



National Early Childhood Development Strategy

**Report to the ECD Subgroup of the Productivity Agenda
Working Group, COAG**

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THE BOSTON CONSULTING GROUP

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Executive Summary

Over the past few decades, conditions under which families raise young children have changed profoundly. They have become more challenging because of society's high expectations for children, the many trade-offs facing families and a wide, confusing array of service options. Family composition, circumstances and cultural backgrounds have also become more diverse. However, early childhood family support services and systems have not altered significantly in the way they are organised, and as a result often struggle to meet the needs of families.

Many countries are going through similar transitions. Some have determined that their early childhood and family support service systems are not supportive enough of children and their families. These are now being strengthened and configured by:

- Seeking greater integration of services (including establishing integrated child and family centres)
- Expanding early childhood services (including funding active outreach services and extending the availability of preschool programs)
- Developing national early childhood strategies (including national early learning frameworks)
- Consolidating early childhood services under one government department's jurisdiction.

There is good evidence from trials and long term studies around the world that investment in basic early childhood services more than pays for itself. For the average Australian family, these services form an essential component of choices about their children's cognitive, social and emotional development, as well as enabling parents to rejoin the workforce. Furthermore, evidence from other countries suggests that a more intensive, integrated 'recipe' of services significantly enhances the long-term prospects of more vulnerable children.

Australia is some way off from fully exploiting this opportunity to improve its early childhood environment. Despite having reasonable overall outcomes in early childhood, there are significant prospects for improvement, and therefore increases in long-term national productivity, which may be expressed as four key issues:

- We are not focused on enhancing human capital for the future. Australia does not provide the consistency or intensity of early childhood services to really make a difference to long term outcomes. In particular, outcomes for the highest risk children fall below the average; yet it is these children for whom the human capital gains would be greatest
- Parents have limited access to information about cognitive development milestones, and many face difficulty in proactively identifying services that may support them, resulting in low service uptake among vulnerable families.
- There are opportunities to reduce service complexity and both save money and reduce stress among families — the current complex and fragmented service offerings often exacerbate the difficulties in accessing early childhood programs
- We provide insufficient support for parental choices in balancing work and family needs. Australia maintains low parental workforce participation rates, with families facing high effective marginal taxation rates, and a lack of flexibility in access to services, in particular in relation to child care and integrated ECEC.

This report proposes that it is feasible to create an early childhood environment where these opportunities are fully addressed by building on current structures and services. This has already been evidenced in some locations in Australia today, where significant obstacles have been overcome to improve children's outcomes. However, best practice has not yet been replicated Australia-wide, because policy has been less than systematic and explicit about priorities and the primacy of outcomes.

Therefore, the vision for ECD for 2020 proposed in this report has certain key elements which should not be diluted.

Firstly, parents have sent a clear message in focus groups that a long-term early childhood vision should be strongly community-based. They believe it should extend well beyond the traditional boundaries of health, education and family support into recreation, safety, and opportunities for family bonding. This is backed up by international evidence demonstrating the value of inclusive, whole-of-community approaches to ECD. Importantly,

this whole-of-community approach requires some form of capable and accountable local entity to organise tailored and responsive early childhood services.

Secondly, this report proposes that a far more systematic approach should be taken to the service 'recipe' for different types of need. Currently, due to a lack of overarching coordination, more resourceful citizens (not necessarily those most in need) capture a disproportionate share of services. The proposed approach explicitly identifies different service 'platforms' for different levels of need:

- A core platform of essential early childhood education, care and health services, conveniently accessible to all families
- A secondary platform, focused on services for children at risk of poorer developmental outcomes. This platform recognises that some children require an additional level of support beyond the core platform, be they children at risk of a developmental delay, families requiring additional support to avoid poorer outcomes for their children, or additional locality-based support for children from disadvantaged backgrounds
- Intensive case-managed services for children with established, ongoing problems in need of ongoing specialist attention. This platform will meet the additional service needs of children with persistent and severe problems, such as a disability or child abuse. The critical element of this platform is a multidisciplinary case manager, who would facilitate clients' access to the full range of existing Commonwealth, State and Territory service entitlements.

Thirdly, the vision involves a set of mechanisms to achieve change in both communities and services. While elements of the three service platforms already exist, considerably more effort is needed at a national level to ensure they are delivered consistently and efficiently across Australia to meet the above objectives. This effort will include:

- Alignment of policies (especially new ones) using existing or new intergovernmental forums
- Realignment of funding arrangements to suit new policy objectives, for direct service funding, ECD-related payments to families, and leverage of broader welfare payments to incentivise uptake of essential services
- Structural changes in roles and responsibilities between States and Territories and the Commonwealth, as well as the creation or adaptation of community governance structures.
- Initiation of enabling activities around regulation, workforce development, reporting and research and evaluation.

Background

Over the past few decades, conditions under which families raise young children have changed profoundly. They have become more challenging because of society's high expectations for children, the many trade-offs facing families and a wide, confusing array of service options. Family composition, circumstances and cultural backgrounds have also become more diverse. However, early childhood family support services and systems have not altered significantly in the way they are organised, and as a result often struggle to meet the needs of families.

Many countries are going through similar transitions. Some have determined that their early childhood and family support service systems are not supportive enough of children and their families. These are now being strengthened and configured by:

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- Consolidating early childhood services under one government department's jurisdiction.

This report seeks to articulate what early childhood in Australian society should look like by 2020, and what transformations should be sought to realise this vision. It is intended as a first step in forming consensus across functions and jurisdictions involved in the early childhood domain.

Vision for ECD in 2020

A number of broad aspirations statements for early childhood have already been created, tabled or agreed across jurisdictions over the last few years. This report does not seek to reinvent these; rather, it suggests a practical policy framework which can be used to achieve them

The desire here is thus to paint a picture of how society would support ECD in 2020 in practical terms. This can be depicted using three approaches:

- A community perspective – how communities can work to support child development
- A services perspective
 - A set of design principles to which all ECD services and programs would need to adhere
 - A three-level model for service delivery and funding, which can efficiently address the needs of different children and their families
- A child and family perspective – how Australia believes individual experiences of early childhood should differ from the present.

Most of our focus is on the services perspective, as this is where government is able target early childhood outcomes most specifically

A Community Perspective

An ecological perspective is a socio-cultural theory that places the child at the centre of the system, and focuses on the child's relationship with his or her social contexts. From this perspective, early childhood development is perceived to occur in a set of overlapping and mutually influencing ecological systems, with all of these systems operating together to influence the child as he or she develops.¹

As a result, it is vital to consider not only the child, but the family and the broader community context in which the child is situated. This report addresses the child and family perspective below. However, from both an evidence and a public perception perspective, communities play an important role in delivering services and programs to children and their families, as well as providing an important setting where a child spends time. Once an ecological perspective is adopted, the question is raised of how communities can work to support child development, and how the quality of connections between community and families can be strengthened. As a starting point, this report proposes a set of principles for sustaining child-friendly communities that would need to be delivered (Figure 1).

Figure 1

Respect and empowerment	<ul style="list-style-type: none">■ Community and Government services that acknowledge community strengths and respond to their particular needs, preferences and circumstances■ Meaningful community involvement in decisions regarding community services, facilities and environments■ Processes that promote partnerships between communities and services / Governments■ Programs to identify and support community leaders, as well as broaden participation by community members
Community cohesion and trust	<ul style="list-style-type: none">■ A variety of places and activities that promote positive interactions between community members
Safety	<ul style="list-style-type: none">■ Physical environments (roads, parks, public spaces, transport) that are safe and pleasant■ Protection from violence in public places

¹ Urie Bronfenbrenner. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press. 1979.

	<ul style="list-style-type: none"> ■ Refuges to provide protection for those suffering family violence or housing stress, particularly for families with young children
Healthy physical environment	<ul style="list-style-type: none"> ■ Clean air and water, and presence of natural spaces (trees, parks) ■ Absence of exposure to toxic chemicals (contaminated building sites, toxic waste and crop spraying) ■ A built environment that promotes physical activity (walkable streets, bike paths)
Child- and family-friendly built environment	<ul style="list-style-type: none"> ■ Traffic calming measures ■ Provision of safe and easily accessible service locations
Transport	<ul style="list-style-type: none"> ■ Community transport that is reliable, frequent, affordable and child- and family-friendly ■ Easily accessible transport hubs providing access to other localities
Local services	<ul style="list-style-type: none"> ■ Affordable local health services (GPs, community nursing, local hospital, dentists) ■ Community-based family support and welfare services ■ Services managed flexibly, so they can be tailored to local needs
Local facilities	<ul style="list-style-type: none"> ■ Community houses ■ Parks and playgrounds ■ Libraries ■ Swimming pools ■ Sporting facilities
Employment opportunities	<ul style="list-style-type: none"> ■ A range of employment opportunities for parents and for school leavers

The development of how such communities would be created is outside the scope of this paper. Nevertheless, implementation of the principles set out above would have a major impact on early childhood outcomes, and creating such environments is an important adjunct to the delivery of child-specific services.

A Services Perspective

This report has identified seven design principles defining how services should be designed and experienced in order to move from the current state to the 2020 vision outlined, with a focus on creating service environments that will facilitate good ECD outcomes for children. These form the basis both for the specific model proposed, and constitute a proposed set of criteria (in addition to effectiveness and cost) that will be used to evaluate future components of the strategy.

1. Services should be child-centred, aiming to deliver the best and most appropriate service for the child, without being bound by sectoral, jurisdictional or departmental boundaries. Young children should be understood as a distinct group with rights, whose development occurs through participation in society, bolstered by a range of supports and services. While some policies might have benefits for other stakeholders (for instance, child care allowing women to return to work may enhance their self-esteem), the primary focus here is on benefits for, or avoiding harm to, the child.
2. Services should empower families by allowing them choice of provider where possible,² and should be designed to recognise the need to flexibly balance work and family. Services should provide families with information and opportunities to engage in their children's learning.

² In some areas, choice of provider may not be possible, such as rural or remote communities with insufficient population to sustain more than one provider or a mix of public and private provision.

3. Families should be supported to choose services within a mixed economy of service providers – public, not-for-profit and for-profit. All of these would be required to meet the same regulatory standards.
4. The focus for organising ECD services should be local communities. The consensus from international evidence suggests that strategies will fail to engage the critical people unless this happens³. By 2020 this local integration should have extended to broader community development activities such as schooling, economic empowerment and infrastructure improvement.
5. The basic service offering should be universal: Every child in Australia should be able to access certain core services without cost or geography preventing them. This does not mean that everything should be free, however, and co-payments could be required for universal offerings. More intensive services for areas or groups with greater need should have the same look and feel as services available in well-off areas.
6. There should be multiple entry points and no ‘wrong door’: Whatever service a child is brought to should either provide help, or help find a more suitable service that is easy to access.
7. There should be clear lines of accountability between local, State, Territory and Commonwealth Governments for funding, delivery and enabling activities.

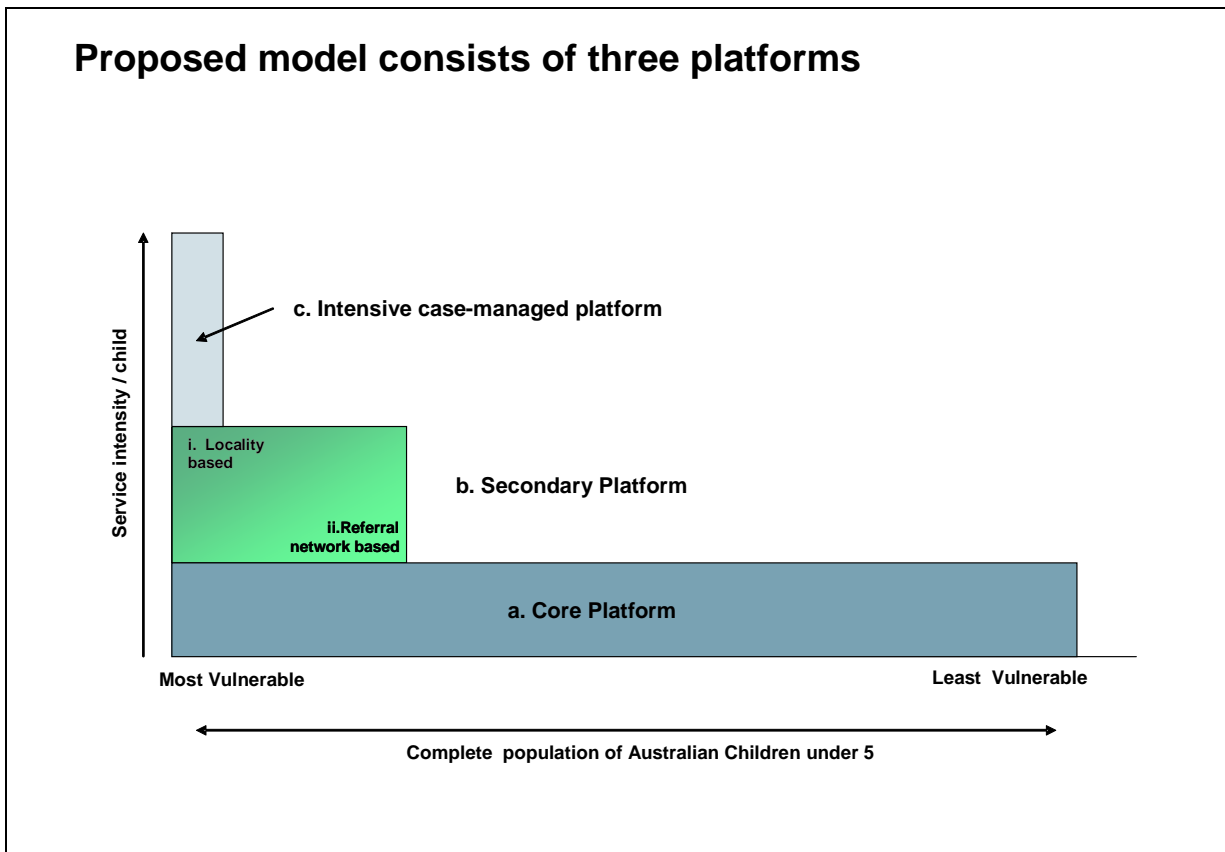
A Service Design Model

To achieve the vision by 2020 will require an approach that recognises that Australia’s children experience a range of different individual, family and community circumstances on their way to developmental outcomes. Failing to place this concept at the forefront of policy design and implementation risks either inequitable outcomes or expensive and wasteful policies and programs. This report therefore proposes three distinct ‘platforms’ to address these different circumstances in order to support strong outcomes for all children. This model (Figure 2) should be seen as an integrating framework for policy design and funding, and not a way of physically organising the services themselves.

Each of the platforms is essential – they are not alternatives, but integral components of the overall package. Failure to develop any one level will lead to a misallocation of resources to the varying levels of need experienced. However, from a child and family perspective, the platforms will be experienced as one seamless system at the local level. In addition, the platforms will operate based on flexible design principles that enable services and programs to deliver consistent evidence-based quality, but sufficiently adaptable to be appropriate and engaging to the communities in which they are located.

³ OECD. *Starting Strong II*. OECD 2006.

Figure 2



- A core ‘universal’ platform of essential services, conveniently accessible to all families. This would ensure that every young child in Australia would have easy access to quality ECEC services, together with existing universal health service entitlements. In addition to supporting children’s development, this platform also encompasses the economic rationale of enabling parents and carers to be more flexible about their workforce participation choices. Services would be supplied by a mixed economy of providers under a consistent, national set of regulations. The core platform would also include non-service offerings such as safe neighbourhood programs and information provision for families
- A secondary platform, focused on services for children at risk of poorer developmental outcomes. This platform recognises that some children require an additional level of support beyond the core platform, be they children at risk of a developmental delay, families requiring additional support to avoid poorer outcomes for their children, or additional locality-based support for children from disadvantaged backgrounds.
- Intensive case-managed services for children with established, ongoing problems. This platform would consist of services only available to children and families with significant ongoing problems or vulnerabilities. It would not include a set of ‘typical services’, but would instead deliver individually tailored packages of care to children and families with significant and relatively unusual needs. The critical element of this platform is the case manager concept — a designated individual (who may also be a service provider) tasked with, and paid for coordinating services for a child and their family across all functions, departments and jurisdictional responsibilities.

a. The Core Platform

This platform aims to:

- Provide access to safe combined ECEC to support children’s preparation for school and commence the process of lifelong learning, ultimately building Australia’s human capital

- Make service access convenient for families and reduce the stress of bringing up children in a modern family (for instance, through an integrated ECEC offering)
- Enable parents to make suitable workforce participation choices
- Include health services, built on existing MCH and GP services, which focus on preventive and promotive interventions, responding early and thoroughly to developmental concerns of parents and carers
- Provide information to families to support decision-making and enable access to other services
- Constitute a mechanism for identifying at-risk children and their families, through referral pathways for assistance at the secondary platform level.

