

Early childhood development and the social determinants of health inequities

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'Fair Foundations: The VicHealth framework for health equity' was developed by VicHealth under the leadership of author O'Rourke. It was published in 2013. It is a conceptual and planning framework adapted from work done by the WHO Commission on the Social Determinants of Health (Solar and Irwin, 2010). Social determinants of health inequities are depicted as three layers of influence – socioeconomic, political and cultural context; daily living conditions; and individual health-related factors. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair. The layers of influence also provide practical entry points for action (VicHealth, 2013). Fair Foundations can be accessed at www.vichealth.vic.gov.au.

Summary

Children's health and development outcomes follow a social gradient: the further up the socio-economic spectrum, the better the outcomes. Based upon a review of multiple forms of evidence, and with a specific focus upon Australia, this article investigates the causes of these socially produced inequities, their impact upon health and development during the early years and what works to reduce these inequities. Using VicHealth's *Fair Foundations* framework, we report upon child health inequity at three different levels: the socioeconomic, political and cultural level; daily living conditions; the individual health-related behaviours. Although intensive interventions may improve the absolute conditions of significantly disadvantaged children and families, interventions that have been shown to effectively reduce the gap between the best and worst off families are rare. Numerous interventions have been shown to improve some aspect of prenatal, postnatal, family, physical and social environments for young children; however, sustainable or direct effects are difficult to achieve. Inequitable access to services has the potential to maintain or increase inequities during the early years, because those families most in need of services are typically least able to access them. Reducing inequities during early childhood requires a multi-level, multi-faceted response that incorporates: approaches to governance and decision-making; policies that improve access to quality services and facilitate secure, stable, flexible workplaces for parents; service systems that reflect the characteristics of proportionate universalism, function collaboratively, and deliver evidence-based programs in inclusive environments; strong, supportive communities; and information and timely assistance for parents so they feel supported and confident.

Key words: children, health and social policy, Australia, inequalities in health

INTRODUCTION

In every society, including Australia, differences in socioeconomic status translate into inequities in child development (Hertzman *et al.*, 2010; Strategic Review of Health Inequalities in England post-2010 Committee, 2010; Goldfeld and West, 2014). Discrepancies between children that are based upon avoidable differences in social and economic circumstances are evident as early as 9 months of age in a range of domains, and they grow larger over time (Heckman, 2008; Halle *et al.*, 2009).

It is well established that health follows a social gradient: progressively better health is associated with increasing socioeconomic position (WHO Commission on the Social Determinants of Health, 2008; Bamba *et al.*, 2010). This phenomenon is also evident across a wide range of indicators pertaining to children and families: outcomes for children and families improve progressively the further up the socioeconomic spectrum they are, and worsen progressively the further down they move (Hertzman *et al.*, 2010; Strategic Review of Health Inequalities in England post-2010 Committee, 2010). Hence, poor child and family outcomes are not concentrated exclusively at the bottom of the socioeconomic spectrum in a small group of disadvantaged families but are distributed across the entire spectrum in a graded fashion (Denburg and Daneman, 2010; Strategic Review of Health Inequalities in England post-2010 Committee, 2010; Wilkinson and Pickett, 2009).

The circumstances in which children are born determine their exposure to environments that promote or compromise healthy development. Children's health, development and well-being can be compromised by a number of direct adverse experiences during the prenatal and postnatal periods including: sustained poverty, recurrent abuse and neglect, parental alcohol or drug abuse, homelessness, and family violence. The trends regarding the prevalence of these problems in the families of Australian children are worrying (Moore and McDonald, 2013).

Inequities during the early years (typically defined as the first 8 years of life) are especially concerning because of the nature of early childhood development. During this period, a number of key capabilities and competencies develop (McCain and Mustard, 1999; Shonkoff, 2012), a process that is particularly sensitive to social determinants (Dyson *et al.*, 2010; Hertzman, 2010).

Experiences during early childhood play a major role in shaping later life (National Scientific Council on the

Developing Child, 2007; Shonkoff *et al.*, 2009; Currie and Rossin-Slater, 2014). There are three key ways in which the life-long effects of early experiences impact on the later achievements, health and longevity of individuals:

- 'Biological embedding' is a developmental process whereby prenatal and early childhood experiences affect physiological and neurological development in ways that have long-term consequences (Gluckman *et al.*, 2010; Hertzman and Boyce, 2010);
- 'The cumulative effect of adverse experiences' during childhood can lead to toxic stress that influences every aspect of health and well-being in childhood and beyond (Anda *et al.*, 2009; Brown *et al.*, 2009; Shonkoff *et al.*, 2009; Shonkoff, 2012); and
- 'Escalations in risk over time' shape children's development so that exposure to adverse experiences at one stage of the life course increases the probability of similar exposures subsequently (Repetti *et al.*, 2002; Hertzman and Boyce, 2010).

