



Equity and Access to Services for Children with Language Difficulties: from Part Three - Impact, Intervention and Equity

Author

Reilly, Sheena, Law, James, Conway, Maya, Krahe, Michelle

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Equity and Access to Services for Children with Language Difficulties

Sheena Reilly, James Law, Maya Conway and Michelle Krahe

Introducing Key Concepts

The health and education sectors of nations are impacted by economic and demographic changes which together drive supply and demand. When health and education services are inequitably distributed and access is impacted, well-recognised disparities in health and educational outcomes emerge and these are directly related to inequalities in economic and social circumstances (Calder et al., 2019). The Commission on Social Determinants of Health (2008), established by the WHO, called for closing the health gap through improving conditions of daily life, tackling the inequitable distribution of wealth and resources, measuring the problem, evaluating actions and expanding the knowledge base.

This chapter explores the distribution of and access to health and education services for children with language difficulties. We first introduce some key concepts pertinent to health and well-being, before moving on to explore these in relation to child language difficulties. We then review the way in which services have been traditionally planned that is, aligned to the 'clinical' model in which individuals with a problem present to a 'place' such as a hospital, community health centre or clinic. If general health and education services are inequitably distributed and access is impacted, it is reasonable to predict that services for children with language difficulties might be similarly affected. One potential solution we propose is the place-based approach, attractive because it permits the location and distribution of services based on community need. We conclude by highlighting some key steps that need to be taken to ensure the design and delivery of services to meet the future needs of the population, and outline some of the challenges in adopting this approach.

In addressing equity and access to services for children with language difficulties, we introduce four concepts that are integral to this chapter.

(1) *The relationship between health and education and socio-economic position.* In 2010 Sir Michael Marmot captured the essence of this relationship in his review entitled *Fair Society, Healthy Lives* (Marmot, 2010):

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health.

(p. 3)

In ‘The Marmot Review 10 years on’ (Marmot et al., 2020), the authors lamented that inequalities were increasing and that the health of the population was declining. Further, the report highlighted that these poorer outcomes were ‘closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health’. Whilst the Marmot Reports focus on England, there is no doubt that these are global problems, as is clearly indicated in the 2019 report from the OECD (2019) *Health for Everyone?* which reported on a large set of 33 OECD and EU countries.

(2) *Care injustice.* There is a perverse relationship between healthcare utilisation and population needs, known as the inverse care law (Hart, 1971), which implies that those who most need care are least likely to receive it and, conversely, those who least need services use them more. Injustice exists when individuals with healthcare needs are not able to access service or the services available are of poor(er) quality. Multiple factors may drive care injustice including gender, race or ethnicity, education or income, disability and location (Braveman et al., 2011). Regarding location, the term ‘postcode lottery’ was coined to describe the relationship between the availability and accessibility of healthcare and where an individual resides (Graley et al., 2011). For example, the distribution of services is concentrated in middle- to high-income areas, and the services may also be of better quality due to superior infrastructure and equipment. This in turn promotes a more desirable working environment, thereby attracting more skilled and experienced staff, all of which results in better patient outcomes. Conversely, lower-income areas are found to have fewer services with less resources, which are often more difficult to access. This will be addressed later in this chapter.

(3) *Inequity and inequality* in health are two key concepts which are often confused but are not interchangeable. Inequity refers to unjust, preventable systematic differences in health status, whereas inequality is the uneven distribution of health or health resources across the population as a result of conditions in which we are born, live, grow and age (i.e., genetics, geography, education, housing, socio-economic factors). This uneven distribution of health may be unnecessary and avoidable as well as unjust and