The list below provides a non-comprehensive overview of the types of services contained in this platform:

1. Preschool education for all four year olds as per the universal access commitment, fully integrated with child care when required
2. Access to affordable, quality child care for all young children, that is sufficiently flexible to support families' work and study choices, as well as other commitments
3. Access to preventative and promotional community maternal and child health services (including immunisation, well baby, screening for early signs of problems, and provision information and parental advice on the development of their children)
4. Antenatal/perinatal care entitlement, including delivery and at least one post-birth home visit
5. Parenting information provision, education and support
6. Existing universal entitlements to primary medical, pharmaceutical and hospital care through the MBS, PBS and State and Territory hospital systems respectively
7. Light touch service integration facilitated by a service integration officer and a cross-discipline electronic child health and development record
8. Facilitation of informal community engagement for families and carers, such as playgroups and toy libraries
9. Capacity to identify children who may benefit from more intensive services through the secondary or case-managed platforms
10. Access to incentives for increased uptake of services with broad community benefits, eg, considering new links between family payments and preschool attendance and health services usage

Although these services have reasonably broad eligibilities, none are universally accessible by children now, due to geography, cost or other under-supply. In the proposed model, services would be supplied by a mixed economy of providers under a consistent, national set of regulations. The core platform also includes non-service offerings such as safe neighbourhood programs and information provision for families.

While the core platform constitutes a national 'common denominator' for early childhood services, individual jurisdictions would be at liberty to extend entitlements or services provided at their own discretion, consistent with the evidence base for effectiveness. The Australian Government's commitments to 220 child-care and early learning centres and universal access to preschool in the year before school fit well within this platform's objectives.

b. The Secondary Platform

This platform recognises that some children require an additional level of support beyond the core platform, characterising this in three ways:

- **Child-specific needs**, such as when a child is at risk of developmental delay and requires a speech therapist or psychologist. These children come from all backgrounds, localities and parts of the income spectrum and are likely to require assessment and relatively brief intervention. Specialists are accessed via a referral network of core service providers throughout Australia, and will work with the family to devise a program addressing the concern within the parameters of the child's usual care, education or home environment
- **Family needs**, such as family breakdown or parenting difficulties, where families require support beyond the core MCH service to avoid poor outcomes for their children. Outreach is a critical service component here through things like supported playgroups, intensive nurse home visits, or residential accommodation for mothers and babies undergoing parenting programs. Families are identified both through their involvement in core services and through caseworker outreach, and will be referred for additional

support, to be delivered in their usual service setting wherever possible. A primary aim here is to avoid the progression of families into the intensive case-managed system due to factors such as child abuse.

- **Disadvantage-related needs**, on the basis that children from disadvantaged backgrounds are at risk of poorer developmental outcomes. This involves a locality-based approach in the form of child and family centres, where every child and family living in the area has access to core- and secondary-level services on the same site. Services would have the same look and feel as core services, but may be in a more intensive form, such as longer preschool hours and playgroups supported by facilitators. While instances of disadvantage exist across all Australian communities, there are significantly more in a small subset of localities.^{4,5,6} An analysis of economic disadvantage at the suburb level suggests that the 20 percent most disadvantaged suburbs contain 41 percent of the most disadvantaged children under five.⁷ In addition, the sheer volume of disadvantage in these localities may have an additional effect above the individual economic status of the families living there, where the lack of successful role models is an important driver of long term adverse outcomes.⁸

Ultimately, these services should deliver on the promise of 'turning around' children and families on the brink of developing significant problems. They should ensure that vulnerable children have the same chance as more well-off children, and challenges that they face do not place undue stress on their families or cause them to simply 'fall through the cracks'. In order to achieve this aim, there is a strong need to develop referral pathways in the core platform; in this way, the platforms work together to engage and identify at-risk children and families.

It is important to note that 'integration' is not limited to physical boundaries, and working with services in their current form to develop an information-sharing network may well be more appropriate than physical co-location in certain circumstances, taking into account both geography and limitations on funds. In this way, a number of alternative secondary platforms would need to be designed for States with remote populations. Some States already have examples of these — such as the Rural Care program in South Australia and the hub-and-spoke preschool model in Northern Territory. However, the current low levels of overall spending in these communities does make a case for greater investment in innovative remote community services.

A key element of the secondary platform is to prevent children from requiring serious treatment or support at a tertiary level, such as through the child protection system. In this way, the secondary platform is a means both of easing the pressure on highly intensive services and a more moderate level of support where that is all that is required. At the same time, the implementation of a more cohesive and integrated referral network aims to address currently overstretched diagnosis processes, by enabling a comprehensive assessment of gaps and bottlenecks in the system.

Components provided over and above the core package might include:

1. A single physical site, purpose built to provide multidisciplinary early childhood services in disadvantaged locations. The proposed 'child and family centre' (CFC) model would fit this type of need
2. A set of work processes to ensure seamless referral between providers, on- and off-site
3. Proactive outreach to new clients, those who have missed appointments, or have other risk markers
4. Intensive active outreach programs for new mothers for at least six months following birth
5. More intensive 'soft outreach' programs including supported playgroups and other flexible engagement strategies
6. Intensive early childhood education, in terms of more hours per week, higher teacher-child ratios, and free provision to younger age groups
7. Provision of respite child care for at-risk families and carers
8. Specific programs to engage families in their children's education (such as supported reading sessions) and other ECD activities. These programs should also engage the broader community interaction - for example, through playgroups

⁴ Tony Vinson. "Dropping off the Edge." 2007.

⁵ Stephen Lamb and Richard Teese. *Equity Programs for Government Schools in New South Wales: a Review*. Melbourne University. 2005.

⁶ Stephen Lamb. *School Performance in Australia: Results from Analyses of School Effectiveness*. Melbourne University. 2004.

⁷ BCG analysis of ABS population data on 4 year olds and income brackets (average weekly income) at suburb level.

⁸ Stephen Lamb and Richard Teese 2005. *Equity Programs for Government Schools in New South Wales: a Review*. Melbourne University. 2005.

9. Family relationship counselling and family functioning support proactively offered to families where appropriate
10. Incentives to engage with more intensive services as appropriate, e.g. income support benefits might be linked to a child attending preschool and having a health care checkup every 6 months.
11. Professional advice around economic security, welfare benefits, job search facilities, household economics and related issues

c. The Intensive Case-Managed Platform

This platform would consist of services only available to children and families with significant ongoing problems or vulnerabilities. It would not include a set of 'typical services', but would instead deliver individually tailored packages of care to children and families with significant and relatively unusual needs. This is not dissimilar to the current autism spectrum commitment, but would cover all serious conditions, and would envisage programs operating in integrated mainstream settings rather than condition-specific ones as far as possible.

Without aiming to provide a comprehensive list, these could include:

1. Interdisciplinary intervention and family support services for children and their families who are experiencing complex health, family or wellbeing issues, including the earliest possible intervention for families of vulnerable infants
2. Community-based, telephonic and online support and therapy offerings/entitlements for children with a disability or a serious chronic condition
3. Ongoing community or hospital OPD based treatment from specialists (e.g. psychologists, physiotherapists, speech and hearing therapists), including assistance with behaviour difficulties
4. Specialist preschool places for children who have suffered abuse or neglect – ideally within integrated ECEC centres
5. Additional payments and other support to enhance the wellbeing of children at risk of neglect and abuse
6. Child protection services including foster care and ongoing counselling.

The critical element of this platform is the case manager concept — a designated individual (who may also be a service provider) tasked with, and paid for coordinating services for a child and their family across all functions, departments and jurisdictional responsibilities. In severe cases, the case manager would also have a service budget and/or set of eligibilities to use to construct a package of care. Most importantly, the case manager would help families with very complex needs to locate suitable services within the existing service environment. As case management is an expensive activity it would be provided for cases where:

- Families have a particularly complex set of needs and hence service providers to deal with, and
- The circumstances are ongoing, and
- Families have limited capability to navigate their own interaction with services.

An intermediate form of low-touch case management might involve telephone advice lines, which are currently often provided by community support and advocacy groups.

A Family and Child Perspective

It is not possible to outline all changes under the proposed model because current service provision levels are quite variable. However, some potential illustrations are provided in Figure 3. Importantly, families are seen here as both beneficiaries of services, and as effective agents for delivering services to children. The policy objective is thus to empower families through the provision of services and/or payments whilst ensuring they expend their resources for the benefit of the child.

Figure 3

Client group	Experience under Current Model	Experience under Proposed Model
Child with both parents working	<ul style="list-style-type: none"> ■ Parent leaving work at lunch to move child from child care to preschool. ■ Parent leaving work early at 3pm because 	<ul style="list-style-type: none"> ■ Child dropped off at 10am and picked up at 5pm having had seamless preschool and child care through an ECEC centre

	<p>no care available after preschool session</p> <ul style="list-style-type: none"> ■ Parent takes time off work to have child's routine checks and immunisations done 	<ul style="list-style-type: none"> ■ Option of having medical checks and immunisation at drop-off or pick-up time at the integrated centre.
Deaf child	<ul style="list-style-type: none"> ■ Repeated otitis media leads to conductive deafness at age two ■ Unable to attend local preschool by age four because he is considered disruptive ■ On an eight-month waiting list for ENT specialist assessment to determine eligibility for surgery and a 12 month waiting list for speech and hearing therapy thereafter 	<ul style="list-style-type: none"> ■ Deafness suspected by teacher at child care centre at age two ■ Referred to Speech and Hearing Therapist for assessment at her weekly visit to Centre. Priority referral to ENT clinic arranged ■ Deafness and requirement for surgery diagnosed. S&HT becomes case manager for child and organises for him to receive priority surgery at local hospital. Works with preschool and family on behaviour management on advice from paediatrician. ■ S&HT follows up child on a weekly basis thereafter until he is achieving satisfactory development outcomes
Child in foster care	<ul style="list-style-type: none"> ■ Multiple carers for a four-year-old child who has been removed from family with substance abuse problems. Reason for changing foster family is difficult-to-manage behaviour ■ Case workers have changed twice over last 18 months. Poor handover between case workers and foster carers fails to communicate that child has asthma and requires daily medication, plus hyperactivity and difficult behaviour ■ Taken to multiple GPs by foster carers with limited prior history, and several medical assessments requested by social workers – multiple inconclusive diagnoses and duplicated medications prescribed 	<ul style="list-style-type: none"> ■ Single ongoing case manager with communication across and understanding of family support, health and education needs. Understands the importance of attachment and avoids changing foster carers ■ Support to foster carers in form of parenting groups, behaviour management training to allow them to cope with difficult child ■ Electronic health and wellbeing record allows sharing of case information between professionals and avoidance of wasted medical consultations ■ Preschool has good link with local school and children engaged in transition to school program over last term of preschool ■ Child feels more competent at start of school
Single mother	<ul style="list-style-type: none"> ■ Keen to go back to work part time, but CCB is inadequate to compensate for loss of parenting allowance, so she stays at home until her child starts attending primary school ■ Feels isolated and unsupported but no immediate source of advice. Local community centre refers her on to a private psychologist, but fees are very high 	<ul style="list-style-type: none"> ■ Able to go back to work two days a week with no loss of benefits ■ Local integrated care centre provides ECEC for free ■ On site parenting support provides opportunity for advice and support around times of pick-up and drop-off. Also links her in with other mothers in similar circumstances and she enrolls in a parenting program and joins a local mother's group

Potential National Delivery Mechanisms

Elements of the three service platforms already exist. However, considerably more money, effort and time is needed at both national and local levels before they can be delivered consistently and efficiently across Australia. This is not just a question of investing in new services; but transforming the way in which existing functions and services work with each other. This effort will include:

1. Alignment of policies (especially new ones) using existing or new intergovernmental forums
2. Structural changes in roles and responsibilities between States and Territories and the Commonwealth, as well as the creation or adaptation of community governance structures.
3. Funding levels and mechanisms, including the use of family benefits as incentives
4. Initiation of enabling activities around regulation, workforce development, reporting and research and evaluation.

Policy Alignment

Policy alignment is the fundamental objective of much of the intergovernmental activity already occurring in Australia. Forums operate at two levels: linking together agencies within a jurisdiction, and linking between jurisdictions. Early childhood development will need significant work at both of these levels. Within-government alignment forums include a variety of inter-official arrangements rolling up ultimately to cabinet. Inter-jurisdictional forums include COAG, the ministerial councils, their subgroups and working groups, and various ad hoc forums.

At this early stage of the ECD strategy, alignment through these forums is the only viable route to reach agreement. However, this would be very inefficient as a long-term operating strategy. Successes in intergovernmental alignment over the decade have been few and hard-fought, with considerable difficulties in separating out policy alignment from funding negotiation.

In addition, different jurisdictions are rarely at the same stage regarding any given policy question. It would be unworkable to expect all jurisdictions to reach a position before any one State or Territory could implement it. Stakeholders consulted during this process agreed that COAG and its related processes are already operating at full capacity. Therefore, without a fundamental change to its modus operandi, COAG should not be expected to achieve alignment between jurisdictions on anything but the most critical national policies.

Therefore, a more realistic approach would be to delineate accountabilities to ensure that there is no overlap or duplication between the Commonwealth and States. The following section details this approach.

A related element is the importance of communicating policy developments in the ECD area; in particular, changes in the way that Government, the community and specific target groups understand and conceptualise ECD. Achieving common endorsement will require significant stakeholder and public engagement.

Structural Change to Roles and Responsibilities

Almost every potential role in ECD is undertaken by both State and Commonwealth levels of government in some aspect, and often by private sector organisations as well. This is the main reason for service complexity, wasted administration expenditure and poor accessibility for families. In simple terms, structural role change can be thought of at the macro (national) level, State and Territory level and local/regional levels. All these will need to be addressed.

Commonwealth-State Roles

This report proposes that clear delineation of roles remains a significant lever to effect change in ECD. This does not change the joint overall accountability of States and the Commonwealth for outcomes, but rather provides a discrete way in which each can play a clearly defined role. It is important to note that local governments may be involved in the ECD space in the future (their role is currently very limited), and should be taken into account when roles are considered. There are a number of different alternatives for this delineation, including:

1. **All roles cede to one entity.** Given the dominant revenue-raising role of the Commonwealth, this would only be likely to work if the Commonwealth took over, or outsourced State planning and delivery roles completely. This seems unlikely

2. **Purchaser-provider split**, where the Commonwealth takes on a hands-off ‘purchaser of outcomes’ role and States and Territories compete for funding as service providers with other sectors
3. **Customer facing – back-office split**, where States and Territories might provide an integrated customer-focused service set of service points that deliver a standard set of national programs (along the lines of a Centrelink). Planning, funding and design of the programs would be done nationally, as well as any bulk processing, IT, call centres and the like, but all client-facing work would be conducted by State employees in State-owned and operated centres
4. **Payments-service delivery split**, in which the Commonwealth would manage any payments direct to private providers or individuals or tax rebates, and States would manage all public service provision
5. **Change – business-as-usual split**, where States are tasked with day-to-day delivery functions, and the Commonwealth monitors value for money being delivered, and catalyses and funds change projects to improve future outcomes
6. **Platform split**, where the Commonwealth funds universal core platform entitlements (with multiple competing providers including States), and States and Territories provide top-up or secondary and intensive case managed services, for those children with greater need, and those who require some tailoring of services, either at the individual level, or by community.

