Health of Victorians
The Chief Health Officer's Bulletin

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Welcome to *Health of Victorians—The Chief Health Officer's Bulletin*. This is the first issue of a quarterly series focusing on the status and determinants of the health and wellbeing of the Victorian population. Peer-reviewed articles by leaders in their field present cutting-edge information to assist in strategic planning, policy development and service delivery. The aim of the bulletin is to raise awareness of the importance of improving public health in Victoria by communicating important issues to decision-makers, health professionals, the media and key stakeholders. The bulletin is available in both hard copy and electronic formats (see www.dhs.vic.gov.au/phd/chob). We welcome your feedback and any suggestions for future items (via michael.ackland@dhs.vic.gov.au).

FROM THE CHIEF HEALTH OFFICER

Investing in the Early Years

John Catford

The childhood shews the man, As morning shews the day

John Milton, 'Paradise Regained' (1671)

Children are at the centre of public health

From the beginnings of time we have known that early childhood experiences set the course for future wellbeing.[1] The origins of the public health movement 150 years ago were founded on the need to protect and promote the health of the young. But interest in early childhood both waxed and waned over the past century. There have been times of strong interest, such as with the development of infant welfare, nutrition, antenatal care, paediatric surveillance, immunisation, health education and school health services.[2] Yet, in many countries over the past few decades health policy—and certainly expenditure on health care—has focused more on the end of life than on the beginning.

Encouragingly, a renaissance of interest in the early years is now apparent around the world. This reflects both an expanding evidence base as well as a broader field of concern from other sectors. An increasing number of international studies have found that poor social and economic circumstances now present the greatest threat to children's growth and development, because the foundations of adult health are laid in prenatal life and early childhood.[3] Parental poverty can reduce prenatal and infant development by acting through poor or inappropriate nutrition and smoking.[4] Poor early growth is associated with reduced cardiovascular, respiratory, kidney and pancreatic functioning in adulthood, which increases the risk of heart and chest disease, renal failure and diabetes.

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

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Canadian research strengthens the case for action

A major study in Canada, undertaken for the Ontario Government by the Canadian Institute for Advanced Research, has strengthened the case for action.[5] The Early Years Study, subtitled ‘reversing the real brain drain’, examined the relationships between early brain development, child development and learning, behaviour and health at different stages of life. The 200-page report, citing more than 150 references, drew from the neurosciences, developmental psychology, social sciences, anthropology, epidemiology, and other disciplines. It presents powerful new evidence that the early years of development from conception to 6 years of age—particularly the first three years—set the base for competence and coping skills that will affect learning, behaviour and health throughout life. Early experiences and stimulating, positive interactions with adults and other children are far more important for brain development than previously realised.

The report’s conclusion was that ‘the period of early childhood development is equal to or, in some cases, greater in importance for the quality of the next generation than the periods that children and youth spend in school or post secondary education’.[5] The recommendations for enhancing the potential in the early years included establishing or developing:

- Early child development and parenting centres in communities, involving the public and private sectors
- Improved maternity/paternity leave benefits for parents
- Family-friendly workplaces
- Tax incentives for developing new centres in communities
- An integrated, independent outcome measure of human development
- A network for community information sharing.

British experience shows what can be done

The UK Government’s White Paper[6]—importantly, signed by the entire Cabinet—also emphasises the central role of early childhood. A new cross-Government program, Sure Start, has been established to provide support to parents and local communities, addressing their needs and making available the support they require to give their children the best possible start in life. It is targeted to areas of disadvantage, binding together existing services to enhance their performance in meeting the particular needs of young families. More than £4.5 million will be spent on 250 local programs in England, focusing on children aged under 4 years and their families. Sure Start works across the boundaries of government departments and is both multidisciplinary and multi-agency at community levels.

Health visitors (community health nurses) are an intrinsic part of this process and have been clearly designated as local public health practitioners. Their role is being modernised to develop a family-centred approach, working with individuals, families and communities to improve health and reduce health inequalities. School health nurses and midwives, who have a strengthened public health role, also make important contributions.

WHO is leading an international renaissance

At an international level, investment in early childhood has been further recognised by the World Health Organisation (WHO) Regional Office for Europe.[7] Health 21—the ‘health for all’ policy framework for the WHO European Region—sets an ambitious social policy agenda based on 21 aspirational health targets for the twenty-first century. These are not meant to be a prescriptive list, but they make up the essence of regional health policy. The targets provide a framework for action for the European region and an inspiration for actions tailored to country and local levels.

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

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

Australian plans are now well underway

In Australia the Attorney-General’s Department has undertaken an international review of early childhood programs as a means of preventing crime and other social problems.[8] A major conclusion of the review was that interventions, such as home visiting, family support and parenting education, can have a major impact on at-risk families and children to improve their quality of life and help prevent future offending. Such strategies were also found to be cost-effective compared with the long-term costs of crime and the criminal justice response.

There is now a growing commitment among States, Territories and the

Commonwealth to mount ambitious programs focusing on these early years, with support from the health, education, community and justice sectors. In Victoria, the Department of Human Services will lead a major initiative, Best Start, commencing 2001–02. This initiative will require the support and participation of a wide range of organisations, professional groups and the wider community.

As we begin to focus on early childhood more as a new area for public health investment, an opportunity exists to develop new measures of progress, in terms of both process and outcome. Tracking the progress and achievements of our strengthened child health strategies will be an important task for the next decade. Future issues of *Health of Victorians* will chart the challenges, responses and lessons learned.

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ANNOTATION

Harmful Drug Use in Victoria: It Is Our Problem

Rob Moodie

Levels of drug use and the impact on Victoria

Drug use in Victoria is increasing. The use of cannabis, hallucinogens, amphetamines, ecstasy, cocaine, heroin, and hazardous drinking has been on the rise since 1991. Reported cannabis use (in the previous 12 months) rose from 10 per cent in 1991 to 18.4 per cent in 1998. Similarly, heroin use rose from 0.3 per cent in 1991 to 1 per cent in 1998.[1]

The only exception to this rule is tobacco. Consumption and prevalence levels declined over the 1990s, with levels of 23 per cent and 18 per cent among men and women at the end of 1999[2] compared with 28 per cent and 24 per cent in 1992.[3] Despite this improvement smoking still remains the major preventable killer in Victoria and Australia.

But it has been the impacts of illicit drug use that have sparked successive waves of community concern. In Victoria deaths from overdose rose from 50 in 1991 to 359 in 1999. A heroin drought has led to a decrease of deaths from 126 during the first four months of 2000 to 17 in the same period in 2001.

During the past decade we also witnessed a rapid rise in the number of non-fatal overdoses, a decline in the age of initiation in heroin use, and the emergence of visible street markets associated with crime, street sex work, overdoses, and public nuisance.[4] Drug-related crimes are on the rise, despite the overall fall in the crime rate, and account for over 60 per cent of crimes against property.[4] Magistrates estimate that 80–90 per cent of the criminal cases appearing before them are related to illicit drugs.[5]

And what does the future hold for us? The Victorian Burden of Disease Study predicts that illicit drug use by 2016 will be the third largest cause of years of life lost among men.[6]

What determines harmful drug use?

The availability of a drug—its cost, its purity and the accessibility and regularity of its supply—is one of the important determinants of its use. The more we have been able to regulate the availability of tobacco, for example, the more successful we have been in decreasing its use, despite it being legal. On the other hand we have virtually no control of the illicit drug market; price, purity, accessibility and regularity of supply are all deter-