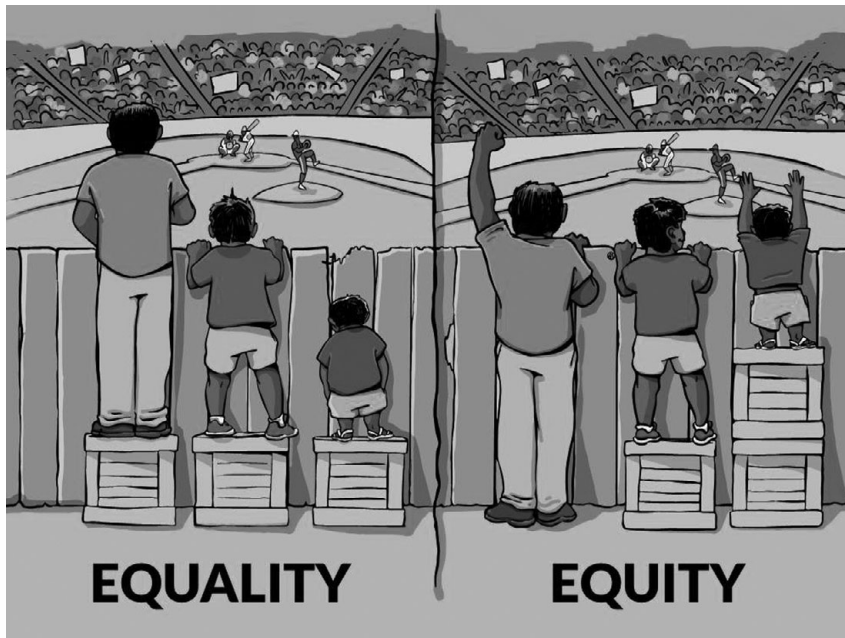


Figure 23.1 An illustration of equality and equity
(Interaction Institute for Social Change. Artist: Angus Maguire)

unfair, and hence the resulting health inequalities also lead to inequity of health. Put simply, equality is about sameness, whereas equity is about fairness (see Figure 23.1). However, Starfield (2011) argues that because fairness is not measurable it is not a useful term, and instead describes horizontal and vertical inequity to characterise what she terms hidden inequity in healthcare. Horizontal inequity is when people with the same needs do not get the same access to the same resources, whereas vertical inequity is when people with greater needs are not provided with greater resources. To achieve vertical equity, socially deprived populations with greater needs would need to have greater access to services, a concept that will be revisited later in this chapter.

(4) *Life-course approaches to health and development* acknowledge that earlier exposures to risk and protective factors can have later and long-term effects and that key life-stages present particular opportunities for positive change (Rashbrook, 2019). In the *Neurons to Neighbourhoods* consensus study report (National Research Council and Institute of Medicine, 2000), editors Shonkoff and Phillips elegantly argue that the early years matter because they are either a ‘sturdy or fragile stage on which subsequent development is constructed’. The authors go on to describe a ‘dramatically altered’ early childhood landscape at the start of the millennium, pointing to significant social and economic changes in the circumstances of many families and the challenges these present to the developing child. These include marked

changes in parental employment patterns, high levels of economic hardship, cultural diversity with significant disparities in health outcomes, variable quality of out-of-home childcare, and escalating levels of serious family problems and adverse community conditions. This is why Heckman (2007) argues that investing early in quality childhood development is critical in order to directly influence later social, economic, educational and health outcomes. This is particularly pertinent for disadvantaged and at-risk children, where families may be strained and have fewer resources available to invest in effective early child development. For these reasons, in this chapter, we focus primarily on the preschool years.

Drivers of Inequality and Inequity in Health

Having established that unnecessary and unfair differences in health and health outcomes within and between populations or social groups exist (McCartney et al., 2019), the next step is to ask why. On a global level, governance, economics, policy and international relations present the foundations for how societies are shaped, and ultimately dictate the social determinants of health for populations nationally and locally (CSDH, 2008). Countless factors, many of which are interrelated, influence the prevalence and form of health inequities within communities. These are described as predominantly relating to socio-economic status (SES) (Adler et al., 1994; Lago et al., 2018; Marmot, 2006), geographic location (Braubach & Fairburn, 2010), race or ethnicity (Ferraro et al., 2017) and education (Avendano et al., 2009; Baker et al., 2011; Feldman et al., 1989; Guralnik et al., 1993).

In terms of interrelatedness, education access and attainment directly influence occupation, income and SES (Baker et al., 2011), which in turn determine an individual's environment, the health risks they are exposed to and their ability to prevent illness or seek treatment when required (Australian Institute of Health and Welfare, 2016). Thus, education is widely acknowledged as a strong predictor of health status, and educational inequalities are known to result in health inequities. However, access to education is not a given for every population, and in areas where educational attainment levels are low, health outcomes may be poorer. For example, within Australia's Aboriginal and Torres Strait Islander population when self-reported health status was compared against socio-economic factors, individuals with lower educational attainment levels were less likely to report 'excellent' or 'very good' health than those with higher levels of educational attainment (AIHW, 2016). Further, education has been found to affect not only the health of the individual but also that of their family. Consequently, inequities in education have a widespread and inter-generational impact on the health of communities and populations (AIHW, 2016).