While each of these are appealingly simple, it is likely that a more detailed role by role negotiation is needed in the absence of broader cross-sectoral direction, at least at the outset. We have identified ten detailed roles to inform this process (figure 4) and propose that these be used to kick off the initial discussions on roles

Figure 4

We have identified ten main roles in ECD	
	Description
1 Set strategic policy	Identifying the long term goals for the sector and weighing these up against the demands of other sectors
2 Decide and fund outcomes	Agreeing what are the specific ECD outcomes Australia is trying to achieve, and allocating funding for achieving those outcomes. Funding may be delineated between states and Cth, or pooled
3 Decide delivery model	Specifying the broad delivery model (eg, direct payments to citizens, open tenders for private sector, IGA's with lower levels of government, etc)
4 Set standards	Determining acceptable minimum standards for services provided under each program. Standards may be two-tiered, with minimum standards to be achieved for licensing purposes, and additional standards to be achieved to be eligible for further recognition and benefits
5 Design and manage programs	Deciding which interventions will be selected as effective modes for generating the outcomes in 2 (eg, health visiting, preschool, parenting programs, etc)
6 Enforce standards, license, and accredit services	An entity / forum that administers standards, licenses providers and ensures standards are met
7 Contract providers	Choosing who should provide for the services under each program and entering into pricing and service specification arrangements
8 Deliver services	Providing the services to a citizen (eg, Immunizing a child)
9 Link or integrate local services	Creating linkages between programs, coordinating integrated service delivery, and providing information services to inform users. Include programs that are complementary, and programs that target similar age groups and needs
10 Report on achievements and evaluate effectiveness	There are a number of sub roles including Specifying the reporting requirements, aggregating data and compiling the reports, analysing data to evaluate the impact of programs and interventions and disseminating the resulting insights to policy makers and the broader public

Inter-Functional and Local Organisational Changes

The examples above deal with allocation of roles between jurisdictions, and agreeing these will be a necessary, but insufficient, step to translating the vision into action.

Two other key structural changes are required. Firstly, a model is needed to ensure cooperation and integration between different functions. At a national or State level, the creation of a Ministry of Early Childhood has been a common response. The four Nordic countries, Iceland, New Zealand, Slovenia, Spain and the United Kingdom have taken this step,⁹ as have the States of Victoria and South Australia. Australia has not yet fully tested the potential of its existing inter-functional capabilities, and this should be the first option.

Arguably more important, however, is identifying a community organisational structure that can take responsibility for knitting together different functions (health, family support, education and others) at the local level. In some parts of the world (such as Scandinavia), strong local authorities have been a natural choice, as they already have significant educational and health roles.¹⁰ Other countries, such as the UK, have needed to create new purchasing structures aligned with, but in addition to, local authorities, with focused early childhood responsibilities (what have now become 'Children's Trusts').

Australia does not have an immediate model that could be adapted for this purpose. Local authorities in most States have limited skill or experience in playing a significant coordinating role for early childhood services. While NGOs have been established as local coordinating and purchasing bodies in some programs (such as Communities for Children), it seems unlikely that this could be scaled up to a national level. There are few other strong local entities that exist in most places in Australia. Practical options appear to be:

- Creating new 'standardised' purchasing and coordination entities with a specific childhood focus, under a nationally agreed charter (similar to "Childrens Trusts" in the UK)
- Adapting existing function-specific organisations to include the full range of early childhood programs. These could include health districts or regions, local primary schools or district school boards, or even benefit administration agencies such as Centrelink or Medicare offices
- Catalysing the development of coalitions at a local level through seed funding and/or resources, and with a number of options based on the strength of local institutions (such as local government, churches, community organisations and large employers)
- Fundamentally revising the remit of local government, and building its capability to assume greater early childhood responsibilities.

These would all take a considerable period to roll-out at nationally. In addition, processes must be designed to avoid potential fragmentation of services and accountability at the local level. Therefore, to achieve the early childhood goals outlined in this report, Australia would have to work with a few different and probably imperfect models for some time, with the intent to eventually converge these on a preferred approach.

Reallocation of Funds and Funding Mechanisms

Funding of Service Delivery

Funding models for ECD services are not discussed in detail here as they are subject to decisions regarding roles and responsibilities, as well as finalisation of inter-jurisdictional funding models.¹¹ Any changes to current funding models are likely to require a significant period of consultation and refinement. However, as a starting point, some potential basic principles for Commonwealth funding of States are put up for discussion in the context of ECD:

- **Equal funding for equal need.** This assumes a base level of funding for each Australian child, and an increase in allocations for those who are at most at risk, or already have established service needs. Importantly, any long-term funding allocation would be driven by underlying child characteristics, rather than current service usage, as the latter could increase the variation in current outcomes

⁹ OECD. *Starting Strong II*. OECD 2006.

¹⁰ OECD. *Starting Strong II*. OECD 2006.

¹¹ Heads of Treasuries SPP working Group. Circular no 1. 2008/01 — Implementing the new Commonwealth-State financial arrangements.

- **Aim for leverage, not ownership.** By being strategic in how much funding is used to drive each initiative, the Commonwealth Government will be able to ‘titrate’ its own funds against those of others, bringing about the most impact with the least investment
- **Joint funder-recipient accountability for outcomes.** Since both the level of funding, and how it is spent will affect outcomes, States and Territories and the Commonwealth would be jointly accountable to the public for the outcomes that spending achieves¹²
- **Timing aligned to State readiness.** States and Territories have differing levels of coverage and different immediate priorities in terms of extending. Expecting that all will achieve similar outcomes and need similar levels of funding at the same time could lead to significant wastage. Instead, earmarked funding tranches should be released according to the readiness of State programs to use them, and whether or not they comply with entry level criteria (for instance, collecting and reporting on the outcomes of interest)
- **Different funding vehicles may be needed for different provision patterns.** Depending on the public-private mix of providers in a State, the most effective funding mechanisms (for ECEC in particular) may include a lump sum payment to the States and Territories (for example, an NPP or SPP), or a child-linked entitlement to be used with private and NGO providers.

Use of Family Benefits

Approximately \$6.5 billion is paid annually through family payments to Australian families for support of children under 5.¹³ These payments are income tested to ensure most is targeted at lower-income families. Undoubtedly, much of this is used to provide for the needs of children which will aid their long term development. However, the sheer size and coverage of these payments presents opportunities for improving early childhood outcomes:

- **Identifying children who do not have contact with services:** Research evidence, as well as this report’s conducted interviews, suggest that infrequent service users are among those that stand to benefit most from them. Almost all these families would already be receiving some form of child-related benefit (such as the Baby Bonus). Interaction with Centrelink is an excellent source of information on children generally, and likely to capture parents of high-risk children. Efforts could be made to increase the data sharing between payment systems and service records, and to provide service information to those parents collecting payments.
- **Earmarking expenditure.** Existing cash or tax-rebate benefits could be directed towards specific purchases that benefit children, such as nutritious food, healthcare, medicines or books, and away from purchases that are likely to harm them (for example, alcohol). This should be done in such a way as to avoid unduly limiting the use to which payments are put, because the individual circumstances of families will vary, so that parents may well be in the best position to assess which purchases will be most effective (for example, purchasing cleaning services to enable them to spend more time with their children). A similar approach has already been introduced for certain income support-recipient families.
- **Making benefits contingent on service use.** Here the payment of a benefit or tax rebate could be contingent on the uptake of certain children’s services. For example, a portion of some payments could be payable for four and five-year-olds only if there is evidence the child is attending preschool or primary school. However, conditionality of payments must be structured so as to ensure that vulnerable children are not further disadvantaged, regardless of their family circumstances.

These levers need to be used appropriately as part of a suite of measures to improve uptake of services. Primary goals should still be to remove barriers to access, be they cost, proximity, staff attitudes, or convenience. It should also be noted that the use of payments as incentives does have associated costs, in particular due to increased workforce needs (eg, Centrelink staff to identify and engage with families around these conditions).

Enabling Initiatives

This report identifies five key enablement requirements – activities that will not directly deliver improved early childhood services, but are important prerequisites for rolling out this model successfully by 2020. Discussions

¹² Heads of Treasuries SPP working Group. Circular no 1. 2008/01 — Implementing the new Commonwealth-State financial arrangements.

¹³ This rises to \$11b if the Parenting Payment (\$4.4b) is included within the definition of child-related payments.

with jurisdictions suggest there is already support for and progress on consistent national approaches on all of these enablers, which should therefore not present significant obstacles to delivery. They include:

- Regulation and quality
- Workforce development and training
- Work process change
- Research and evaluation
- Monitoring and reporting

Not all enablers have the same degree of importance for each aspect of the platform. Figure 5 shows the relative contribution of each of the enabling streams of work, based on consultation with key stakeholders. It should be noted that this is a relative measure of criticality based on current gaps, and all elements serve an important function.

In terms of regulation and quality, the core package is a critical area, due to the large numbers of children and the significant participation of the private sector. The secondary and intensive-case managed platforms would also benefit from an increased focus on regulation and quality, but the urgency is less due to the inherent flexibility and smaller scale of these services.

The quality of ECD programs will always reflect the quality of the workforce providing them, so workforce development must always be a primary concern. Workforce development and training in the core and secondary platforms is a critical focus due to the need to ramp up the ECEC workforce to meet commitments around coverage and quality. In the intensive case-managed platform, it is also important to focus on workforce development and training in regards to allied health professionals, to overcome current service gaps.

Work process change is crucial across all three platforms, both for the inherent benefits of increased cross-functional communication and coordination, and because the three-platform structure depends on such processes occurring, through integrated centres, referral systems etc.

Research and evaluation is vital in the secondary platform, where limited funds and attention have typically been focused, particularly in Australia. Of the three-platform model, the prominence of the secondary platform is arguably the most significant shift, and this must be supported by a robust body of evidence as to effectiveness. However, all elements of the platforms would benefit from greater research and evaluation, particularly in an Australian context.

Finally, monitoring and reporting standards are an important enabler across all three platforms, particularly in terms of obtaining consistent and comprehensive national data sources.

Figure 5

Enabler	Core package	Secondary services	Intensive case-managed
Regulation and quality	Critical – combined ECE and CC regulation required	Helpful	Helpful
Workforce development and training	Critical – ECEC	Critical – ECEC	Important – Allied Health
Work process change	Critical	Critical	Critical
Research and evaluation	Helpful	Critical	Helpful
Monitoring and reporting	Important	Important	Important

Regulation and Quality

Discussions across the various jurisdictions suggest there is already a reasonable agreement that a single, integrated accreditation and licensing system for preschool and child-care institutions, and preschool teacher qualifications is needed. Similar moves are underway to consolidate the registration/accreditation bodies for health professionals and institutions. The benefits from such consolidation could be significant and reach many different stakeholders:

- Providers, especially larger ones can operate across State boundaries more easily
- Staff can move between States to better meet demand fluctuations
- Users can better trust and understand quality standards of providers
- The costs and effort of maintaining overlapping regulatory systems will be reduced

Regulatory consolidation will not be a painless process; it will need to overcome considerable inertia among both regulatory enforcement bodies and service providers for whom there is a change cost. However, the range of long-term benefits for individuals, agencies and providers should be sufficient to swing the majority over two to four years if there is joint Commonwealth-State agreement about the desirability of consolidated regulation.

Regulation and accreditation might focus on three domains, which are currently at different levels of maturity:

Regulating inputs – such as specifying staffing ratios, qualifications

- Regulating activities – such as minimum service offerings of MCH clinics or the early years learning framework for ECEC
- Regulating outcomes – for example specifying a maximum level of low birth-weight babies in a district.

Workforce Supply

ECEC Workforce

The strategy outlined here involves a significant increase in the level of qualification for staff involved in ECEC. Several States, including New South Wales and Victoria, are already experiencing shortages of teaching staff, particularly in disadvantaged and rural locations; most others are concerned about meeting staffing requirements by 2013 under the universal access commitment.¹⁴ If, at the same time, staff qualification requirements and hours of preschool offered are increased, this will place further demands on the number of qualified staff.

In order to increase the size of the ECEC workforce and reduce the current higher-than-manageable levels of attrition, complementary measures must be addressed such as increased pay (both in response to higher qualifications and to approach equity with primary school teachers), greater professional development and improved conditions, which will create a significant downstream labour cost. Other critical factors are the current industrial agreements that specify contact hours of between 20 and 30 hours per week, disparity of pay and conditions between government and non-government preschools, and disparities between long day care and stand-alone preschools.

The Commonwealth has already committed to 450 additional preschool teacher trainees to enter training each year until 2011, with maintenance of this level of training thereafter. This commitment is likely to require augmentation, as well as specific initiatives aimed at increasing qualified teacher numbers in disadvantaged and rural locations, such as scholarships and incentive payments to individual teachers. Increasing the number of indigenous teachers is a priority in several States, in part by way of support for current assistant teachers to complete their teaching degrees.

The gap can be partially covered by up-skilling existing ECEC teachers and workers through convergence courses for TAFE, diploma and three-year degree qualifications. Other transitional measures should be considered, including more intensive and formalised on-the-job training. Given that the system would not be able to lose existing ECEC staff to training before substantially larger numbers of new graduates come through, training existing staff could not commence in earnest before 2013. It is therefore unlikely that the full quota of qualified ECEC staff will be reached much before 2020.

Health Workforce

Although some measures are underway to address acute staff shortages in the health side of ECD, this remains a significant problem in particular areas.

¹⁴ DEEWR feedback from bilateral Commonwealth-State meetings and 2007-08 Universal Access projects. *The Early Childhood Education Workforce in Australia*. Surveys and workforce analysis section, skills analysis and quality systems branch, Department of Education, Science and Training, December 2006.

- Significant projected shortages of nurses began being predicted in the early part of this decade, and there were over 2000 unfilled nursing roles across the health care system in 2006.¹⁵ There have been several measures in recent years designed to address workforce shortages such as increases in the nurse undergraduate places, which will have an impact on MCH nurses. Recent national initiatives introduced in 2008 include the Bringing Nurses Back into the Workforce Program, which provides \$139.8m over 5 years to deliver up to 8750 extra nurses and an additional 1170 ongoing university nursing places per year; a commitment to deliver up to 50000 additional health-focused vocational education and training places over three years, in areas of chronic shortages such as nursing and allied health. In addition, measures that target Indigenous health workforce capacity building include the National Indigenous Health Workforce Training Plan (\$19m over three years). However, the projections on which these measures were based do not factor in a significant increase in requirements for ECD, nor take into account the increased birth rate in recent years. It may be possible to address some of the shortage of MCH nurses and midwives through the instatement of incentives, or through funding training for mothercraft nurses to take on some responsibilities for home visiting, health checks, and so on, that do not always require a registered nurse.
- For most other health professionals, there is a complex set of interlinking levers in terms of supply at the Commonwealth, State and Territory levels. This means that supply levers are difficult to use outside of a multi-jurisdictional forum. The long lag time between changing working professionals, and current net declines, create the case for concerted effort to increase both basic training, and the relative attractiveness of the job.
- Significant shortfalls exist with the adequacy of certain specialist health inputs in ambulatory settings (such as allied health resources) for both assessment and care of children with chronic illness or disability. Their services generally cannot be reimbursed under the Medicare Benefit Schedule, and workforce shortages have limited their presence outside of the hospital setting, so the children who need such services may easily 'fall through the cracks' in provision in this area. An Allied Health Clinical Placement Scholarship Scheme has been recently introduced to encourage allied health students from metropolitan, rural and remote areas to undertake a clinical placement in a rural or remote community during their degree, and some barriers may be addressed as part of the workforce workstream of the National Health and Hospital Reform Commission (NHHRC). If the allied health workforce can be sufficiently increased, it may allow the possibility for appropriate substitution for other tertiary trained allied health professional positions, such as a dental therapist for a dentist to deliver instruction on teeth brushing for young children. Similarly, the possibility may exist to develop an early childhood specialisation among allied health professionals to allow better cross-diagnosis, although this would require balancing the aim of improved quality against the need to maintain access.

Integrated Service Managers

A third workforce category warrants particular attention – that of the integrated services manager. The secondary platform described above relies heavily on the ability to integrate different functional services at the local or regional level. Australia does not currently train many professionals with a broad view of children's wellbeing across family support services, education and health, and the absence of such a cadre will significantly slow service integration.

Anecdotal experiences with existing health service, education and social work managers suggests this is extremely difficult, with a strong tendency to discount other professional inputs at the expense of client service. The UK has now initiated Masters degrees in integrated children's services management; a similar initiative might be considered locally.

Work Process Changes

An important element of achieving greater quality in the early childhood workforce is in changing the way it works together. The last 25 years have seen increasing specialisation in family services health and educational professionals. While this probably improves quality by providing expert assistance for specific problems, it often decreases service efficiency and their accessibility to parents.