This article focuses on the social determinants of health inequities during these critical early childhood years. The questions we seek to answer are:

1. What are the causes of inequities in health and development during early childhood, and how do these inequities impact upon health and development during this period?
2. What works to reduce inequities in health and development during the early years?

In terms of reducing inequities, we focus upon policies and practices that work—or show promise—in the Australian context or in countries similar to Australia such as the UK, Ireland, the USA, Canada and New Zealand.

The 'layers of influence' outlined in *Fair Foundations: The VicHealth framework for health equity* (VicHealth, 2013) are used to explore each question. According to the *Fair Foundations* framework, there are three layers of influence that lead to inequitable, socially produced, systematic differential health and well-being outcomes:

1. The socioeconomic, political and cultural context, encompassing governance, policy, and dominant cultural and societal norms and values
2. Daily living conditions, which are the circumstances in which people are born, grow, live, work and age; and

- Individual health-related factors, that is the health-related knowledge, attitudes and behaviours of individuals that result from, and are responses to, their socioeconomic, political and cultural context, social position and daily living conditions.

The socioeconomic, political and cultural context generates a process of social stratification that allocates people to different social positions, with the end result being unequal distribution of power, economic resources and prestige (VicHealth, 2013).

For the purposes of this article, health inequities are defined as differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair (as opposed to health inequalities which can also refer to biological differences between children that impact upon their health, well-being and development and that are not preventable, e.g. a chromosomal abnormality). Secondly, early childhood is defined here as the first 8 years of life and the prenatal period. Our inclusion of the prenatal period is based upon the fact that inequities during this stage can impact upon an individual's outcomes during infancy, childhood and adulthood (Guyer et al., 2009; Shonkoff, 2010).

METHODOLOGY

The search strategy we used for this review combined three different approaches:

- A traditional database search: a targeted search of electronic databases to identify literature;
- A search for authoritative summaries, conceptual and theoretical works outlined in various sources including books, grey literature and handbooks; and
- A search of relevant websites: websites that were likely to have relevant grey literature from developed countries similar to Australia.

A more detailed description of the methodology is provided in Supplementary Appendix 1.

What are the causes of inequities in health and development during early childhood, and what works to reduce those inequities?

The causes of inequities in health and development during early childhood are vast and wide ranging, from macro-level social and economic factors right down to micro-level factors such as parent knowledge regarding health services. As such, reducing inequities in early childhood is likely to be a complex task involving a range of stakeholders, environments, interventions and external

influences. What follows is a brief description of the findings of our review, including some key illustrations of how inequities in health and development during early childhood could be achieved. We conclude with a description of the strategies that, based upon the evidence we reviewed, appear to have the strongest potential to reduce inequities during early childhood in the Australian context.

Socioeconomic, political and cultural level

Over the last 50 years, developed nations have experienced rapid and dramatic social changes resulting in significant changes in the conditions under which families are raising young children (Giddens, 2002; Trask, 2010; Bauman, 2011). Although most children have benefited from these changes, a minority have not and experience significant problems across all aspects of development, health and well-being (Stanley et al., 2005; Li et al., 2008).

One outcome of these rapid social changes is that the nature of the problems facing society and governments have altered—they are now more likely to be 'wicked' problems (Weber and Khademan, 2008; Moore and Fry, 2011). Wicked problems are complex and intractable and, as such, cannot be resolved using traditional governance and leadership models, nor by service-driven approaches (Grint, 2010; Moore and Fry, 2011). Some wicked problems (e.g. poverty, child abuse) are not new, but have become more of a concern because of an increasing awareness regarding the adverse consequences of these problems upon child development and the complex nature of their underlying causes.