Access and Equity in Healthcare

There is debate about what constitutes ‘access’ to health services. Access has been measured in some evaluations by the potential to utilise services if required and the initiation of service use (Levesque et al., 2013). This type of evaluation considers the physical presence of services, their distribution in geographic areas and the adequacy of financial supports to facilitate participation. This is essentially the premise of the universal healthcare coverage provided by the National Health Service (NHS) system in the United Kingdom (UK) and the Medicare system in Australia. However, the concept of access does little to account for the quality of the services and the level of care delivered. In addressing the Australian Health services arrangements, Calder et al. (2019) suggested that the inequitable distribution of and access to services is threatening the very ideals of the Australian Medicare/Medibank system.

Quality is an important factor in health service provision, as it determines if any benefit is to be gained from attending the service or if patients will instead make little improvement, or worse, be harmed by unsafe or inappropriate care (Berwick et al., 2018). A comprehensive study of 195 countries and territories compared countries’ sociodemographic index (SDI) (an overall development measure accounting for income per capita, average years of education and total fertility rates) and healthcare access and quality index (HAQ) (a measure of the quality and accessibility of healthcare, based on causes of death which are preventable with effective medical care) and found that almost all countries demonstrated improved HAQ from 1990 to 2015 (Barber et al., 2017). Although associations between HAQ index scores and individual causes of death were evident based on region and level of development, inequalities in health service quality and access did not always correlate with a country’s financial position. Instead, numerous factors can determine access to high-quality primary care services even in areas where services physically exist, including the specific presenting health condition, flexibility of clinic hours and types of insurance providers accepted (Barber et al., 2017).

In 2018, the UK’s Care Quality Commission delivered an annual assessment of the quality of health and social care in England. Whilst the report stated the overall quality had been largely maintained, it was clear that ‘people’s experience of care varies depending on where they live; and that these experiences are often determined by how well different parts of local systems work together’ (Care Quality Commission, 2018). Some people can easily access good care, while others cannot access the services they need, experience ‘disjointed’ care, or only have access to providers with poor services. Deficits in the quality of healthcare services are responsible for health and economic burdens in both developed and developing settings.

So far in this chapter we have introduced four key concepts that underpin health and well-being and explored access and equity in health in general terms. Now we turn our focus to child language difficulties.

Access and Equity to Services for Children with Language Difficulties

In order to consider what is known about access and equity to services for children with language difficulties, we examined the published literature from the last 15 years and identified four relevant English language reviews: three from the UK and one from Australia. The UK reports, reviewing services for children and young people with speech, language and communication needs, included the *Bercow Report* (Bercow, 2008), followed by *Bercow: Ten years on* (Bercow, 2018) and the Children's Commissioner (2019) report entitled *We need to talk: Access to speech and language therapy*. In 2014, the Commonwealth of Australia launched a Senate Enquiry into the prevalence of speech, language and communication disorders and speech pathology services in Australia (Commonwealth of Australia, 2014). The enquiry was broad and concerned all aspects of speech and language provisions; parts of the report concerned access to services for children with language difficulties.

A common theme across both countries and the four reports was the wide variation in service delivery. *Bercow: Ten years on* (2018) revealed four positive changes in the context of a changing landscape and four negative changes, one of which was cuts to services resulting from austerity policies (a point also made by Marmot et al., 2020). The report drew attention to the need for accessible and equitable services for all children and families, concluding that the postcode lottery, described 10 years prior, remained, and stating 'the support you get depends on where you live or where you go to school' (p. 19). These findings were echoed in the Children's Commissioner (2019) *We need to talk* report, which revealed huge variations in government and local authority spending across different areas of the UK. Estimates suggest that, whilst the spend on speech and language services per child between the financial years 2016/17 and 2018/19 grew, this was not equitably spread across areas, with around 20 per cent experiencing a decrease in spending and a further 20 per cent seeing an increase. The Australian Senate enquiry identified an inadequate supply of speech-language therapy services to meet the current demand in Australia and identified numerous barriers to service access such as long waiting lists, long travelling distances to reach services from rural and remote areas where they are sparse, and the high costs associated with privately provided services (Commonwealth of Australia, 2014).