¹⁵ Barbara Preston. Nursing Workforce Futures - Development and application of a model of demand for and supply of graduates of Australian and New Zealand pre-registration nursing and midwifery courses to 2010. Council of Deans of Nursing and Midwifery, Australia and New Zealand, 2006.

Problems that could previously be addressed by one consultation with a professional in an hour might now require four or five consultations spread over a period of weeks or months. Highly motivated and informed families will typically go the distance and reap the benefits, but those who either fail to understand the benefits, or cannot navigate the referral networks receive very little benefit.

It is precisely this problem that has led to the push for services to be integrated. Co-location and the employment of linkage workers could improve outcomes for children and families. However, the work processes, incentives, and sets of accountabilities for ECD professionals must also be transformed. This will arguably be the most difficult aspect of achieving the 2020 vision.

Figure 6 sets out the proposed key changes in top level work processes by 2020.

Figure 6

	From	To
Accountability	Output accountability for each individual professional for each consultation or episode of care only	Outcomes accountability for a defined geography, shared across all professionals
Client service model	Individual contacts over long periods and in different places, connected only by referral letters	Joint contact with all relevant professionals at the same time and place
Child and Family information	Multiple individual records of consultations with no picture of overall development	Single shared record of a child's development
Use of specialist expertise	Referral out of core platform services to experts	Bringing in of expertise to basic service settings where possible, to assess and assist children, and support and educate staff and parents. However, in particular circumstances, referral out to experts may still be the most appropriate service delivery model
Line management	Most staff have manager with the same core training to themselves Managers hired for their depth of expertise in the discipline concerned	Most staff have a manager with different core training to themselves Managers hired for their breadth of multidisciplinary expertise and coordination skills
Risk management	Making sure that all decisions are referred upwards, and that decisions are to be made only if my superior tells me to do so	Making sure that the key issues are identified and appropriate tradeoffs made through a joint decision making process
Success is achieved for a child with complex needs when ...	Definitive diagnosis made and child enrolled in all the correct specialist services	Child coping well within mainstream ECD services, using specialist services as an exception

These will require a fundamental transformation to the way services are delivered. To illustrate, almost ten years after the UK program Sure Start commenced, there are still many on-the-ground obstacles to coordinating different professionals around the needs of each child.¹⁶ The added fragmentation that exists in Australia due to uncertain Commonwealth and State roles will, if anything, render work processes an even bigger issue in this country.

Research and Evaluation

Australia is a relative under-contributor to the global body of research on early childhood development. This is at least partly due to:

- A relative paucity of large flagship programs amenable to rigorous evaluation (and correspondingly large number of small-scale, ad hoc interventions that cannot be easily assessed)
- Historical under-emphasis of the value of formal early childhood education relative to primary, secondary and tertiary education

¹⁶ The first National Evaluation of Sure Start is currently underway, covering the period 2001-2008. <http://www.ness.bbk.ac.uk/>.

- A related lack of emphasis on large-scale population research. Compared to the US, UK and Canada, Australia spends relatively little on large clinical, social or population research and has neither the precedent for such investment, nor the immediate capacity for activities such as data collection required to run such projects¹⁷.

Failure to achieve a minimum level of research intensity will probably only add to the body of subscale and inconclusive studies already existing in this domain. From an Australian perspective, with limited resources compared to the US and UK settings, there is a strong case for supporting one large controlled trial of one or two intensive integrated interventions, with follow-up for at least five to ten years.

Monitoring and Reporting

Australia lacks examples of national performance reporting on outcomes for public services in general, and this also applies to early childhood. This is typically not due to a lack of data per se, but that:

1. States collect data in different, and often non-comparable forms
2. Not all data are aggregated at a national level
3. Where data are collected and aggregated, there are strict limits on what these can be used for, and it is difficult to report them publicly or to use them for performance management of individual units or planning for specific geographies

The current intergovernmental reform agenda is heavily reliant on comparable outcomes data,¹⁸ and there is some urgency in building these up well before new funding agreements conclude so that progress can actually be tracked. Significant work has already been done on outcome indicators for early childhood.¹⁹ Implementing these, as well as a few crucial indirect 'environmental' indicators for families and communities represents no more than 25 or so metrics, but is no small task from Australia's current position. However, more importantly, there are a number of process prerequisites for successful reporting and monitoring:

1. **An agreement to share data openly between jurisdictions.** It should be a prerequisite for engagement that both States and the Commonwealth freely share data on the cost and success of activities down to the local level. This does not necessarily mean that all data need to be made public. Current data-sharing arrangements often effectively prevent access by requiring onerous 'approval to use' permissions.
2. **The appointment of a neutral 'umpire'.** Because this agenda frames accountabilities for outcomes as joint between States and the Commonwealth, any evaluation should optimally be coordinated by a third, independent party (although obviously, providers and funders will need to continue to supply data). This should help facilitate point 1 above. While the COAG Reform Council will have to address this need at the highest level, it will also have to commission more expert groups to be able to manage the details of outcomes comparisons in each specific field of joint endeavour.
3. **A national minimum dataset** should be negotiated at an intergovernmental level, and updated annually, rather than current multiple overlapping reporting arrangements set program by program. This will considerably reduce the level of effort required in collection and collation, and provide a far more usable picture.
4. **Line of sight at a local level between outcomes, activity and investment, and risk factors.** To be able to act upon reported information, it will need to be ensured that information can be broken down to the most meaningful local level of aggregation possible, because:
 - a. Opportunities for improvement in Australia will be detected by examining differences between local communities, which highlight best practice and pinpoint the need for a specific service in a particular location. The current approach to averaging outcomes at the State level will not yield actionable insights.
 - b. While outcomes measures are critical, they alone are not enough to spur action. Two communities with different outcomes might require fundamentally different interventions if they consume different amounts of ECD resources now, or have different levels of key risk factors.

¹⁷ Amanda Scoggins. Health and Medical Research in Australia. Observatory on Health Research Systems. RAND Corporation – Europe, 2008.

¹⁸ Heads of Treasuries SPP working Group. Circular no 1. 2008/01 — Implementing the new Commonwealth-State financial arrangements.

¹⁹ AIHW. Key national indicators of children's health, development and wellbeing. Bulletin 58, April 2008.

Current State of Early Childhood Development in Australia

At the highest level, Australia appears to be well on its way to achieving this 2020 vision. While Australia does not currently have comprehensive indicators to measure the full spectrum of early childhood development, several strong indicators do exist in the key ECD domains of education, health and family support, as reflected in the elements of the vision. On these measures, Australia's 1.25 million under-fives currently enjoy good educational and health outcomes and a high degree of economic security, compared to peer countries.

However, there is still a significant way to go. Australia is missing several key opportunities for highly effective intervention and support for children:

1. **We are not focused on enhancing human capital for the future.** Australia does not provide the consistency or intensity of early childhood services to really make a difference to long term outcomes, with funding for quality preschool and preventative health as particular issues.²⁰ This is of concern for all Australian children; however, evidence shows that the human capital gains of strong ECD services are greatest for the highest risk children in particular, whose families are less likely to be service users.²¹ Australia experiences notable variation in outcomes between population groups, with at-risk children, such as indigenous children, CALD children, and those from low-income or new migrant backgrounds or rural and remote locations, falling behind the average.
2. **Parents have limited access to information.** While evidence indicates that the early years are the best time to invest in a child's development, Australian parents often lack access to information about cognitive developmental milestones.²² In addition, many face difficulty in proactively identifying services that may support them.²³ As a result, many potentially beneficial services are not taken up – often, by those who most need them
3. **Service complexity stresses families and wastes resources.** Changing family structures and roles, combined with workplace pressures and dual income needs, are creating stress for Australian families. The complex, fragmented and provider- (rather than citizen-) oriented services often exacerbate family pressures. Service complexity is a particular issue for families facing additional challenges such as having a child with a disability²⁴
4. **We provide insufficient support for parental choices in balancing work and family needs.** Most Government support is currently focused on child care for working parents, yet Australia maintains low parental workforce participation rates.²⁵ Families face high effective marginal taxation rates and a lack of paid maternity leave.²⁶ These issues are compounded by a lack of flexibility in child care, including a lack of co-located preschool and child care services.²⁷

1. Lack of focus on enhancing future human capital

Australia appears to be missing some key opportunities for effective intervention to improve future human capital – opportunities which peer nations have successfully taken up.

While it is important that the human capital be maximised from all areas of society, of particular concern is that a large number of the most disadvantaged Australians have early childhood outcomes that diverge substantially from the averages. Interventions later in life appear to do little to address these disparities. Figure 7 shows the

²⁰ OECD, *Starting Strong II*. 2006. AIHW. *National Public Health Expenditure Report 2005-6*. Australian Institute of Health and Welfare, Canberra, 2008.

²¹ In the UK under the Sure Start program, the ratio of public expenditure in the most disadvantaged communities compared to the least disadvantaged is approximately 3.5:1. The first National Evaluation of Sure Start is currently underway, covering the period 2001-2008. <http://www.ness.bbk.ac.uk/>.

See also Merrell, Christine, Tymms, Peter and Jones, Paul. "Changes in Children's Cognitive Development at the Start of School in England 2000-2006". CEM Centre, Durham University 2007.

²² Mocan, H.N. (2001) "Can Consumers Detect Lemons? Information Asymmetry in the Market for Child Care" NBER Working Paper 8291.

²³ OpenMind focus groups August 2008.

²⁴ OpenMind focus groups August 2008.

²⁵ OECD. *What works best in reducing child poverty: A benefit or work strategy?* OECD 2007. Jennifer Buckingham. **Subsidies increase child care prices, not mothers' participation in work.** Centre for Independent Studies, Executive Highlights No 645, 2008. Anu Rammohan and Stephen Whelan, *Child care costs and the employment status of married Australian mothers*. ANU Centre for Economic Policy Research, Apr 2006.

²⁶ AMP-NATSEM. *Trends in effective marginal tax rates 1996-97 to 2006-07*. AMP September 2006.

²⁷ OpenMind focus groups August 2009.

strong socio-economic status-related variation in school test results. There is little evidence that existing school services narrow the SES-related gap between year 3 and year 12.

Many national averages hide a range of outcome variation between local communities – a large number of which can be traced back to before birth. One example is the highly variable rate of teenage motherhood between statistical districts across Australia (driven by a mix of socio-economic and indigenous status) in Figure 8.

Figure 7

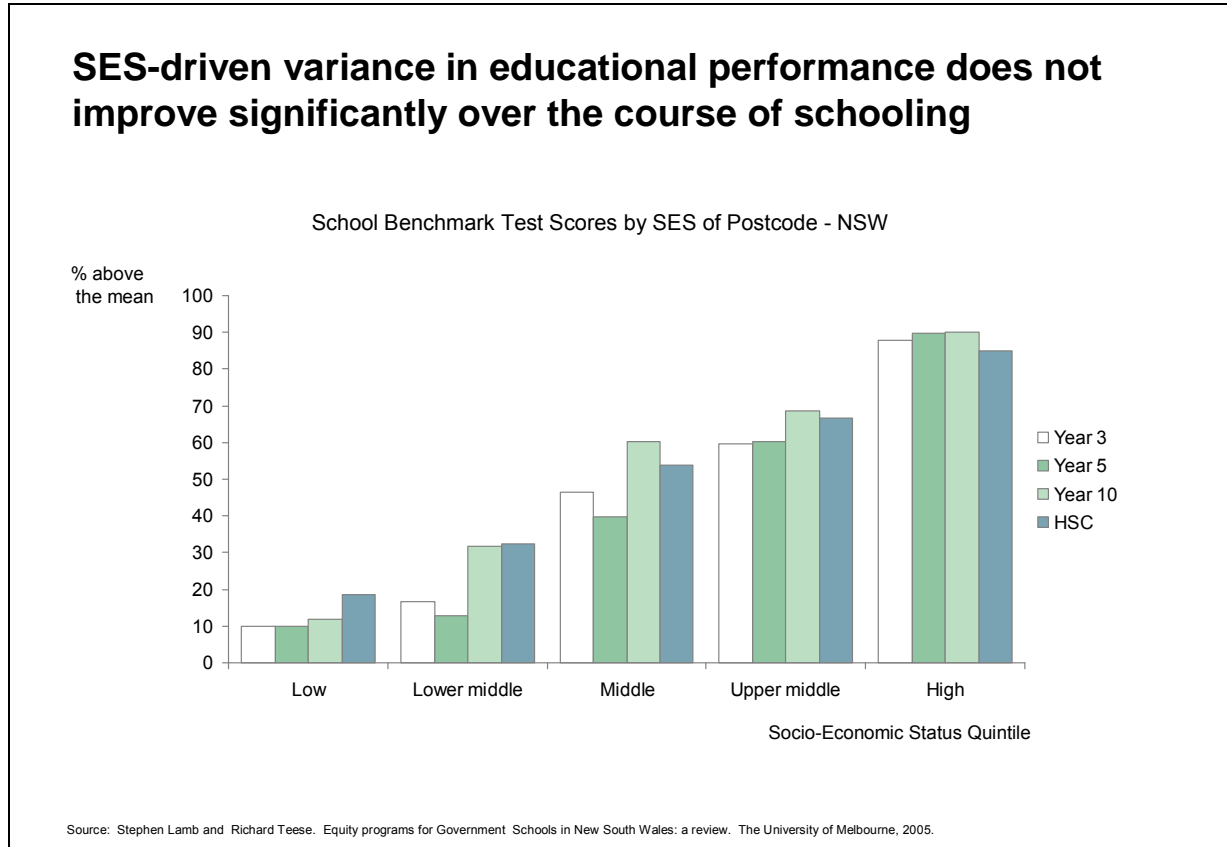
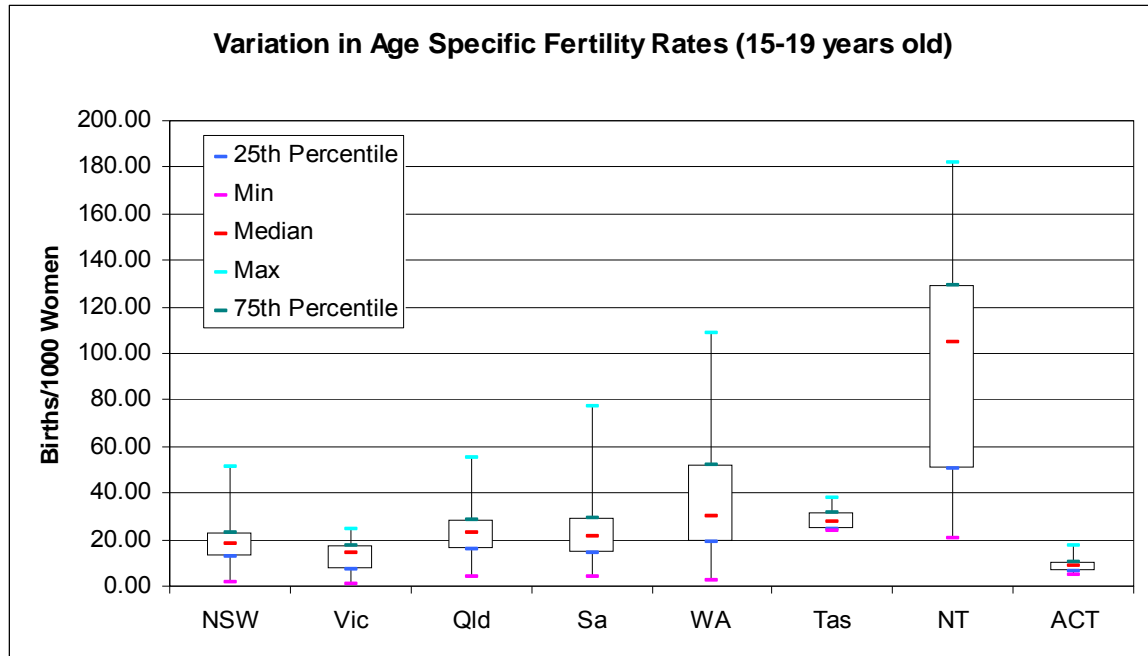


Figure 8

Considerable variation in outcomes between localities within states



Note: age specific fertility rates measured at statistical sub-district level
Source: ABS 2006

Overall, Australia funds children relatively generously, ranking in the top quartile of OECD countries for the level of family benefits as a proportion of GDP. However, a significant proportion of early childhood funding in Australia (\$6.5 billion of \$16 billion) is spent on payments to families, rather than service provision or reimbursement for services provided privately (Figure 9).²⁸ This is significant, as the research shows that intensive high quality interventions can substantially improve outcomes. However, of the funding that goes to services, Australia does appear to under spend on some proven cost-effective interventions.

