New millennium’s resolution: start young and track fast

The childhood shows the man,
    As morning shows the day
(John Milton (1671), Paradise Regained)

From the very beginnings of time we have known that early childhood experiences set the course for future wellbeing (Bible). Indeed, the origins of the public health movement 150 years ago were founded on the need to protect and promote the health of the young. But over the course of the last century interest in early childhood has both waxed and waned. There have been strong times, e.g. the development of infant welfare, nutrition, antenatal care, paediatric surveillance, immunization, health education and school health services (Catford, 1994). Yet over the last few decades, in many countries, health policy—and certainly expenditure on health care—has focused more on the end of life than on the beginning.

Encouragingly, a renaissance of interest in the early years is now apparent internationally. This reflects both an expanding evidence base as well as a broader field of concern from other sectors. An increasing number of international studies have found that poor social and economic circumstances now present the greatest threat to children’s growth and development, as the foundations of adult health are laid in prenatal life and early childhood (e.g. Barker, 1994). Acting through poor or inappropriate nutrition and smoking, parental poverty can reduce prenatal and infant development (Wilkinson and Marmot, 1998). Poor early growth is associated with reduced cardiovascular, respiratory, kidney and pancreatic functioning in adulthood, which in turn increase the risk of heart and chest disease, renal failure and diabetes.

As well as the physical health effects, there is increasing recognition of the impact of early childhood on mental health, cognitive development, and social, addictive and criminal behaviour. This has brought new constituencies to the table including mental health, drug and alcohol, childcare, education, employers, police, justice, prisons and correctional services.

In Australia, the Attorney General’s Department has recently undertaken an international review of early childhood programs as a means of prevention for crime and other social problems (National Crime Prevention, 1999). A major conclusion was that interventions, e.g. home visiting, family support and parenting education, can have a major impact on at-risk families and children to improve quality of life and help prevent future offending. Such strategies were also found to be cost effective when compared to the long-term costs of crime and the criminal justice response. There is now growing interest amongst a number of Australian states to mount ambitious programs focusing on the ‘first three years’ with support from the health, education, community and justice sectors.

The case for such action has recently been strengthened by a major study in Canada, undertaken for the Ontario Government (McCain and Mustard, 1999). The eminent authors together with the support of an expert reference group examined the evidence from the neurosciences, developmental psychology, social sciences, anthropology, epidemiology, and other disciplines about the relationship between early brain development and child development, and learning, behaviour and health at different stages of life. They concluded that the period of early childhood development is equal to, or, in some cases, greater in importance for the quality of the next generation than the periods children and youth spend in school or post-secondary education.

The Early Years Study, subtitled ‘reversing the real brain drain’, gave special attention to research emerging from the neurosciences.
200 page report, citing more than 150 references, demonstrated that there was powerful new evidence that the early years of development from conception to age six, particularly for the first 3 years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life. Early experiences and stimulating, positive interactions with adults and other children are far more important for brain development than previously realized.

Recommendations for enhancing the potential in the early years (McCain and Mustard, 1999) included establishing or developing:

- early child development and parenting centres in communities, involving the public and private sectors;
- improved maternity/paternity leave benefits for parents;
- family-friendly workplaces;
- tax incentives for development of new centres in communities;
- an integrated, independent outcome measure of human development; and
- a network for community information sharing.

In Britain, the Government’s recently published White Paper (HMG, 1999)—signed importantly by the entire Cabinet—emphasizes the central role of early childhood. A new cross-Government programme Sure Start will be established to provide support to parents and local communities, addressing their needs and making available the support they require to give their children the best possible start in life. It will be targeted to areas of need, binding together existing services so as to enhance their performance to meet the particular needs of young families. More than 450 million (GBP) will go into 250 local programmes in England, focused on children under four and their families. It is intended that Sure Start will work across the boundaries of Government departments, and at community levels will be both multi-disciplinary and multi-agency.

Leading this work will be health visitors (community health nurses) clearly designated as local public health practitioners. Their role will be modernized to develop a family-centred approach, working with individuals, families and communities to improve health and reduce health inequalities. Important contributions will also be provided by school health nurses and midwives, who will have a strengthened public health role.