The barriers identified in these reports often overlap and may well be cumulative for some families. Taylor and colleagues (Chapter 10) raise this possibility, and demonstrate that children living in more advantaged circumstances, where families have access to human capital and material means, may be buffered from developmental constraints – whereas the opposite may be true for children in less advantaged environments. In other words, the inverse care law may operate and those with the greatest need do not have access.

Cost may be a significant service barrier. Access to speech-language therapy is not always free and may vary between private and public providers. Costs associated with attending therapy, such as transport or loss of potential income if a parent is required to take time away from work, may be prohibitive. Differing levels of financial support provided by government policy or health insurance companies exist to offset fees; many families experiencing disadvantage will not have access to private health insurance. Chapter 19 concludes that the costs of speech-language therapy services in Australia are high, with children living in less advantaged circumstances less likely to be able to afford services. The costs of services across the preschool and school years towards the management of language difficulties increase, and service access may reduce further.

Navigating complex systems with multiple providers is a known barrier (Calder et al., 2019). Australia has a mix of public and private providers. The Australian Medicare scheme was established to provide universal healthcare coverage for all Australians administered in accordance with a schedule of benefits that allows for out of hospital essential health services to be subsidised and accessed at little or no cost. For allied health services such as speech-language therapy, only limited Medicare subsidies are available (five sessions are subsidised per calendar year). This results in substantial out-of-pocket cost for families requiring continued assistance. Some preschool speech-language therapy services are publicly funded in Australia and can be accessed by families at little or no cost. These are usually associated with state-based community health systems, and the availability and provision of speech-language therapy services varies. The main challenge for families attempting to access these services can be availability; there may be long waiting lists of up to 12 months in some areas (Commonwealth of Australia, 2014; Ruggero et al., 2012). In the public education system, speech pathologists provide services at primary and secondary levels, with no out-of-pocket costs for families to access these services; however, there is limited capacity (Commonwealth of Australia, 2014). More recently the National Disability Insurance Scheme (NDIS) was established to provide funding for an estimated 500,000 Australians aged under 65 years who have permanent and significant disability. All Australian governments (Commonwealth, State and Territory) have committed to a unified, national approach recognising the need for greater collaboration and coordination (National Disability Insurance Agency, 2020), and under this scheme speech pathologists deliver a range of services, which are complemented by private health providers with reimbursement by private health insurance schemes.

There are, however, stark differences between metropolitan and rural and remote areas, where services can be sparse (McCormack & Verdon, 2015; Verdon et al., 2011) and families must travel long distances to find speech-language therapy support. The time away from work or loss of potential income can have considerable impact on access to services as

highlighted in Chapter 11 and previous research studies (O'Callaghan et al., 2005; Ruggero et al., 2012; Verdon et al., 2011).

In both the UK and Australia, governments are seeking solutions to address the challenges in ensuring equity, quality and access of speech-language therapy services (Children's Commissioner, 2019; Commonwealth of Australia, 2014). Solutions will be dependent on understanding how existing services have been planned, whether they align with need and what tools might exist to help with planning future services.

Planning Services for Children with Language Difficulties

The predominant system of healthcare service delivery for children with language difficulties is based on a traditional clinical model whereby children attend a service (such as a hospital, community health centre or clinic), are individually diagnosed, and receive therapeutic intervention to remediate their presenting difficulties (Law et al., 2013). However, as our understanding of the social context in which children's language develops and the social determinants of poorer language outcomes has evolved, there is a need to rethink not only how services are delivered, but where they are delivered from.

As illustrated earlier, areas with geographical or locational concentrations of disadvantage typically have limited access to services and facilities, employment, training and educational opportunities, and physical and social infrastructures (Crimeen et al., 2017). Substantial variations in the UK government's spending for speech-language therapy service provision has been identified, with rural areas generally receiving less funding per child than urban areas (Children's Commissioner, 2019). Importantly, the rate of spending was not associated with need; that is, lower spending was not because there were fewer children with identified needs. Similar disparities were identified in the Bercow Report (2008), which identified that services were not well distributed in areas of most need.