Australia's public and private spending on quality preschool is less than half of the OECD average as a percentage of GDP,²⁹ with resulting level of enrolment in the bottom quartile of OECD countries. Australia has one of the lowest preventive and promotive health care spends among OECD countries (1.8 per cent of health care spending), which is the category that most effective health-related ECD interventions would fall into.³⁰ The majority of health funding instead goes into more expensive hospital-based interventions, typically for late-stage disease.

In addition, the money Governments currently spend on early childhood interventions does not always reach those most able to benefit. Analysis of a subset of early childhood funding tracked by geography suggests that funding for the types of basic services that all children are likely to need is lower for the least well-off Australians. This is particularly evident for children in regional and remote areas (Figure 10). This difference is driven almost entirely by poor Child Care Benefit (CCB) uptake. This is likely due to two reasons; firstly, higher parental unemployment results in lower eligibility for the payment; and secondly, the barriers to providers to offer services in the area, due to low population levels and difficulty in obtaining staff. However, high quality ECEC in disadvantaged or remote areas might well provide stimulation not otherwise available to children, and this is thus an inefficient allocation of funds from an ECD outcomes perspective.

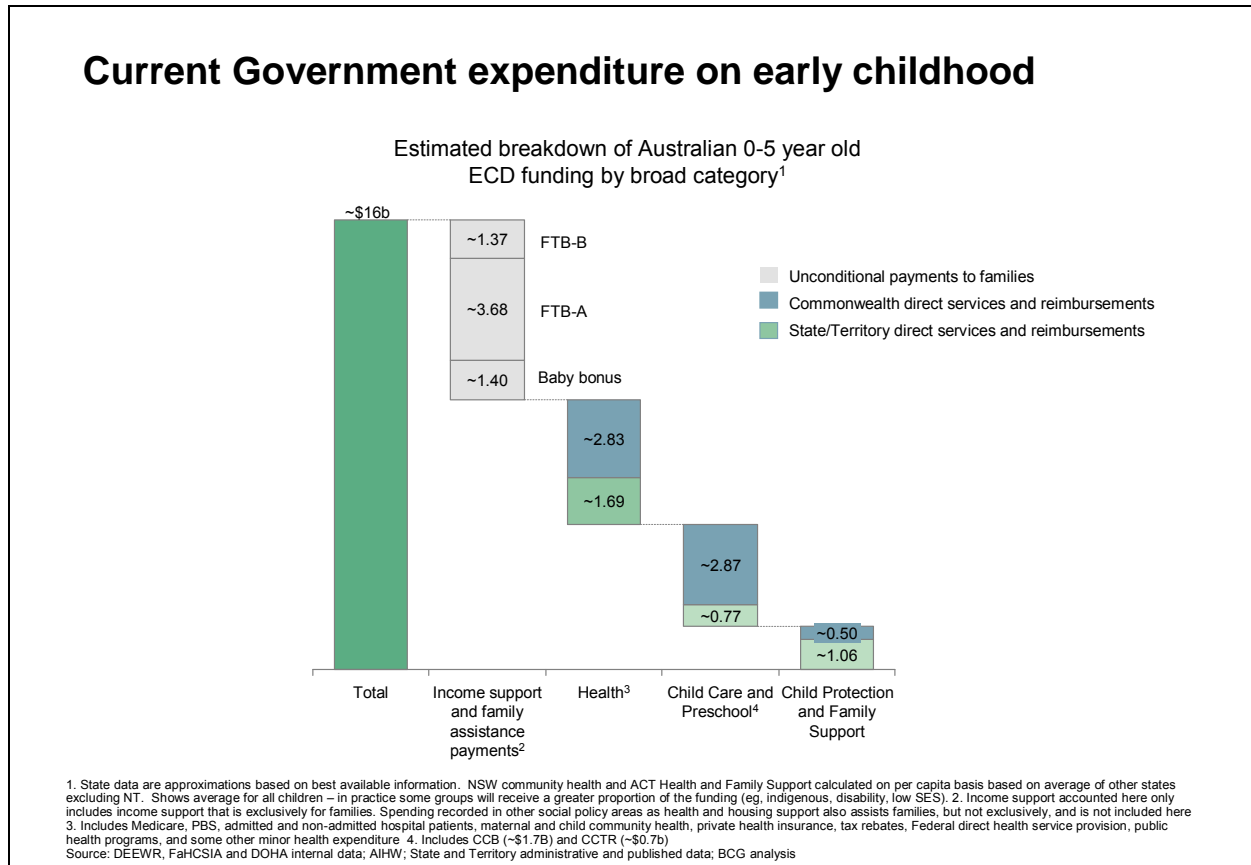
²⁸ Including Parenting Payment, this figure increases to \$11b of \$20.5b. Figures are based on FY08/9 budget for each jurisdiction.

²⁹ OECD. *Starting Strong II*. OECD 2006.

³⁰ AIHW. *National Public Health Expenditure Report 2005-6*. Australian Institute of Health and Welfare, Canberra, 2008.

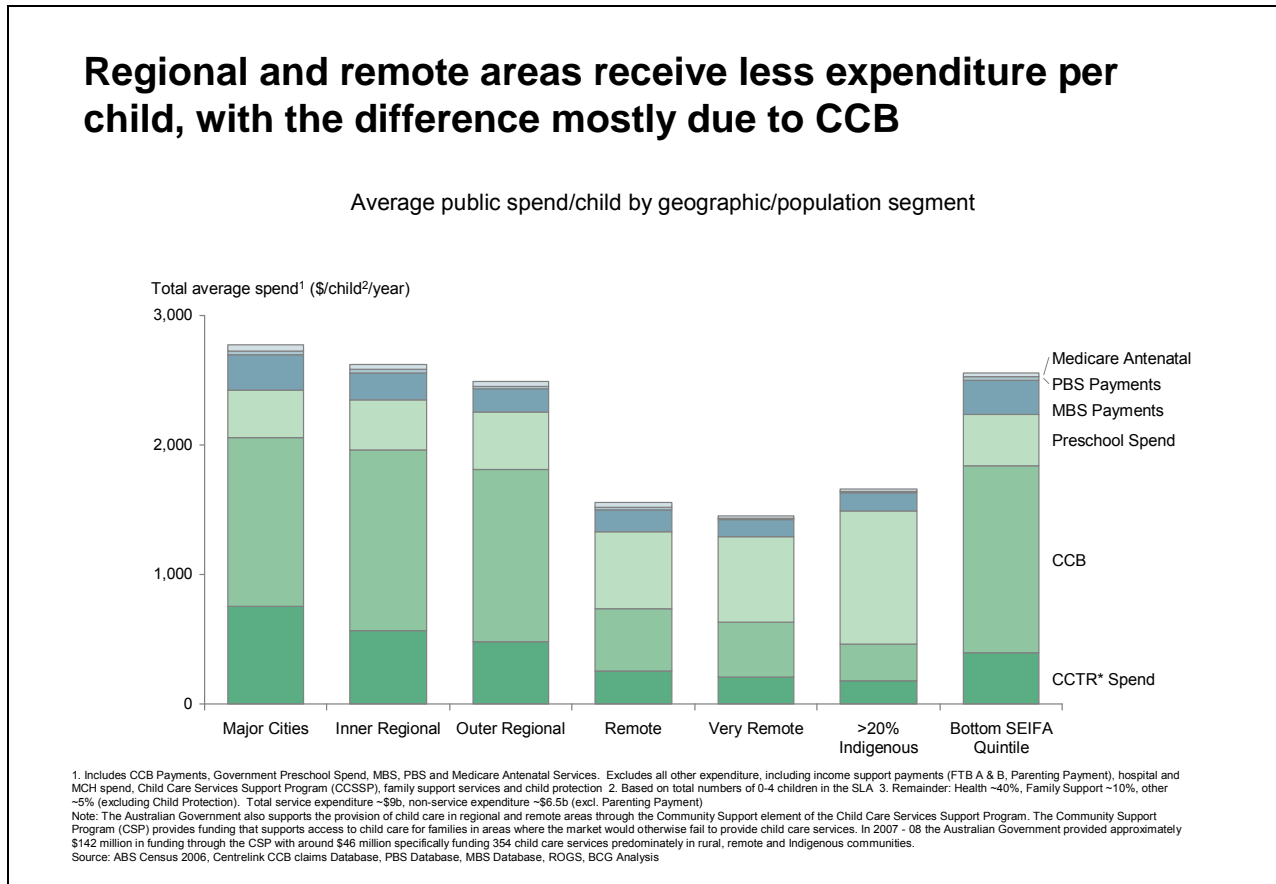
In the UK under the Sure Start program, the ratio of public expenditure in the most disadvantaged communities, compared to the least disadvantaged is approximately 3.5:1.³¹ It should be emphasised that this is not an equity-based criticism. Most of the \$6.5 billion child-linked payments described above goes to families who are not well-off. However, research suggests that human capital formation is best improved in the long term by spending on specific services for particular groups, rather than providing income support payments.

Figure 9



³¹ It should be noted that the impact of the Sure Start program has not yet been fully quantified. The first National Evaluation of Sure Start is currently underway, covering the period 2001-2008. <http://www.ness.bbk.ac.uk/>. See also Merrell, Christine, Tymms, Peter and Jones, Paul. "Changes in Children's Cognitive Development at the Start of School in England 2000-2006". CEM Centre, Durham University 2007.

Figure 10



There have been suggestions that gaps in outcomes and service coverage are due to supply failure. This may be due to true market failure, or to simply the poor viability of businesses providing services under current funding models. True market failure would exist if families had sought and were able to find early childhood services, but no suppliers had arisen to address this need. The two main areas of early childhood provided privately, and hence potentially subject to market failure, are child care and medical services. However, it is notoriously difficult to get a firm fix on the demand that exists in an area, and hence to estimate supply shortfalls. This is because measures such as waiting lists for child care can be grossly inaccurate because a child's name may be wait-listed at multiple centres (especially when there is a real or perceived supply shortfall).

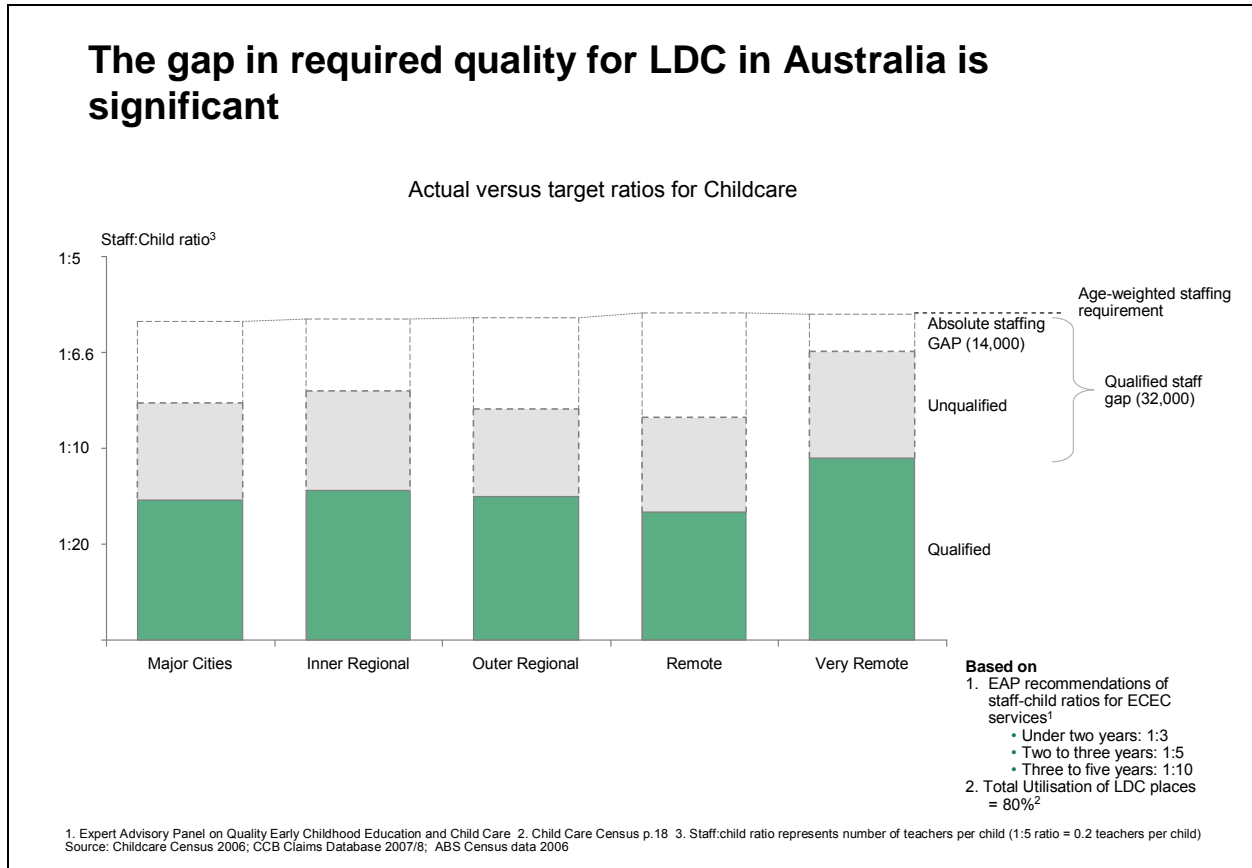
In other areas, such as antenatal care, while there is a reasonable understanding of demand levels, the number of different uncoordinated providers (GPs, community midwives, private obstetricians, and public hospitals) makes it difficult to assess how much demand is actually being met. Australia has a reasonably dynamic private market for child care in particular, which suggests that where the affordability constraint is removed (in this case by CCB and Child Care Tax Rebate – CCTR), private providers can and do emerge to deliver services.

There is stronger evidence to support simple supply failure due to non-viability of businesses. This is evident mainly in very small or dispersed remote populations, where there is not sufficient demand for services to justify even a single supplier. Therefore, to provide services to these areas requires significant additional subsidies or direct public provision. While there have been some efforts to address this supply failure through increased provision of preschool, there remains a significant undersupply of child care in many of these regions.

Undersupply might also be evident in the quality of services provided. By the criteria currently being set by Australia's ECEC Expert Advisory Panel on Quality, Australia currently has a gap in terms of qualified child care staff ratios equivalent to 32,000 staff. Without taking qualifications into account, the gap reduces to 14,000 (Figure 11). While there is considerable international evidence suggesting quality is important especially for interventions in disadvantaged communities, this report has not been able to link quality deficits to any outcome differences in Australia. It should also be noted that this gap exists partly because of variations between different

States' currently regulatory requirements and the Expert Advisory Panel's recommendations on the ideal standard.