One 'wicked' problem that has wide-ranging and long-lasting consequences on young children is sustained poverty, which impacts on brain development and health during childhood, and psychological health and educational outcomes in adulthood (Gibb et al., 2012; Blackburn et al., 2013; Duncan et al., 2013). Evidence suggests that policies targeting disadvantaged families—such as welfare-to-work initiatives—can have positive effects for both children and their families (Coley et al., 2007; Millar, 2010). However, the evidence indicates that factors such as mandatory employment requirements and irregular or insecure forms of employment can have a negative impact on children (Strazdins et al., 2010; Cooklin et al., 2011; Coley and Lombardi, 2012). Such social policies have differing impacts depending upon the context within which they are implemented; in the Australian context, the limited research available suggests that welfare-to-work initiatives have largely negative effects (Summerfield et al., 2010; Grahame and Marston, 2011).

International evidence indicates that policies targeting financially disadvantaged families that involve the

provision of additional money through, for example, direct cash payments and tax credits, have a limited effect on the circumstances in which young children from disadvantaged backgrounds develop, or indeed upon child outcomes (Lucas *et al.*, 2008; McEwen and Stewart, 2014). Evidence from the USA suggests that intensive, long-term initiatives that provide a range of support in addition to financial support (e.g. child-care, health care benefits) may be a more effective means of improving outcomes for children living in significantly disadvantaged households [see, for example, the New Hope program (Huston *et al.*, 2005; Miller *et al.*, 2008)]. However, it is unclear whether—and to what extent—these lessons are equally applicable to the Australia where, in comparison to the USA, more generous welfare provisions lessen the impact of poverty on families (Kalil *et al.*, 2012) [It may be that these policies are ineffective (in as far as outcomes for children are concerned) because of the complex nature of wicked problems, or it may be that the amount of money families received was too small to make a significant difference to their daily living conditions (Lucas *et al.*, 2008)].

Although there are a range of interventions that have been shown to improve the absolute position of the most disadvantaged families, evidence pertaining to interventions that have been shown to reduce the relative gap between the best and worst off families is fairly limited. One exception pertains to income-related nutritional disparities among pregnant women: instituting a policy of mandatory fortification of commonly consumed foods with folate reduces income-related nutritional disparities between women, thereby limiting the potential for inequities in foetal tube defects among children (Ricciuto and Tarasuk, 2007). One intervention that has been shown to potentially increase inequities between children in the long term is smoke-free legislation designed to reduce children's exposure to second-hand smoke in the home. Evidence demonstrates that such legislation is ineffective at reducing inequities relating to second-hand smoke exposure between children from the highest and lowest SES groups, and may increase those inequities in the long term (Akhtar *et al.*, 2010; Moore *et al.*, 2012a).

In addition to considering the socioeconomic causes of childhood inequity, it is important to also consider the impact of cultural factors. One abiding cultural misperception among Australians is that young children are 'passive absorbers of content' and their lives 'simplified and uncluttered by influences' (Kendall-Taylor and Lindland, 2013). These misconceptions could indirectly maintain or increase inequity in early childhood by influencing how the general public views—and the extent to which they support—government investment in early childhood initiatives designed to reduce inequity [Fenech (2013) provides an example of

how a specific view of early childhood can impact upon public support for early childhood initiatives. In Australia, education and care during the early years has typically been viewed as a personal rather than a public concern. As a result, there has been limited public support for universal high-quality early childhood education for *all* children in Australia (Fenech, 2013)]. Government investment in initiatives that seek to improve the quality of learning environments experienced by young children, for example, may be viewed as being of lesser importance than other education investments if young children lives are perceived to be as 'uncluttered by influences.'

Daily living conditions

Early child development

Children's development in both the short- and long term is shaped by the environments they experience in the pre-natal and post-natal periods. These environments are not always optimal: common environmental risk factors in pregnancy and early life include: stress, cigarette smoking, alcohol consumption, obesity, poor nutrition, poverty and exposure to environmental toxins (Martin and Dombrowski, 2008; Brown *et al.*, 2011; Robinson, 2013; Platt, 2014; Taylor *et al.*, 2014).

There is now strong evidence that the biological and neurological development of an individual can be shaped by environmental conditions in the womb (Martin and Dombrowski, 2008; Robinson, 2013). One effect of sub-optimal prenatal conditions is premature birth, which is associated with greater risk of problems both in the short and in the longer term (Patton *et al.*, 2004; Platt, 2014). One relatively common method for improving prenatal conditions is food subsidy and food voucher programs that target pregnant women experiencing disadvantage. Although these programs may have some direct impact on pregnant women's nutritional levels, there is limited evidence to support a sustainable impact on dietary behaviour (Black *et al.*, 2012). Similarly, there is a lack of evidence to recommend one intervention over another in regards to the cessation of smoking during pregnancy, although those that focus on parent attitudes and behaviours, as opposed to parent knowledge, appear to be more successful (Priest *et al.*, 2008). Targeted motivational smoking cessation interventions and holistic cessation support have demonstrated some promising results among low-income pregnant women in the USA and the UK (Parker *et al.*, 2007; Bryce *et al.*, 2009).