Understanding need is fundamental to planning and locating services where they are most essential. This requires surveillance tools that provide a profile of local, regional and national outcomes. One such tool is the Australian Early Development Census (AEDC) (see Chapter 10), a nationwide instrument used to capture child development markers across five domains (language and cognitive skills, communication, physical health and well-being, social competence, and emotional maturity) during the first year of primary school (Commonwealth of Australia, 2018). The most recent AEDC data indicate that one in five Australian children are developmentally vulnerable in one or more of these domains (Commonwealth of Australia, 2018). The data can be mapped by geographical region, thereby comparing child vulnerability on the indices with locational disadvantage.

In Australia the greater proportion of children considered at risk or vulnerable live in rural or remote areas, and the AEDC is being used to guide the provision or enhancement of services to the most vulnerable children in some of the most disadvantaged areas of the country. This includes metropolitan and rural and remote areas.

Australian studies have mapped the geographical location of speech-language therapy services against levels of community vulnerability (using the AEDC) and found service availability to differ markedly (McCormack & Verdon, 2015; Verdon et al., 2011). Reilly and colleagues (2016) explored the distribution of child speech-language therapy services in Melbourne, Australia and found that there were three times more privately provided services compared to public services for children aged 0–5 years and that these were predominantly located within the inner metropolitan areas. When service distribution was compared against population need (as measured by child vulnerability through AEDC data), it was evident that services were not located in the areas of most need; instead, services were clustered in more advantaged, inner-city areas. The authors conclude that inequalities may be exacerbated because of the evident inequity of access to services, and hypothesise that this may not be unique to Australian communities but replicated in other countries.

The evidence suggests that preschool services for children with language difficulties are not always located in geographical areas of greatest need. This indicates the need to improve equity and access for our more vulnerable populations of children. The challenge is how we achieve this and better support our most vulnerable children growing up in disadvantaged communities.

Place-based Approaches to Reducing Inequalities in Childhood

Whilst there is agreement about the value of, and drivers for, place-based approaches to reducing inequalities, there is no single, agreed definition, which in part may be because communities or places can be defined in different ways. In this chapter we adopt a working definition from the Scottish Government Working Group on Place-based Approaches (Bynner, 2016) and outline key features of place-based initiatives. The definition is as follows:

A community of people bound together because of where they live, work or spend a considerable proportion of their time, come together to make changes to that place which they believe will improve the physical, social or economic environment and in doing so tackle issues of inequality.

(Bynner, 2016)

Key features of place-based approaches can be summarised as follows:

- recognition that a diverse range of community organisations (and people within these) hold knowledge about health inequalities and seek to identify local resources, capability and capacity (Klein, 2004)
- long-term, collaborative efforts that guide systemic change and contribute to a cycle of learning about investment and impact (Griggs et al., 2008)
- a common purpose that aims to form a collective understanding of the complex factors that underpin health inequalities and provide a framework and tools to reduce health inequalities (Public Health England, 2019)
- a set of drivers including: (i) delivery of higher-quality services that are responsive to the community's needs; (ii) improving the coordination and integration of services; (iii) shifting resources to the front line where they are most needed and (iv) innovation resulting in new preventative measures and performance
- strong collaborative leadership, shared governance and access to data in order to agreed local priorities and solutions.

Some argue there is a strong evidence base for place-based initiatives, showing that connecting and integrating services that are planned and delivered in defined sociogeographical areas improves outcomes for high-risk families (Moore & Fry, 2011). Others have questioned this notion, pointing out that a major challenge is in the setting of realistic and achievable outcomes and goals and not over-estimating what place-based approaches can achieve, the latter being a fundamental principle (Bynner, 2016).

We now turn to consider place-based approaches within the context of child language difficulties. A reasonable question at this stage might be to ask: what evidence underpins the adoption of place-based approaches for children who have difficulty learning language? The simple answer is very little, because place-based approaches are not singular interventions that can be measured at the end point of a process such as a trial. Rather, a place-based approach is a means to an end. Sometimes this is described as a platform or a mechanism by which actions can be taken to deliver prevention and intervention programs where they are most needed, which is why this is an attractive approach for communities with entrenched disadvantage. Place-based approaches do not tend to focus on a single domain such as language development; instead, they are designed to provide the broad support that many children and their families require, including activating enablers and removing barriers to access (see the Sure Start example in Table 23.1). Embedded within this approach may be support of the child's communication needs.