Figure 11



2. Limited information access and service navigation capabilities

Levels of service uptake

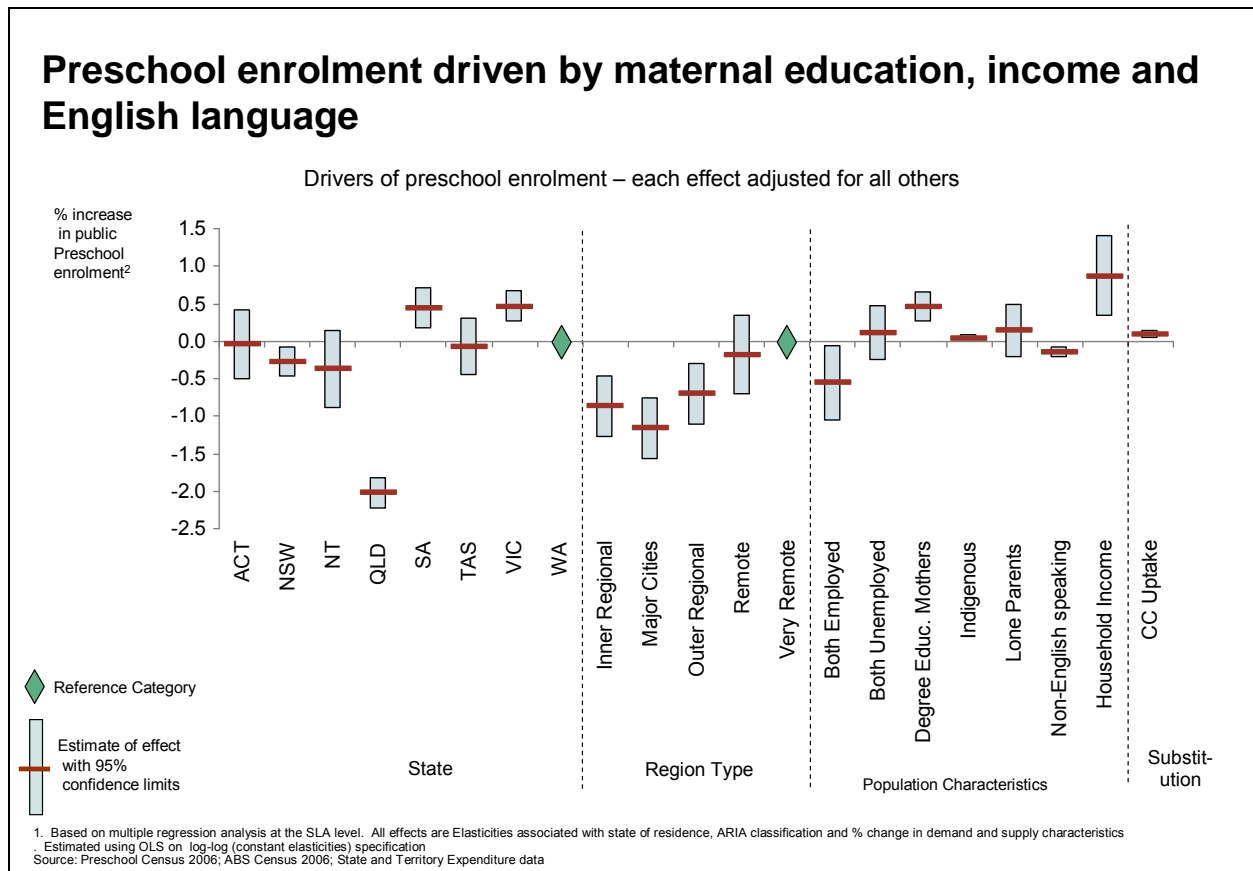
It is clear from the research in this area that not all parents fully appreciate the long-term impacts of early childhood services. Even after adjusting for State and region they live in, income and employment, it is noticeable that uptake of certain low cost or free services, such as preschool, are lower among certain groups. To quantify these effects on preschool uptake in particular, this report has used multivariate regression to disaggregate the independent effects of a number of family characteristics. After adjusting for the State and type of region (urban versus remote) where families lived, this report examined the impact on enrolment of:

- Both parents being employed
- Both parents being unemployed
- Mothers having degree level education
- Indigenous status
- Lone parenthood
- Not-speaking English at home
- Household income
- Use of child care (to test for substitution effects)

This analysis has been conducted at the SLA level. Figure 12 shows the main drivers of preschool enrolment. The red line for each effect indicates the percentage increase or decrease in preschool enrolment associated with a one percent increase in that explanatory factor. For example, a one percent increase in average household

income is associated with an approximately 0.8 percent increase in four-year-old preschool enrolment.³² Where the confidence limit bars overlap the zero line, this indicates an effect is not statistically significant at the five percent level.

Figure 12



The relatively high adjusted levels of preschool enrolment in Victoria and South Australia, and very low rates in Queensland are well known. Of greater interest are the population characteristics, indicating that low income, poor maternal education and a non-English-speaking home environment are all associated with significantly lower levels of preschool enrolment. This suggests that either these characteristics are associated with poorer service provision or there is failure of uptake³³.

Lower enrolment where both parents work is likely to be driven by the difficulty of getting children to or from preschool in the middle of the day. Use of child care is positively associated with preschool enrolment, which suggests that child care does not substitute for preschool. Enrolment rates for preschool in rural and remote areas and in indigenous communities are better than the norm, indicating the impact of policies, largely at the Commonwealth level, that target these environments.

Reasons for low service uptake

Evidence from focus groups suggests some of the reasons behind individual non-uptake of services. Interventions such as preschool were seen as potentially 'preventing kids being kids', and facilitating time to be spent with parents was perceived as a much more important policy objective.

Similarly, few parents had distinct views on the quality of ECEC services, although most when prompted could identify potential poor quality markers in child care they had used (however, international evidence suggests

³² For State and region types, these indicate a ratio increase in a State or region compared to a reference State (WA) or region (very remote). For example, adjusting for all other factors, being in SA increases a child's chances of preschool enrolment by ~40% relative to WA, whereas being in Queensland reduces a child's chances by around 2/3.

³³ Given that there is no data on unmet demand, and that demand and supply are likely to be endogenous, it is not possible to definitively separate these two possibilities.

parents that are relatively poor judges of quality).³⁴ Some participants' comments on antenatal care, which is a critical determinant of birth outcomes, suggested they did not realise how important it was:

"I was working 42 hours a week right up until the birth, my feet were killing me ... I didn't have time to go to the classes".

A significant number of parents spoke of their lack of awareness of what services are provided, or even where to obtain information on services.³⁵ Parents emphasised the value of 'one-on-one' discussions with professionals, in particular MCH nurses, who could advise them on where to go and identify problems that they may not be fully aware of (such as perinatal depression). However, these opportunities were often not sufficiently provided, particularly for those struggling with broader family issues – who are perhaps most in need.

Many parents identified a lack of systemised outreach of information services, indicating they had only found out about services such as speech therapy through chance comments by a friend or neighbour:

"I don't know what's available, as a new mum it'd be nice to have more info on what services are available at what age"

"Services in [my town]? There's plenty, but YOU have to seek them out"

"[When asked about child and maternal health] ... I didn't know where to go, didn't know that's where you could get advice, like if your baby was crying."

"My biggest criticism is not being able to get information, cause then you can't really feel confident."

A distinct subset of focus group discussants mentioned that they had been alienated by ECD service providers and as a result would not use these services.³⁶ These were also often participants who felt isolated from the broader community and lacked confidence:

"I hate taking the kids to ER. They yell at you"

"They don't like single mums in there"

"I didn't like the nurse coming around. She was nosey"

"I didn't like the Mums' group. They were all bitches. I just went twice and gave it up"

In contrast, parents who had a better understanding of childhood development, and were linked in to their communities, were frequent and appreciative service users (especially of MCH services, public hospitals and playgroups), but demanding of more intensive services as well:

"My child needs a specialist and we have to fly to Adelaide. You get some money back, but you still have to get there"

"I spent a lot of time researching, weighing up, I went on three waiting lists so of course I could get into the right child care when I needed it"

Families less linked-in to information about services are at risk of falling into a vicious cycle, because attending one service is the most common means of identifying or being referred to other relevant assistance. This split in community attitudes and ability to access information suggests that simply providing more services, without actively outreaching to those who are currently underusing them, could simply increase disparities in outcomes as new services are rapidly taken up by more proactive families.

³⁴ Mocan, H.N. (2001) "Can Consumers Detect Lemons? Information Asymmetry in the Market for Child Care" NBER Working Paper 8291.

³⁵ Mona Basta. "Information Flow and Trust Dynamics in Child Care Decision Making: The Case of Philadelphia". Paper presented at the annual meeting of the American Sociological Association, Hilton San Francisco & Renaissance Parc 55 Hotel, San Francisco, CA. 14 Aug 2004. http://www.allacademic.com/meta/p109946_index.html.

Brenton Wright. *The Virtual Village: Raising a Child in the New Millennium – Report of the Inquiry into Early Childhood Services*. Government of South Australia Department of Education and Children's Services, January 2005 p.65.

Hornsby Shire Council. "How Should Families Be Supported?" *Children's Services Plan*, Issue Paper 4. New South Wales 2004. <http://www.hornsby.nsw.gov.au/ourcommunity/index.cfm?NavigationID=1757>.

KPMG, *Review of the Tasmanian Family Support Service System*. Department of Health and Human Services. 2005, p. 10, 55. http://www.dhhs.tas.gov.au/data/assets/pdf_file/0003/9156/Review_of_the_Family_Support_Service_Final_Report_KPMG_October_2005.pdf.

³⁶ United States Government Accountability Office. "More Information Sharing and Program Review by HHS Could Enhance Access for Families with Limited English Proficiency". August 2006. http://www.naccrra.org/policy/background_issues/gao.php.

3. Stress and wastage due to complexity

Changing family structures and lifestyles, loss of extended family care arrangements and increasing work demands are placing significant stress on Australian families.³⁷ Current government early childhood efforts do not necessarily alleviate this stress, and in some cases may exacerbate it.³⁸ Focus group participants' most frequent request of government was for help so they could spend more time with their children. This was seen as far more important than government funding or provision of services.

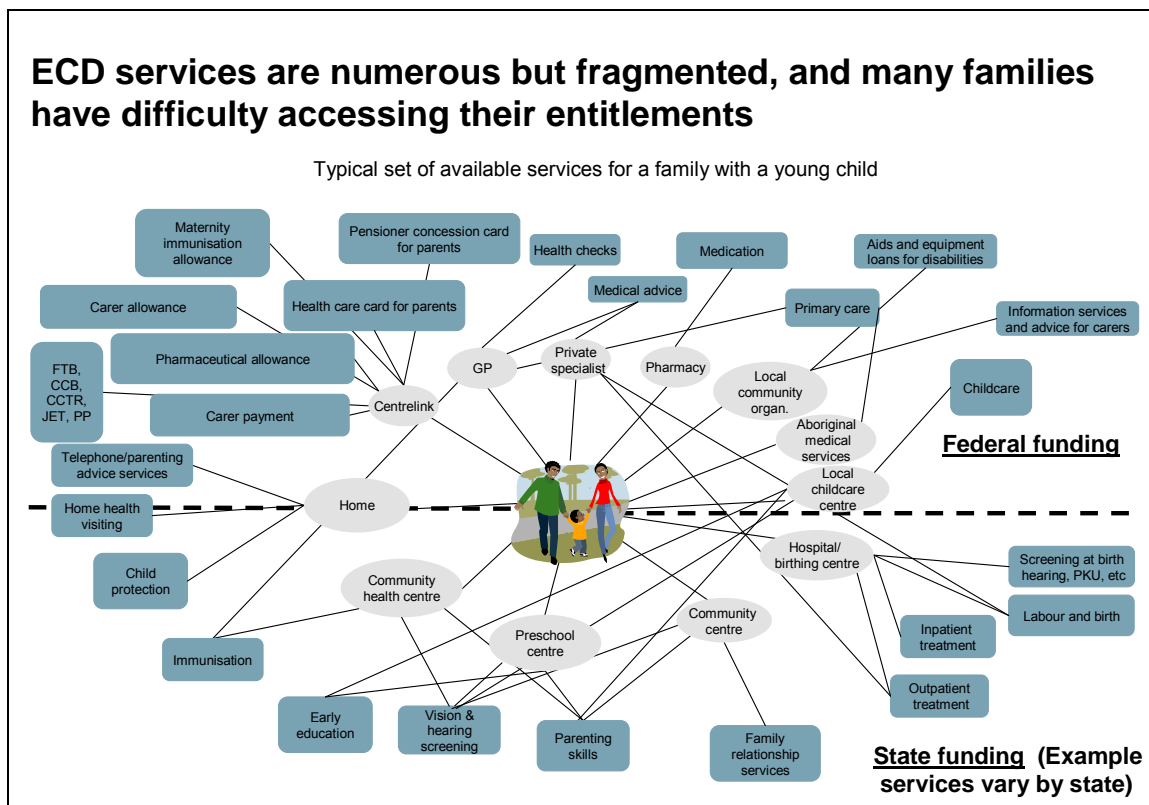
Poor coordination and lack of integration at the local service level may lead families to be confounded by myriad different entitlements and service points. Figure 13 illustrates the typical array of public services available to a young child in Australia. Many parents and carers do not fully understand even common entitlements such as CCB and CCTR, let alone the interaction with more complex services such as special needs and concession entitlements.

This is a particular issue for children facing significant challenges such as disability,³⁹ who have multiple vertical payment and service entitlements, with services often using a significant proportion of their resources simply to test for eligibility:

"I love the idea of one case manager across all of early childhood that would be great. It's very exhausting repeating your history all the time." - Parent of child with a disability

Splits in responsibilities (between and within Commonwealth and States, and between functional departments within each) are a significant cause of this complexity. One of the most commonly experienced frustrations is the separation of child care and preschool in many States, which means parents working fulltime and unable to leave work during the day may have to forego preschool altogether.

Figure 13



³⁷ Katherine Power. "Parents under Pressure", *About the House*. Parliament of Australia, House of Representatives Standing Committee on Family and Human Services, November 2005.

³⁸ Tim Moore, "The challenge of change: Why services for young children and their families need to change, and how early childhood interventionists can help." Keynote presentation for the Gippsland Early Childhood Intervention Advisory Network (GECIAN) 2006 Conference - Managing Change. Traralgon, 24 October 2006.

³⁹ Jan Matthews and Meredith Rayner, "Engaging with families and children with a disability". Parenting Research Centre. 27 August 2007.

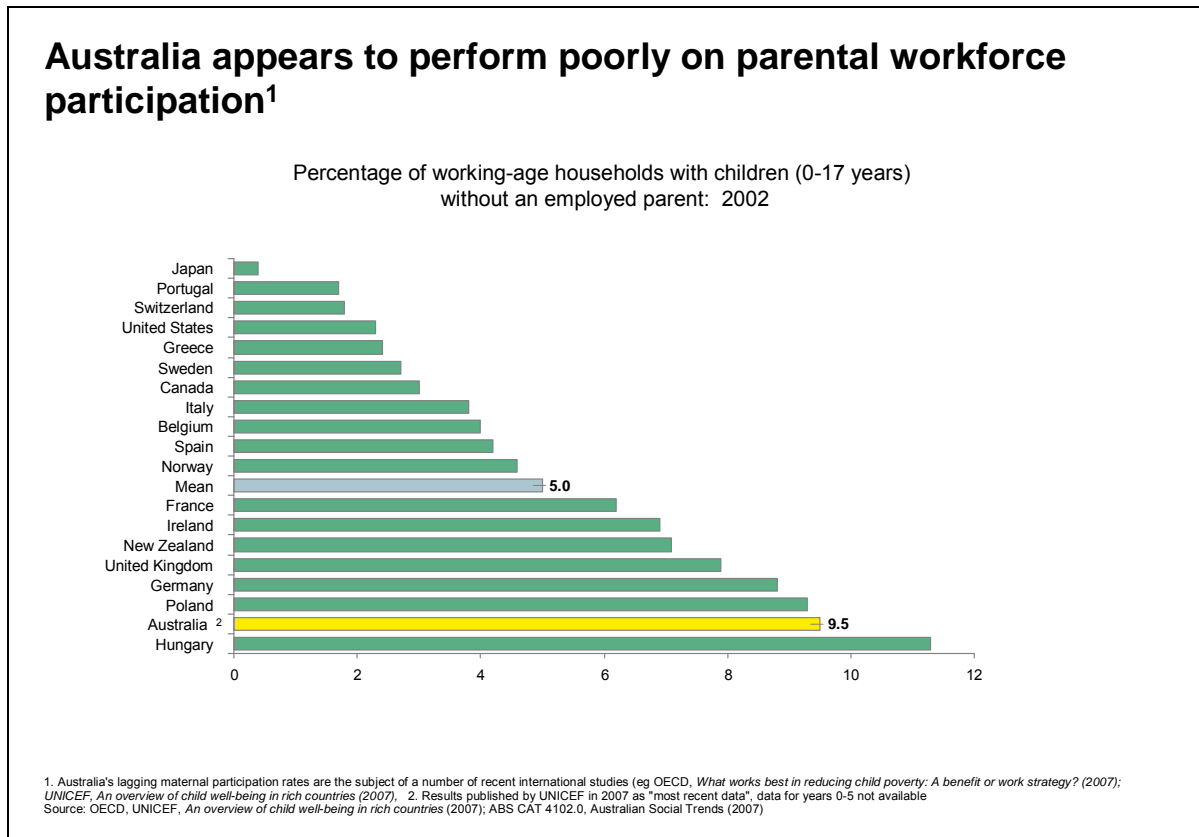
K. M. Plant and M. R. Sanders. "Predictors of care-giver stress in families of preschool-aged children with developmental disabilities", *Journal of Intellectual Disability Research*. Vol 51(2), 2007, p.109-124.