Postnatal environments are also vitally important for health and development, with early caregiving relationships being critical (National Scientific Council on the Developing Child, 2004; Siegel, 2012). Sensitive and

responsive care giving and positive attachments with caregivers are essential for the healthy neurophysiological, physical and psychological development of a child (Cozolino, 2012; Shonkoff, 2012). Workplace flexibility for parents and caregivers (e.g. parental leave schemes) during their child's early years is especially important in this respect as it provides parents and caregivers with greater opportunity to build those critical relationships with their children (O'Brien, 2009).

Caregiving that is inadequate and negligent, and attachments that are weak or disrupted, results in adverse consequences for children's health and development (Waldfoegel, 2006; McCrory et al., 2010). Physical and emotional abuse, neglect and family violence can have long-term consequences for the mental and physical health of children, as well as their social adjustment, academic achievements and employment histories in adulthood (Fergusson and Horwood, 1998; Reeve and van Gool, 2013; McLeod et al., 2014). Some parenting programs have been shown to reduce behaviours associated with child maltreatment among parents who have previously abused their children or are involved with child protection authorities (Barlow et al., 2006; Thomas and Zimmer-Gembeck, 2012); however, evidence regarding direct impact (i.e. actual maltreatment) is limited (MacVear et al., 2014).

Early environments vary in the extent to which they support learning: the development of competence and autonomy depend upon the learning opportunities and support provided to the child in their daily home and community environments (Deci and Ryan, 2011; Blair and Raver, 2012; Pianta, 2013). Learning and development are cumulative—the skills acquired early form the basis for later skill development (Cunha et al., 2006; Rigney, 2010). High-quality ECEC programs support young children's learning and, in this sense, play an important role in reducing inequity across the social gradient, because they benefit all children in a range of ways including cognitively, socially, behaviourally and in relation to school readiness (Durlak, 2003; Camilli et al., 2010). The quality of ECEC programs is especially important; high-quality ECEC programs produce better outcomes for children than lower quality programs in both the short- and long term (Sylva et al., 2003, 2012) [The quality of ECEC is determined according to structural factors (e.g. the number of children in a room) and process factors (e.g. the nature of adult-child interactions) (CCCH, 2013)]. Furthermore, high-quality ECEC has been shown to be especially beneficial for children from significantly disadvantaged backgrounds (Schweinhart et al., 2011; Campbell, 2012).

In Australia access to high-quality ECEC is especially important considering young children from traditionally

disadvantaged groups access ECEC at a lower rate than other children, and the quality of ECEC in disadvantaged neighbourhoods is generally poorer than other neighbourhoods (Baxter and Hand, 2013; CCCH, 2013). It is important to note that if an improvement in the quality of ECEC results in increased costs for families from disadvantaged backgrounds, there is likely to be increased inequity; children from higher socioeconomic backgrounds whose parents can afford ECEC will reap the benefits and enter school with skills their disadvantaged counterparts will not have had as many chances to develop.

Family environments

While families who are relatively well resourced have benefitted from recent rapid social change, poorly resourced families can find the heightened demands of contemporary living and parenting overwhelming (Gallo and Matthews, 2003; Barnes et al., 2006a,b), with negative impacts on their children. Gaps in family functioning are cumulative: the more advantaged families are initially, the better they are able to capitalize and build on the enhanced opportunities available, so that the gap between them and those unable to do so progressively widens (Social Exclusion Task Force, 2007; Rigney, 2010).

There also appears to be an increase in the numbers of families with multiple and complex needs (Cleaver et al., 2007; Bromfield et al., 2010). Such families are often experiencing a range of external stressors (such as housing instability, poverty and social isolation) and parents within those families may also be grappling with their own experiences of trauma and victimization (Bromfield et al., 2010).

