework for Universal Child and Family Health Services sets out the core universal services that all Australian children and families should receive, regardless of where they live, and how and where they access their health care. Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

Figure 3.4: The following are core services for children and families to be provided by child and family health services from birth to eight years of age

Core services	Activities
<i>Responding to identified needs</i>	<p><i>Advice and assistance</i></p> <p><i>Practice-based interventions (for example, sleep intervention or smoking cessation)</i></p> <p><i>Referral to targeted or specialist service (for example, speech pathologist or intensive family support)</i></p>
<i>Health promotion and prevention</i>	<p><i>Health promotion education – core topics are support for breastfeeding, sudden infant death syndrome prevention and education, injury prevention, promoting early literacy and oral health education</i></p> <p><i>Immunisation</i></p>
<i>Support for parenting</i>	<p><i>Anticipatory guidance – practical information about ‘what to expect’ in the child’s behaviour, growth and development in the upcoming age period</i></p> <p><i>Promoting positive parenting, including engaging fathers</i></p> <p><i>Peer support programs which build parental confidence and capacity and provide a social network of support.</i></p>

Source: Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers’ Advisory Council.

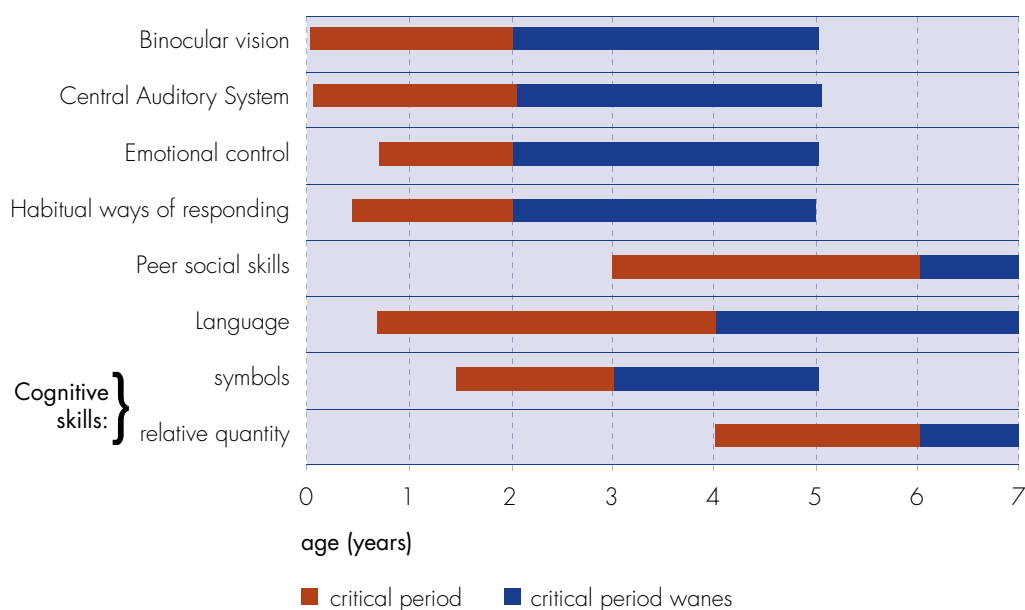
Under the schedule, contacts would align with critical periods for identifying and responding early to issues. Figure 3.5 illustrates the sensitive periods for early development. There would also be regular enough contact to develop a relationship between the family and the service. A relationship based on trust is essential for the effective identification of needs and risks in a family. Regular contact also enhances participation in the service and ensures the family remains engaged for critical monitoring points.<sup>29</sup>

There is also strong evidence supporting the importance of the very early years (as shown in Figure 3.5), and contacts would be weighted towards the first three years of life. Where possible, the initial contact by the service would be universally offered as a home visit within the first two weeks following the birth. A home visit has two benefits: it is convenient for new parents so it engages those who may otherwise be ‘hard to reach’, and it provides an opportunity for the home visitor to observe the home environment and provide advice to parents tailored to their individual needs.<sup>30</sup>

29 Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers’ Advisory Council.

30 Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers’ Advisory Council.

**Figure 3.5: There are sensitive periods for early childhood development**



Source: M McCain and J Mustard (1999), *Early Years Study Final Report: Reversing the Real Brain Drain* (Publications Ontario: Toronto)

**Reform direction 3.5**

We propose that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life). The initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting.