Complexity created by multiple small programs is also a significant cause of waste and administrative overhead. Many programs are so small that their commissioning and reporting costs constitute a major part of the overall cost of services. There is a significant financial opportunity in consolidating these into a few, large, well administered programs at both Commonwealth and state levels.

4. Insufficient support for parental workforce participation choices

Despite subsidies such as the CCB and the CCTR, Australia has relatively low rates of maternal employment, particularly in areas of socio-economic disadvantage (Figure 15).⁴⁰ There is also broad agreement that families should be supported to make a choice as to whether their children will be cared for at home or in child care (be it centre-based long day care or family day care), and that the benefits of quality child care are greater for low-income families.

Figure 14



Overall workforce participation elasticities with regard to the cost of child care are quite low (around -0.2).^{41, 42} That is, for a 10 percent decrease in child care costs there is an approximately 2 percent increase in number of mothers who return to work). This suggests that payments such as CCB and CCTR will at best have only a modest impact on workforce participation, although these effects will be stronger for single parents and low-income earners.⁴³

However, there are several other drivers which, up to this point, have received relatively little attention. Paid maternity leave is likely to be an important policy lever, preserving a formalised link to pre-pregnancy

⁴⁰ OECD. *What works best in reducing child poverty: A benefit or work strategy?* OECD 2007.

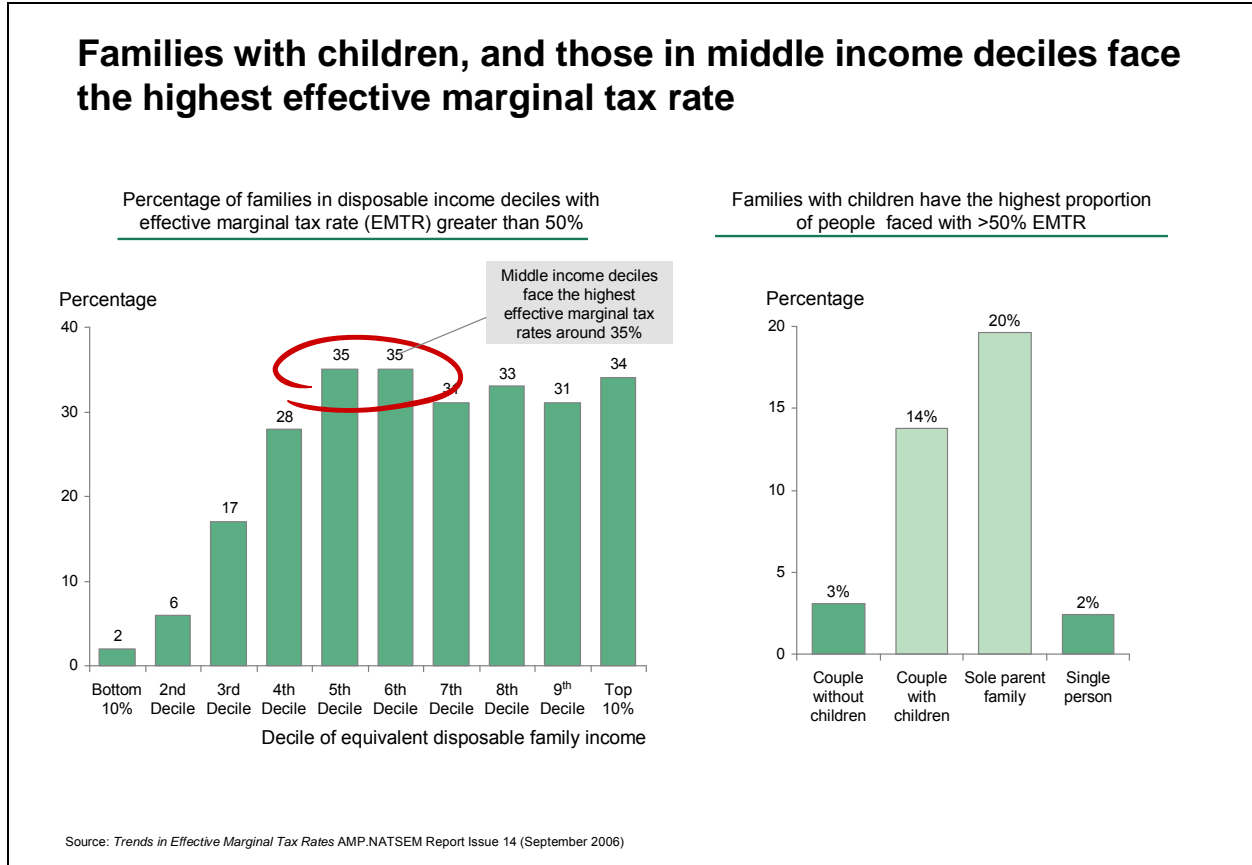
⁴¹ Jennifer Buckingham. *Subsidies increase child care prices, not mothers' participation in work*. Centre for Independent Studies, Executive Highlights No 645, 2008.

⁴² Anu Rammohan and Stephen Whelan, *Child care costs and the employment status of married Australian mothers*. ANU Centre for Economic Policy Research, Apr 2006.

⁴³ Doiron, Denise and Kalb, Guyonne. "Demands for Child Care and Household Labour Supply in Australia". *Economid Record*, 81(254). September 2005, p.215-236.

employment, allowing mothers to remain “attached” to the workforce and hence reintegrated more easily. In addition, broader review of the tax and benefits system would be required to address the relatively high effective marginal taxation rates for families with children and the lack of appropriate jobs.⁴⁴ Figure 15 demonstrates that families with children, and those in the middle income deciles, face the highest effective marginal tax rates.

Figure 15



Parents interviewed also mentioned significant constraints on the nature and quantity of work that interviewees could undertake. The main constraints here are inflexible child care services and the lack of wrap-around care for preschool, coupled with a lack of flexible employment opportunities:

“Not every job is 9 to 3 ... I have to get the kids to their gran’s by 6:30 in the morning and I’m probably lucky that I can do that”

“Child care’s fully booked out, my wife has to give up her job in the school holidays”

“I can only do a casual job, can’t get a 9–5er, have to do 10–2, with no holidays, no sick leave ...”

In conclusion, therefore, while child care is definitely one driver of parental workforce participation, there are a range of factors that should be considered in order to gain significant improvements in this area, from both the perspectives of families and their children, and of national productivity objectives.

The Rationale for Government Investment

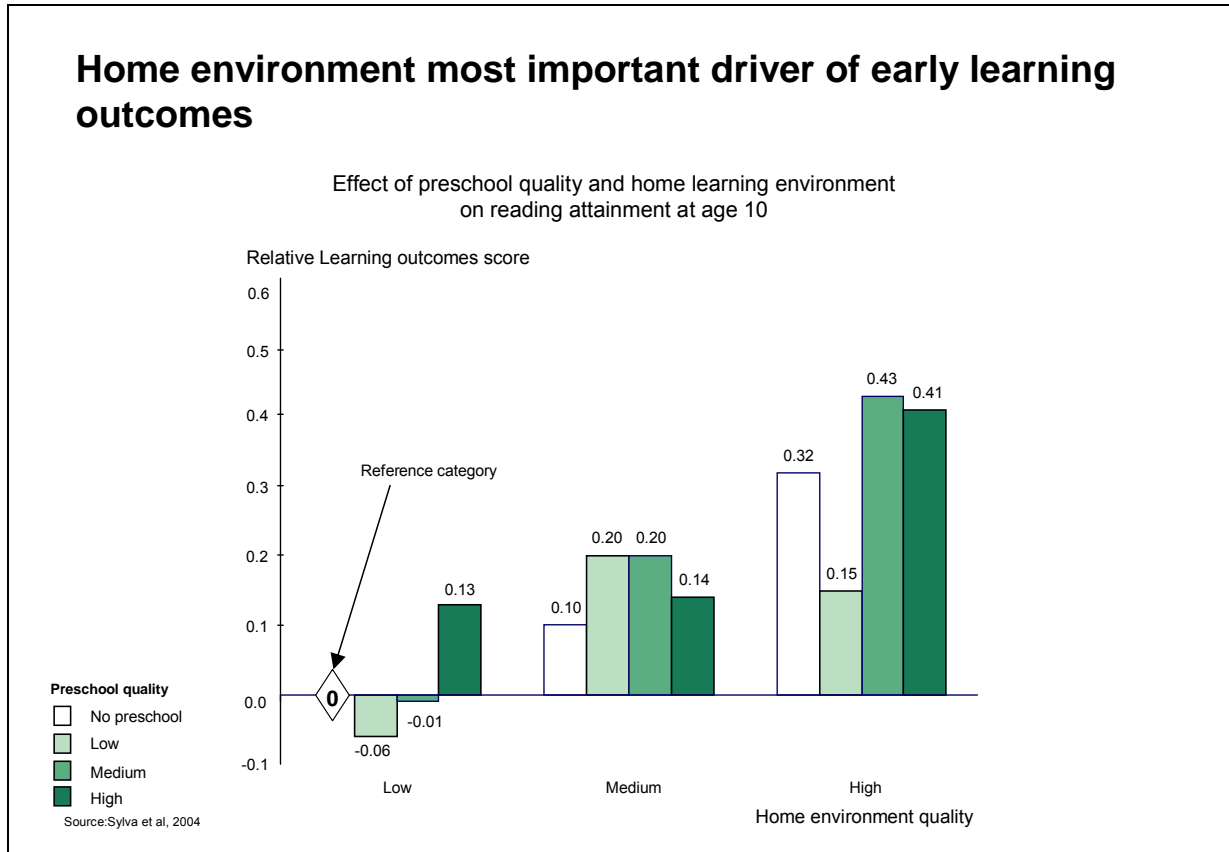
The explicit focus of this report is the potential role of government in early childhood development. However, it must be stated that Government will never be the main influence over a child’s development. Genetics, family and community environments, and socio-economic status are well recognised as being far more significant

⁴⁴ AMP-NATSEM. Trends in effective marginal tax rates 1996-97 to 2006-07. AMP September 2006.

drivers, with research clear that the largest impact by far is due to the family environment.⁴⁵ Any input from Government, private sector service providers and the voluntary sector will always be far less important than the role of the family in a child's early development.

Figure 16 depicts the 2004 results of the Effective Provision of Preschool Education (EPPE) UK longitudinal study, which found that home environment has greater explanatory power for outcomes at age 10 than preschool attendance, especially at lower levels of quality.

Figure 16



Almost without exception, children receive considerable support from their families in achieving good health, educational achievement and social integration. Families are fully aware of the value of investing in their children. Therefore, the primary role of Government in ECD is to facilitate and support the creation of human capital that families are already engaged in. In such circumstances, governmental involvement needs to be justified, in the form of basic support for all Australian children and families or more intense support to children identified as in need.

Not all early childhood interventions are equal, and evidence for some is much stronger than for others. However, by way of broad strategic framing, there is an overarching rationale for early childhood intervention as a whole which relies not only on the research evidence, but also the particular Australian social and political context.

This report proposes that there are six reasons for government involvement in the development of all children, regardless of level of need or background:

1. Scientific evidence that this is a critical period to influence effective lifelong health and learning, and enhance the eventual productivity of the population. Studies such as the EPPE study⁴⁶ and others show improved educational and social outcomes across the full range of children from interventions

⁴⁵ Kathy Sylva, et al. *The effective Provision of Preschool Education (EPPE) Project: Final Report*. Department of Education and Skills 2004.

⁴⁶ Kathy Sylva, et al. *The effective Provision of Preschool Education (EPPE) Project: Final Report*. Department of Education and Skills 2004.

- such as quality preschool, although the effect is significantly greater for children from disadvantaged backgrounds (Figure 17)^{47,48}
2. The cost-effectiveness of certain early interventions relative to later ameliorative ones. In particular, health services such as antenatal care, maternal and child health services and immunisation have a high pay-off in preventing poor health outcomes later in life. In addition, services such as immunisation have strong positive externalities, conferring a whole-of-community benefit.
 3. High marginal tax rates, combined with the cost of child care, can deter parents from going back to work once they have children. A relatively small investment in subsidising child care can thus have a potentially large economic benefit in terms of enlargement of the economy, and a reduction in the number of people drawing income support benefits.
 4. In some instances, a market may not develop for certain highly effective ECD services (eg, due to information asymmetries or barriers to entry) and Government may need to intervene to provide (or catalyse provision) for children who would use the service if it existed
 5. A single national service 'brand' that includes children from all social backgrounds has important benefits for at-risk and disadvantaged children as well. First, universal services provide a crucial mechanism for identifying children and families who are at risk, so that they can be referred for more intensive supports. Second, the universality of services eliminates any stigma that some users might otherwise associate with them. Third, mixing of children from different backgrounds is an important factor in the success of early years of interventions.⁴⁹
 6. There is a broad public expectation that at least a minimum set of early childhood services should be available to all children. Failure to acknowledge this could limit the broad appeal of early childhood investment and prevent it being funded.

However, not all of the evidence supports universal intervention, in particular if excessive levels of universal services are provided. There is a school of thought and some supporting evidence that excessive use of child care or preschool can bring about adverse outcomes for children and families.⁵⁰ Similarly, it is argued that a focus on universal service provision may lead policymakers into the traps of 'more is better' (the idea that high levels of stimulation will necessarily result in smarter children) and the 'critical periods fallacy' (where it is assumed that a door on learning will slam shut after the early childhood period).⁵¹ A 2007 measure of the impact of the UK early years reforms from 2000-2006 found little change so far, but emphasised the difficulty of measuring influences on the development of young children.⁵²

It should also be emphasised that children may already be receiving significant investment in their development because their families independently recognise the benefits and can afford to invest in them. Increased government funding may simply displace private investment, with no net improvement in outcomes. Consequently, it is important that universal services are designed to take this into account, including retaining the ability to charge co-payments to maximise the impact of public spending.

⁴⁷Olds, David L., John Eckenrode, Charles R. Henderson, Jr., et al. 'Long-Term Effects of Home Visitation on Maternal Life Course, Child Abuse and Neglect, and Children's Arrests: Fifteen Year Follow-Up of a Randomized Trial,' *Journal of the American Medical Association*, Vol. 278(8), 1997, pp. 637-643.

⁴⁸ Barnett, W. Steven, 'Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes,' *The Future of Children*, Vol. 5, Winter 1995, pp. 25-50.

⁴⁹ Kathy Sylva, et al. *The effective Provision of Preschool Education (EPPE) Project: Final Report*. Department of Education and Skills 2004.

⁵⁰ Susanna Loeb, Margaret Bridges, Daphna Bassok, Bruce Fuller, Russell W. Rumberger. How much is too much? The influence of preschool centers on children's social and cognitive development. *Economics of Education Review* 26 (2007) 52-66.