Poor quality or insecure housing, and especially homelessness, negatively affects child health and well-being (Dockery et al., 2010; McCoy-Roth et al., 2012). In Australia, housing is especially relevant to the health inequities experienced by ATSI children, particularly in remote communities where the type of infectious diseases that infants commonly present with are linked to poor housing conditions and overcrowding (Kearns et al., 2013; Jervis-Bardy et al., 2014). Interventions that focus primarily on housing infrastructure do not appear to solve housing inequities in these communities. Housing interventions that aim to improve the absolute position of children in remote ATSI communities require a multi-level, multi-faceted, 'ecological' approach (McDonald et al., 2008; Bailie et al., 2011, 2012).

Physical and social environments

The nature and quality of the physical environment in which children grow up can have a significant impact on their health and development (Evans, 2006; Sustainable

Development Commission, 2008). Key aspects of the physical environment include access to parks and green spaces, the nature of the built environment and exposure to environmental toxins (Louv, 2005; Martin and Dombrowski, 2008; Sandercock *et al.*, 2010). People living in low socioeconomic status communities are more likely to be exposed to toxic wastes, air pollutants, poor water quality, excessive noise, residential crowding or poor housing quality (Evans and Katrowitz, 2002; Currie, 2011).

The nature and quality of the social environment also influence the development of young children and the functioning of families (Kawachi and Berkman, 2003; Pearson *et al.*, 2013). Poor social cohesion, social capital and social support have been associated with increased rates of post-natal maternal depressive symptoms, child maltreatment and concurrent drinking and smoking during pregnancy (Wandersman and Nation, 1998; Surkan *et al.*, 2006; Powers *et al.*, 2013; Eastwood *et al.*, 2014), as well as potentially playing a role in the actual health gradient that exists among children (Vyncke *et al.*, 2013).

One way of responding to poor quality social environments is through area-based interventions that target a specific geographical location and aim to bring about change to a whole community (e.g. Communities for Children, Muir *et al.*, 2010). In the UK and Australia, large-scale area-based interventions have had some positive, albeit typically small, effects on children and families living in disadvantaged communities, although the impact of these interventions typically 'fade out' once children start school (NESS, 2012; Edwards *et al.*, 2014). Experiences in Australia and elsewhere suggest that, when working with indigenous communities, the involvement of Indigenous people in health promotion initiatives is critical (Potvin *et al.*, 2003; Signal *et al.*, 2007; FaHCSIA, 2011).

Community-based, multi-setting, multi-strategy approaches to preventing childhood obesity in disadvantaged communities in the UK and Australia demonstrate promise (Williams *et al.*, 2011; Swinburn *et al.*, 2012; Institute of Health Equity, 2014). A focus upon disadvantaged communities is important considering a social gradient in childhood obesity (Bambra *et al.*, 2013).

Health care and other services

Even in countries with universal health services, there are inequities of access to health care among children and inequitable outcomes in health (Teitler *et al.*, 2007). In part, this is because disadvantaged areas tend to receive fewer services. However, it is also because many vulnerable families find accessing health services, as well as other types of services, a challenge. A minority of vulnerable families make little or no use of existing services (Leurer, 2011;

Ou *et al.*, 2011) and it is often those with the greatest need that are least able to access available services (Ghate and Hazel, 2002; Fram, 2003).

The importance of providing accessible, comprehensive universal services for reducing inequity during the early years is underlined by a recent study which demonstrates significant differences in levels of vulnerability among Australian children by jurisdiction. Differences in the availability of universal health services could account for differences in jurisdictional levels of developmental inequity; two of the three states with the most comprehensive universal service coverage during the early years also have the smallest levels of inequity in child developmental vulnerability (Brinkman *et al.*, 2012).

One approach to improving service access is intake promotion and support (e.g. contacting parents prior to appointment to discuss potential barriers to attendance). Pre-intake prompting and support for improving families' registration with and use of services in UK have reported mixed findings (Yuan *et al.*, 2007; Michelson and Day, 2014). The processes of service delivery (i.e. how services are delivered) appear to play a key role in vulnerable families' engagement with services (CCCH, 2006; Moore *et al.*, 2012b).

Another major problem with the current service system is that the planning and delivery of services continues to be heavily segmented, with government departments and their funding streams operating autonomously as 'silos', making it difficult to conduct the joint planning needed to develop and implement a cohesive approach to supporting families of young children, especially those with multiple and complex needs (Moore, 2008). Place-based or 'collective impact' approaches to service delivery—involving a comprehensive, collaborative multi-level effort to simultaneously address all the factors that affect child, family and community functioning in a defined socio-geographic area—would appear to address at least some of these problems; however, the evaluation of such approaches is still in the early stages (Moore and Fry, 2011).