There is strong evidence of the effectiveness of sustained home visits for new mothers with additional risk factors

As part of its set of core services, where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify an appropriate pathway for targeted care, which could be based on an enhanced schedule of contacts for the child, including ongoing home visits. There is strong evidence of the effectiveness of sustained home visits for new mothers with additional risk factors, such as very young age and unmarried. Evidence shows that participants had healthier lifestyles and children visited had fewer health problems.<sup>31</sup> Programs are more effective when they last six months or more, involve more than 12 home visits, and begin early (either antenatally or at birth).<sup>32</sup>

In many cases, the pathway will be a referral to a targeted or specialist service for children with a disability or developmental delay and children or mothers with significant risk factors (such as children in out-of-home care or mothers with symptoms of depression or anxiety). For example, this could include paediatricians, speech pathologists and mental health services (mental health services are discussed in Chapter 10). We noted earlier, however, that many families had problems accessing specialist and allied health services for children with a disability or a developmental delay, particularly in rural areas. We have identified in Chapter 2 the importance of voluntary

31 D Olds and colleagues (2007), 'Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial', *Pediatrics* 120 (4): e832–e845; D Scott (2006), 'Family home visiting: a way forward', Presentation at Second National Parenting Conference Adelaide, at: <http://www.unisa.edu.au/childprotection>

32 J Barlow and colleagues (2008), *Health-led parenting interventions in pregnancy and early years*, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

enrolment with primary care health service for such families to promote improved coordination of care and to reduce the chance that such families will fall through the 'health service gaps'. In addition, we have proposed that there needs to be strengthening of shared care arrangements so that there is better access to specialist, multidisciplinary teams providing care in the community and integration of this care with primary care. Finally, there is also a need to enhance training of health professionals so they can better support the needs of such families.

### Reform direction 3.6

We propose that as part of its set of core services, where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services.

Some children will require more intensive care, particularly children with chronic or severe health or developmental concerns. Where a child requires more intensive care, a care coordinator attached to primary health care services would be available to coordinate the range of services these families often need. This proposal responds to the views of many people in submissions and national consultations of the need for early intervention for children with a disability or developmental delay. As one participant put it:

*... one of our priority areas was early intervention, but in considering early intervention from a health perspective rather than an education system. Focussing on early identification of children with special needs and then helping them to get access to a range of services including allied health. Someone talked about the concept of trying to reduce the lottery, so trying to come up with a better strategy so that families hear about what's available and they are able to get access to those services without having to jump through hoops and, you know, coming up against lots of closed doors.<sup>33</sup>*

■ Some children will require more intensive care, particularly children with chronic or severe health or developmental concerns

### Reform direction 3.7

We propose that, where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.

The beginning of compulsory schooling at age four to five provides the opportunity for a comprehensive health and development check for all children, as provided for by the Commonwealth Government in the 2008–09 Budget. Health or developmental concerns identified at this time would be relayed to the school nurse if appropriate for follow-up action or continued monitoring.

School nurses are an important resource for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school. We support all primary schools having access to a school nurse. This could be done in number of ways. For example, Victoria has a Primary School Nursing Program under which all public schools are visited by nurses. The program provides:

- a health assessment to enable early identification of health problems;
- advice, information and referral to other services;
- health promotion aimed at maintaining and improving the health and wellbeing of children and their families; and

<sup>33</sup> Health professional (9 July), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Adelaide.

- support to families and school communities by providing information and education on issues relating to school-aged children.<sup>34</sup>

#### Reform direction 3.8

We propose that all primary schools have access to a school nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.

### 3.4.3 Making it happen

It is essential that child and family health services are linked to primary health care services

- Ensuring a healthy start to life must be embedded in primary health care. Mostly, the universal schedule of contacts from birth to eight years of age will be provided by child and family health services (although it could be provided by general practitioners and the activities in later childhood could be provided by school nurses). Child and family health services will be incorporated in the Comprehensive Primary Health Care Centres we have proposed in Chapter 2. It is essential that child and family services are linked to primary health care services to ensure continuity of care and a full understanding of a child's health care needs. This would be particularly important for targeted and more intensive care for which referrals would often come from a general practitioner.

As argued in a submission from the Victorian Maternal & Child Health Special Interest Group:

*There needs to be greater consistency of information between maternity services and universal primary health services around the information provided to, and care for new families.<sup>35</sup>*

Ideally, families would be enrolled with a primary health care service (as proposed in Chapter 2) as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of a child and their family. This would be the foundation for a strong partnership throughout life between a person and primary health care.

#### Reform direction 3.9

We propose that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure continuity of care and a comprehensive understanding of a child's health needs. Families would have the opportunity to be enrolled with a primary health care service as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of a child and their family.

34 Department of Human Services (2008), The Primary School Nursing Program, at: <http://www.dhs.vic.gov.au/phkb>

35 Victorian Maternal & Child Health Nurses Special Interest Group (2008), Submission 188 to the National Health and Hospitals Reform Commission.