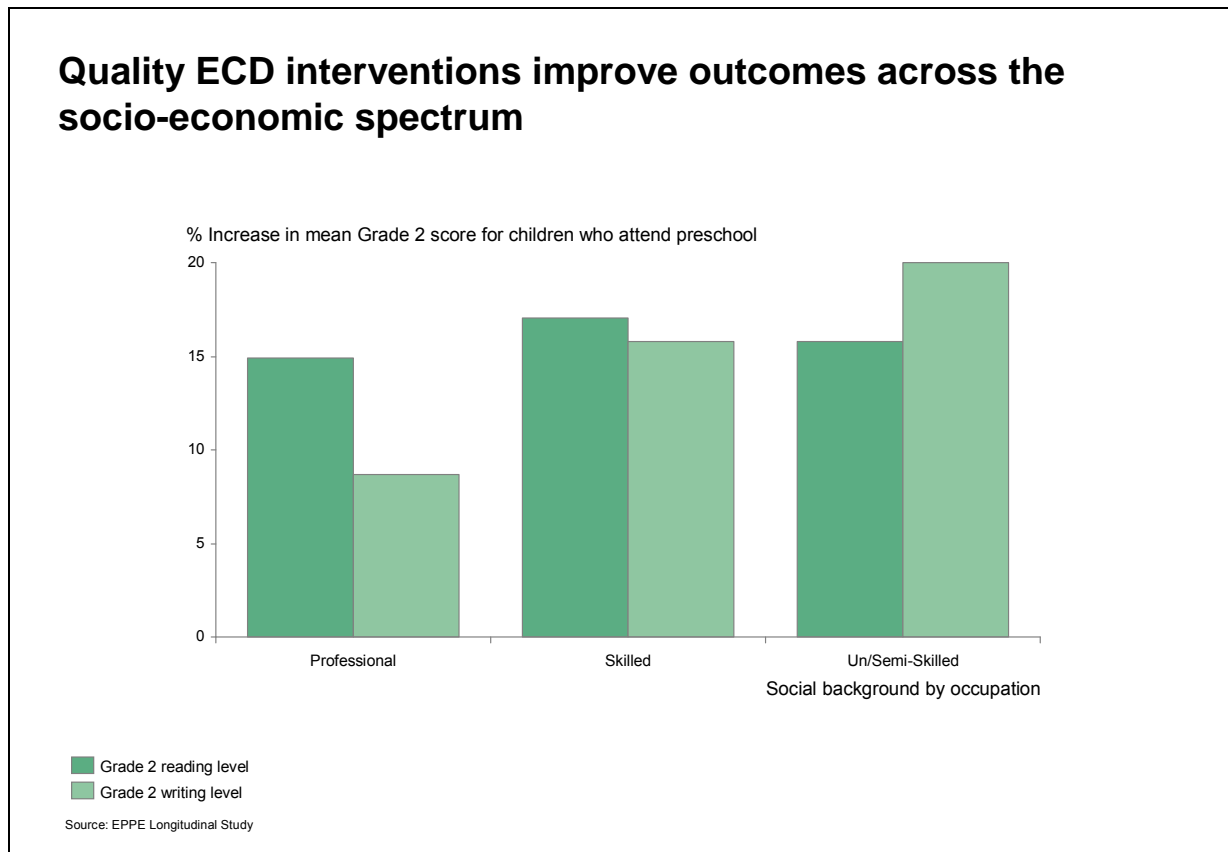
⁵¹ Sara Mead. "Million Dollar Babies: Why Infants Can't be Hardwired for Success". *Education Sector*. April 2007.

http://www.educationsector.org/usr_doc/Million_Dollar_Babies.pdf.

⁵² Merrell, Christine, Tymms, Peter and Jones, Paul. "Changes in Children's Cognitive Development at the Start of School in England 2000-2006". CEM Centre, Durham University 2007.

<http://www.cemcentre.org/documents/pips/Baseline%20Assessment%202001%20to%202006%20%20v03.pdf>.

Figure 17



The case for investment in intensive integrated early childhood services for vulnerable children is driven primarily by long term developmental and productivity benefits. Figure 18 demonstrates the results of the absence of external intervention: in this British longitudinal study of children from aged two to 10, poor-performing (at age two) well-off children did better by age six than initially high-performing but socially disadvantaged children.

The accumulated evidence from over 30 years of international research shows a significant positive return on investment during these early years for disadvantaged children. This is very much a long term proposition, however, and although the benefits are likely to be large, they will materialise much later than, say, immediate workforce participation increases. However, the scope for private investment of this type by less well-off families is limited by:

- Lack of affordable services
- Lack of information on the value of services
- Stigma around accessing support services
- Supply market failure in low-SES areas

The combination of strong evidence of effectiveness, with the constraints on private investment, creates the case for enhanced government investment in the early years for more vulnerable children. Further strengthening this case are the considerable benefits accrued not only to the individual child concerned, but also the broader society (Figure 19). A number of comprehensive reviews of the efficacy and economic return on early childhood investment have been undertaken recently, and support the case for investment in ECD as cost-beneficial in the long run.^{53,54}

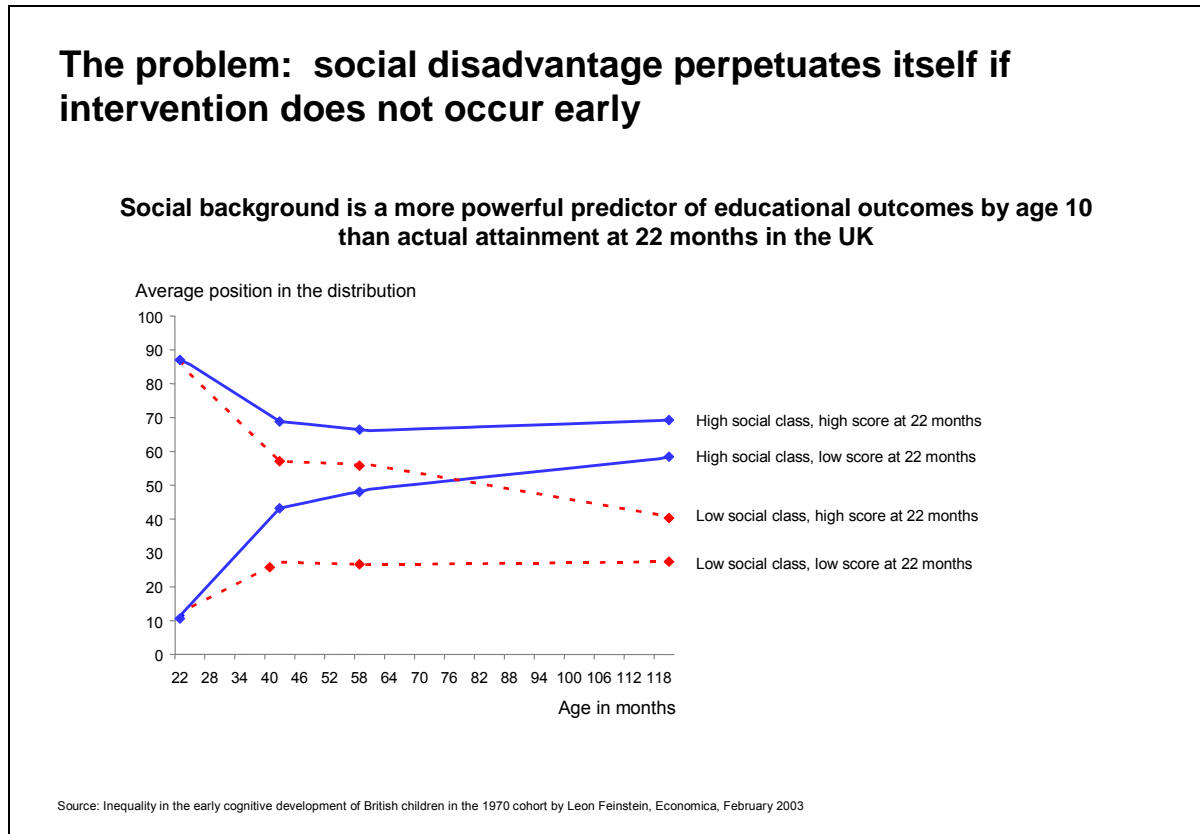
The evidence is also clear that a minimum threshold (of quantity and quality) is required to yield results, and watering this down risks not achieving anything (although the exact level of the threshold has not yet been

⁵³ Angela Hallam. *The Effectiveness of Interventions to Address Health Inequalities in the early years: a review of the relevant literature*. Scottish Government, Health Analytic Services Division, 2008.

⁵⁴ Scoggins, Amanda. *Health and Medical Research in Australia*. Observatory on Health Research Systems. RAND Corporation – Europe, 2008.

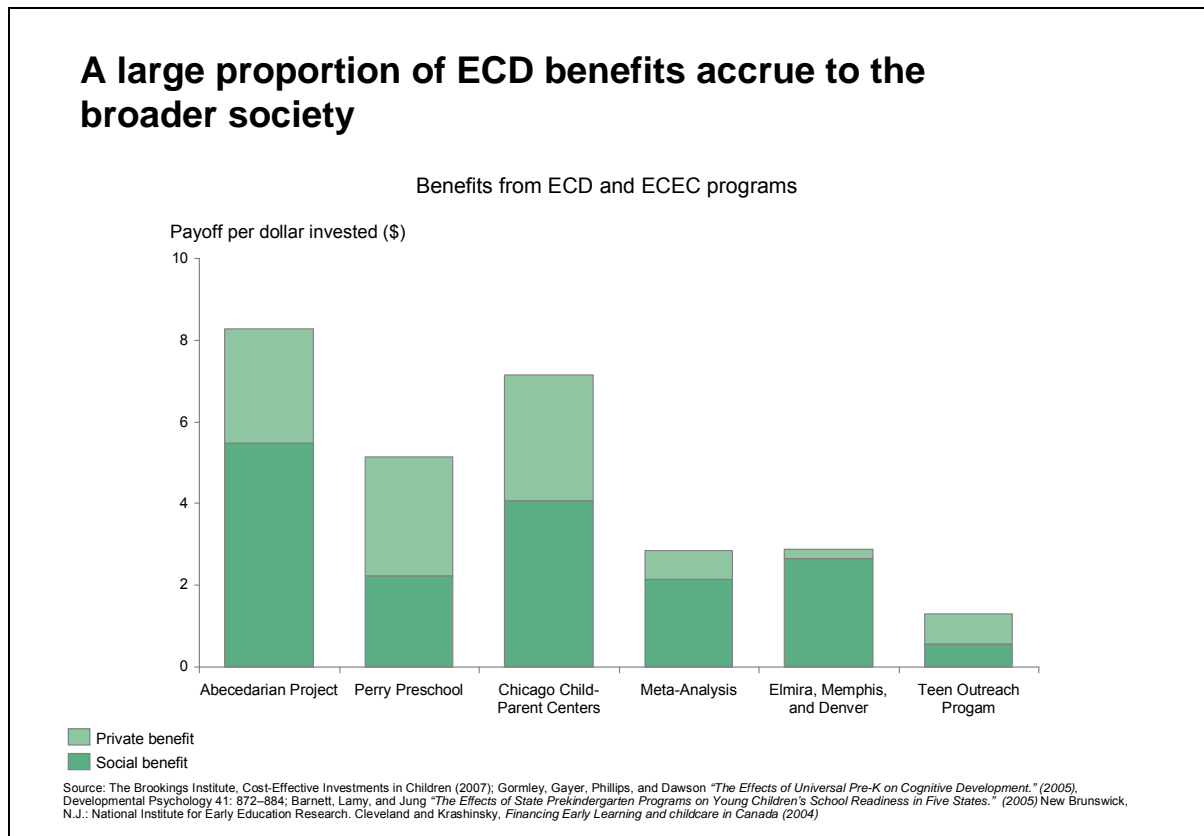
conclusively determined).⁵⁵ Therefore, if funding is in short supply, there is a case for more intensive spending on a small group of the most disadvantaged, rather than spreading efforts too thinly over a larger set of users. Finally, Government investment in disadvantaged children can be justified to achieve broader societal goals of fairness and mutual assistance, especially for those with the most severe problems (for example, for children with a profound disability) where no long term productivity gain is likely.

Figure 18



⁵⁵ Kathy Sylva, et al. *The effective Provision of Preschool Education (EPPE) Project: Final Report*. Department of Education and Skills 2004.

Figure 19



Appendix I: Scope of Early Childhood Development

In the context of this report, Early Childhood Development (ECD) has been interpreted as encompassing the full set of desired direct outcomes for children under six years of age, as well as the indirect effect of these outcomes on their families, communities and the broader economy. ECD also includes antenatal events and aspects of the transition of young children into primary school (including where this may occur at slightly older ages). This scope is depicted in the matrix in Figure 20.

Figure 20

ECD encompasses a comprehensive set of developmental outcomes for children aged from birth to 5 years

Outcomes		Ages								
		Antenatal	Months 0-1	Months 1-12	Age 1	Age 2	Age 3	Age 4	Age 5	Age 6-8
Child-specific	Physical health and well-being									
	Language, communication and cognitive development									
	Social and emotional development									
Family	Parenting capability									
	Economic security and family stability									
Community	Community connectedness									
Economy	Flexible workforce participation for parents									

1. The ages 6-8 category is included primarily to capture outcomes that relate to early childhood, but may be measured late. This includes situations where physical age is a poor indicator of developmental needs (eg, in disability) and developmental transitions.
Note: The term "parents" includes fathers, mothers, extended family and other legally responsible caregivers

This report adopts a child-centric approach to ECD, situated in the context of an ‘ecological’ perspective that recognises the impact of a child’s broader environment on his or her development. This report has defined seven outcome dimensions which together form a comprehensive picture of a child’s development situated in the context of his or her environments, from child-specific outcomes (physical health and well-being; language, communication and cognitive development; and social and emotional development), to those linked to family (parenting capacity; economic security and family stability), community (community connectedness) and the economy (requiring flexible workforce participation for parents, adequate maternity leave, etc).

Children may encounter a broad range of ECD services and programs as they grow from birth to school age. All children will make use of health services, from the hospital where they are born, to GPs, nurse active outreach and MCH centres where regular checkups, immunisation, and treatment of illnesses are delivered. Children with ongoing medical conditions or disabilities will experience the hospital system or visit a range of specialist providers.

Many children will also participate in early childhood education and care services, perhaps through child care if their parents are working, or through preschool in the year before formal school. The educational experience may be supplemented with intensive services for children with special needs. Families may also make use of various support services such as playgroups, family counselling and family functioning support, as the need arises. On top of these services, there are other ECD initiatives contributing to a child’s development, from neighbourhood safety programs to community engagement and provision of parenting information. All these programs are

available to and utilised by children in differing degrees, depending on family income, geographic location, cultural background, indigenous status, special developmental needs and other family circumstances.

Appendix II: Glossary

Access: A child is considered to have 'access' to a service when a place is available and neither distance nor cost present a barrier to attendance. This does not necessarily mean that the service is free

At risk: This report uses the term 'at risk' to refer to children who are vulnerable to poor developmental outcomes. This risk could be due to individual characteristics such as a disability or learning difficulty, or circumstances such as family violence, economic disadvantage, recent migrancy and so on. Children experiencing socio-economic disadvantage are also more likely to be considered 'at risk', although in this report they are most often specifically referred to as "disadvantaged". See also 'disadvantage', below.

Co-location: Services physically located on the same site are co-located.

Co-payment: Private contribution towards the cost of services that might be required of some service users.

Disability: This report refers to children with a disability as those with an ongoing physical or mental problem, including a profound disability, but excluding acute conditions that will be cured by treatment.

Disadvantage: This report uses the term 'disadvantage' to refer to low socio-economic status. Individual children and their families may be disadvantaged, or the locality in which they live may be considered disadvantaged due to the average income level of the locality. Other locality-based factors such as rural/remote status or lack of infrastructure are likely to coexist with socio-economic disadvantage, but are explicitly mentioned in this report where they are substantively differentiated. See also 'at risk', above.

Eligibility: Right to access a service.

Entitlement: Right to access a service with some level of public subsidy of the costs.

Families: Kin-based groups of adults and children. Families can also include non-kin carers of children, such as foster carers or a closely-knit indigenous community.

Family engagement: Deep involvement of family members in the services provided for their children.

Family Support Services: Services aimed at improving outcomes for children by helping families overcome potential or actual difficulties through active outreach, fathers' groups, and so on.

Integration (of services): Services linked together around the needs of the child, so that information and expertise are shared between collaborating practitioners. Clients should be able to move seamlessly between different services within the integrated package.

Location-based: Focused on the needs of people living in a specific geographic area.

Mixed market: A market in which, public, private and community sector organisations participate, potentially in partnership or in competition.

Outreach: Proactive identification and support of children and families, for example through processes such as visiting at home.

Quality (in the context of ECEC): Likely effectiveness of ECEC based on staff qualifications and experience, staff ratios, group size, degree of individual tailoring of curriculum and program.

Platform: An offering of services or programs.

Universal service: Service accessible to all Australian young children (see 'access' above)

Appendix III: Abbreviations

The following abbreviations have been used in this report.

AIFS	Australian Institute for Family Studies
AIHW	Australian Institute of Health and Welfare
AHCA	Australian Health Care Agreement
CCB	Child Care Benefit
CCTR	Child Care Tax Rebate
COAG	Council of Australian Governments
ECD	Early Childhood Development
ECEC	Early Childhood Education and Care
FTB	Family Tax Benefit
HILDA	Household Income and Labour Dynamics in Australia
LBW	Low Birth Weight
MCH	Maternal and Child Health
NHHRC	National Health and Hospital Reform Commission
NP	National Partnership (type of Commonwealth-State funding agreement)
OECD	Organisation for Economic Cooperation and Development
PAWG	Productivity Agenda Working Group (of COAG)
S&HT	Speech and Hearing Therapy
SES	Socio-economic status
SPP	Special Purpose Payment (type of Commonwealth-State funding agreement)