Individual health-related behaviours and attitudes

The health and well-being of children are strongly influenced by the knowledge, attitudes and behaviours of their parents, caregivers and family (Law *et al.*, 2012; Peters *et al.*, 2013). Parent knowledge regarding child development and nutrition are associated with improved child outcomes (Hess *et al.*, 2004; Campbell *et al.*, 2013). Vulnerable families may not have the same level of access to health information as other families or may not even know that particular health services exist (Carbone *et al.*, 2004; Claas *et al.*, 2011; Leurer, 2011). Migrants and families from non-English-speaking

backgrounds are particularly disadvantaged in this respect (Parvin *et al.*, 2004; Carolan and Cassar, 2007; Boerleider *et al.*, 2013; Clark *et al.*, 2014).

Targeted approaches to providing health-related information, such as text messaging and telephone-delivered health education interventions, demonstrate promise in terms of improving some aspects of maternal and child health among disadvantaged families (Pukallus *et al.*, 2013; Song *et al.*, 2013). Other approaches to improving parents' knowledge regarding infant and child health and development include peer-support interventions. For example, peer-support breastfeeding interventions demonstrate promise in terms of their effectiveness among women living in disadvantaged communities in the UK (Alexander *et al.*, 2003; Dykes, 2005).

Parental child-rearing attitudes and behaviours also shape parenting behaviours, and parent-child relationships are influenced by a range of factors including the parents' own experiences of being parented, the child's behaviour, the parents' cultural background and social norms (Gutman and Feinstein, 2007; Kruske *et al.*, 2012; Prady *et al.*, 2014). One service delivery strategy that has been shown to have had positive effects on the behaviour and attitudes of parents is home visiting. Home visiting is a service delivery strategy that aims to provide a range of supports for families and typically targets significantly disadvantaged children, parents and families (Boller *et al.*, 2010). Until recently, there was little evidence indicating the effectiveness of home visiting programs in Australia (Kemp *et al.*, 2008); however, in recent years, Australian home visiting programs have demonstrated their beneficial effects on a range of outcomes including health behaviours among significantly disadvantaged parents (Kemp *et al.*, 2011).

DISCUSSION

Based upon the evidence we identified, the following strategies have the strongest potential to reduce inequities during early childhood in Australia. These strategies are based upon an analysis of what the evidence tells us about the causes and impacts of inequity in early childhood and what the evidence from Australia—and from countries similar to Australia—tells us about what works to reduce those inequities in early childhood. Perhaps the most important point to make about the strategies is that none of them alone are likely to resolve the type of problems that cause inequity during the early years, and many are reliant upon another to be effective. What is needed is a multi-level, multi-faceted response involving all layers of the *Fair Foundations* framework.

Socioeconomic, political and cultural context

1. Because traditional governance and leadership approaches are not an appropriate or effective means for addressing the complex problems that lead to inequity (Grint, 2010; Moore and Fry, 2011) decision-makers (e.g. government, non-government organizations) need to ask questions of and engage communities, service providers and institutions.
2. Because all children benefit from high-quality ECEC, especially children experiencing disadvantage (Durlak, 2003; Sylva *et al.*, 2003, 2012; Camilli *et al.*, 2010), the quality agenda in early childhood education and care needs to be maintained.
3. Because families with young children experiencing disadvantage are less likely to utilize ECEC services (Baxter and Hand, 2013), we need to implement policies that make it easy for families with young children experiencing disadvantage to access high-quality ECEC.
4. Because for young children, the key developmental environments are relational (National Scientific Council on the Developing Child, 2004; Siegel, 2012), we need to implement policies that enable greater workforce flexibility for all parents and caregivers so they can spend more time with their children during the early years.
5. Because employment for parents at any cost could increase inequity (those in the most disadvantaged groups are likely to be employed in the most insecure and unstable jobs, and insecure, unstable employment can have a negative impact upon children) (Strazdins *et al.*, 2010; Cooklin *et al.*, 2011; Coley and Lombardi, 2012), we need to implement policies that ensure secure and stable employment for primary caregivers.
6. Because public perceptions of early childhood can impact upon public support for strategies that aim to support young children's learning and development (Fenech, 2013), and because a number of misconceptions about early childhood and ECEC exist among Australia's general public [e.g. young children are 'passive absorbers of content' and ECEC is a 'child minding service' (Kendall-Taylor and Lindland, 2013)], we need to improve public understanding of the importance of the early years and the role of ECEC.