At an international level, investment in early childhood has recently been given further recognition by the World Health Organisation Regional Office for Europe (WHO, 1999). Health 21, the health for all policy framework for the WHO European Region, sets out an ambitious social policy agenda based on 21 aspirational health targets for the 21st century. These are not meant to be a prescriptive list, but together they make up the essence of regional health policy. The targets provide a framework for action for the European Region as a whole, and an inspiration for ones specifically tailored to country and local levels.

The first two European targets concern reducing inequalities in health between countries and within countries. Of note, the third target then focuses directly on a ‘healthy start in life’. The framework recommends that genetic and dietary counselling, a smoke-free pregnancy, and evidence-based prenatal care will help prevent low birth weight and congenital abnormalities. Policies should be implemented that create a supportive family, with wanted children and good parenthood capacity. Parents need the means and skills to bring up their children and care for them in a social environment that protects the rights of the child. Local communities need to support families by ensuring a safe nurturing environment and providing health-promoting childcare facilities.

WHO’s Target 3 states that ‘by the year 2020, all newborn babies, infants and pre-school children in the region should have better health, ensuring a healthy start in life’ (WHO, 1999). Specific measurable health outcome targets are presented for infant mortality, congenital disease, accidents and violence, and low birth weight. This approach is consistent with previous WHO health for all documents, and has been adopted by many industrialized countries as core components of their national health policies or strategies.

The USA led the way in the 1980s, and since then more than 12 European countries including Finland, Hungary and Wales have developed national health targets. These have normally focused on changes in health status (e.g. mortality, morbidity) or risk factors (e.g. smoking, body weight) over a 5–10 year time frame. Interestingly, England has recently reduced its set of national targets to four, which are described in the White Paper as ‘tougher but attainable’. They focus on cancer, cardiovascular disease, accidents and suicide (HMG, 1999).
There have been a number of benefits from setting health outcome targets including:

- creating an agenda for action;
- strengthening public health approaches;
- winning public and political support;
- establishing priorities;
- setting the pace of change; and
- establishing monitoring mechanisms.

Nevertheless, the process has also met with a number of difficulties. These include:

- poor specification on how the improvements will occur;
- lack of accountability and ownership;
- unrealistic and poorly justified expectations;
- insufficient assessment of the reasons for under/overachievement;
- long lead times for change to occur and be seen;
- high cost and practical difficulties with monitoring; and
- loss of momentum after the first few years.

The overall criticism is that the health outcome targets have often been developed on the basis of informed but wishful thinking, without a clear and realistic strategy being developed as to ‘how’ they will be achieved. A key challenge for the next century is for jurisdictions to consider the health gain and capacity-building programs that are required—and then to ensure that they are put into effect. These could take the form of improvements in service provision, technological application, public education, workforce development, regulatory changes, leadership and co-ordination.

Monitoring the implementation of such strategies will be important to ensure that progress is made. To assist this, a set of indicators should be developed which indicate whether the strategy is tracking correctly or not. Such strategic tracking indicators (STIs) would have the advantage of:

- defining cause and effect relationships;
- reflecting resource investment issues;
- taking account of system capacity;
- addressing common components across several health gain areas;
- specifying responsibility and accountability;
- offering more responsive and attractive time frames;
- ensuring greater commitment and ownership;
- requiring lower cost monitoring mechanisms; and
- providing faster feedback on progress.

STIs would not need to be developed for every aspect of a strategy. Rather, they should focus on the critical components without which the health outcome targets could not be achieved. As there will be an important dynamic between the STIs and the health outcome targets, it will be important for the two sets to be developed in conjunction with each other. This implies that there must be close dialogue between the delivery system and the policy-making groups for the national strategies. To ensure success, broad and high-level support would be necessary from within the health sector and governments.

While organizations begin to focus more on early childhood as a new area for public health investment, an opportunity exists to develop new types of yardsticks to measure progress ‘real time’. Timely and effective corrective action can then be taken if needed to bring strategies back ‘on course’. We could learn much from schools over the last 1000 years in providing parents with fast and focused feedback on their children’s learning. Tracking progress and achievements of our strengthened child health strategies should be an important task for the next millennium.

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REFERENCES

WHO (1999) Health 21, the health for all policy framework for the WHO European Region. European Health for All Series No 6. World Health Organisation Regional Office for Europe, Copenhagen.