Daily living conditions

7. Because most Australian families are doing well (and will continue to do well if any risks or problems are identified early) and because all families will struggle at some point (and some will struggle more than others) (Moore and McDonald, 2013), we need a

- service system that reflects these realities of family life. Proportionate universalism reflects these realities, because it provides a baseline of universal services for all families (i.e. those who are doing well) and additional services according to need (for those who are struggling, including those who are struggling the most).
8. Because there is some evidence to indicate that children in more affluent neighbourhoods of Australia are receiving a higher quality of ECEC than children in less affluent neighbourhoods (CCCH, 2014) and because this has the potential to increase inequities among children (i.e. those who are already worse off receive a poorer quality of care), we need to ensure universal high-quality ECEC in *all* neighbourhoods.
 9. Because the prenatal period plays a critical role in biological and neurological development (Martin and Dombrowski, 2008; Robinson, 2013) and inequities during the prenatal period have the potential to lead to inequities in children's development, and subsequent long-term outcomes (see, for example, Patton *et al.*, 2004; Platt, 2014), we need universal high-quality antenatal services.
 10. Because the type of problems that cause inequity during early childhood are characterized by complexity and no single organization or sector can resolve those problems alone (Grint, 2010; Moore and Fry, 2011), we need service systems that enable collaboration between professions, between services, between sectors and with communities.
 11. Because we need to ensure that the programs we invest in will have the best chance of achieving the desired outcomes in the most efficient way (Bromfield and Arney, 2008), we need evidence-based programs.
 12. Because how services are provided is as important as what services are provided (i.e. the characteristics of the service environment will strongly influence the extent to which families engage in the programs services have to offer) (CCCH, 2006; Moore *et al.*, 2012a, b), we need welcoming, inclusive services that employ a strength-based, partnership-based approach.
 13. Because informal support from extended family, friends, neighbours and colleagues can benefit families with young children by providing a form of flexible and sustainable assistance, as well as promoting a sense of belonging, and reducing the potential for social isolation (Surkan *et al.*, 2006; Vyncke *et al.*, 2013), we need more supportive communities.
 14. Because not all communities will have the resources to participate in new forms of governance and community participation (such as those recommended in strategies 1 and 10) (Skidmore *et al.*, 2006; Adamson and Bromiley, 2008), communities need support

to engage in decision-making and collaborative processes.

15. Because knowing what services exist, and what they provide, is a key facilitator of families' engagement with services (Parvin *et al.*, 2004; Carolan and Cassar, 2007; Boerleider *et al.*, 2013), families need information about services and child development in a range of different languages, tailored to differing circumstances and via a range of mediums.

Individual health-related context

16. Because parents need to be able to get support for themselves, their child and their family when it is needed, parents need to know what services are available, what type of support is offered by those services and feel confident to approach those services (Carbone *et al.*, 2004; Carolan and Cassar, 2007; Boerleider *et al.*, 2013). For some families, the confidence to approach services will rely upon the 'approachability' of those services (see Strategy 12).
17. Because knowledge of child development helps parents understand their child and their child's behaviour (see, for example, Campbell *et al.*, 2013; Hess *et al.*, 2004), parents need to know about child development, the factors that promote positive health and development, and have the capacity to support their child's development.
18. Because a parent's attitudes about parenting mediate how they behave towards their children (Gutman and Feinstein, 2007; Kruske *et al.*, 2012; Prady *et al.*, 2014), parents need to feel confident and supported in their role as parents. Some parents will be confident in their parenting role, some will require reassurance and others may require more intensive support.

CONCLUSIONS

As Urie Bronfenbrenner claimed: 'every child needs at least one person who is crazy about [them]'. But in addition to that one person, children also need a network of support—as do their parents, and their families. They need a service system and broader socio-political environment that facilitates positive parent-child interactions and attachments, high-quality care and learning experiences in all environments and timely, appropriate and effective support when problems arise. If, as a nation, we truly prize children, then we need to work collectively to ensure that the social and economic circumstances of their families and communities—particularly during the antenatal period and the early childhood years—do not compromise their health and well-being, and do not limit who they are, and who they can become.

SUPPLEMENTARY MATERIAL

Supplementary material is available at *Health Promotion International* online.

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