The rationale for embedding child language services within a place-based approach moves from broad developmental concepts to those that are specific to child language:

- *Broad issues.* Growing up in a poor neighbourhood negatively affects children's outcomes over and above the effects of family SES (Barnes et al., 2006). Therefore, place matters for children (Moore & Fry, 2011) because their development and well-being is affected by their neighbourhood, their daily experience in their environment and the opportunities it presents for healthy living (Meltzer et al., 2007).
- *Specific issues.* Poorer language outcomes are evident in children growing up in areas or locations with higher levels of disadvantage. These disparities in language development are evident even in the first 2 years of life (Fernald et al., 2013), and they appear to be well established by the time children enter formal schooling (Law et al., 2017; Reilly et al., 2010). Families living in disadvantaged areas often have fewer resources (i.e., human capital and material resources) to attend to early child development and to access help and services when required. Further, there are barriers that limit those with the greatest need from accessing services, including the fact that areas or locations with higher rates of disadvantage sometimes have fewer services.

We conclude this section by asking if it is fair that the support provided for children with language difficulties depends on where they live or where they go to school. If place matters, as the evidence suggests, then there may be benefits to embedding child language services in existing holistic place-based approaches designed to respond to the child's needs and, where necessary, embedded within a framework that also addresses the family's needs. In Table 23.1 we highlight three examples of place-based approaches that have been rigorously evaluated. The first two examples focus on child development broadly, including child language development, whereas the final example focuses on the evaluation of a specific child language initiative within a broader program designed to enhance child development.

Planning for Child Language Services: Meeting Need, Improving Availability and Accessibility

We commenced this chapter by discussing the inequitable distribution of and access to health and education services and the resulting disparities in health and educational outcomes. We highlighted the social gradient observed in child language outcomes and the mismatch between need and the accessibility and availability of child language services for children living in disadvantaged areas. We acknowledge that there are a growing number of initiatives (Logan Together, 2019; Royal College of Speech and Language Therapists, 2016) being developed to address these problems; however, reports from both the UK and Australia suggest that services remain largely organised around a traditional model where they are not

Table 23.1 *Place-based approaches to enhance child development, including child language outcomes*

Place-based approach	Primary goal	Target population	Outcome/update
<p>Sure Start Local Programs (SSLPs) Year commenced: 1999 Delivered by: National Health Service Location: UK Description: Area-based interventions to improve services for young children and their families in deprived communities, promote health and development, and reduce inequalities.</p>	<p>To enhance the life opportunities for young children growing up in disadvantaged neighbourhoods who were at risk of performing poorly at school, experiencing trouble with peers and authority figures, and ultimately facing compromised life chances</p>	<p>All children under 5 years of age and their families living in a prescribed area being the 'target' of the intervention</p>	<p>The National Evaluation impact study followed over 5,000 children and their families in 150 SSLP areas, who were initially recruited when the children were 9 months old and followed up at 3, 5 and 7 years of age (Melhuish et al., 2010). The SSLPs had some beneficial effects on family functioning and well-being that persisted until the children were 7 years of age. However, the modest benefits for children that were previously present at 3 and 5 years of age (e.g., higher levels of self-regulation and better physical health) were no longer present at 7 years of age.</p>
<p>Communities for Children Year commenced: 2015 Delivered by: Australian Government, Department of Social Services Location: Australia Description: Facilitates a whole-of-community approach to support early childhood development and wellbeing with a focus on children from birth to 18 years, and can include children up to 18 years and their families.</p>	<p>To improve the health and well-being of families and the development of young children, from before birth through to age 12 years and to create strong child-friendly communities that understand the importance of children and apply this capacity to maximise the health, well-being and early development of young children at the local level</p>	<p>Supports early childhood development and wellbeing of children and their families, by facilitating a whole-of-community approach. As a result, this may produce wide benefits for whole communities, in addition to children and families.</p>	<p>There are currently 52 disadvantaged Communities for Children services across Australia. A key local non-government 'facilitating partner' organisation in each site acts as broker in engaging smaller local organisations to deliver a range of activities in their communities. An evaluation of the early impacts of the program on child, family and community outcomes (Muir et al., 2010) found evidence of positive impacts including:</p> <ul style="list-style-type: none"> • fewer children were living in a jobless household • parents reported less hostile or harsh parenting practices • parents considered themselves to be more effective in their roles as parents • higher levels of receptive vocabulary and verbal ability among children of mothers with Year 10 education or less.

Families as First Teachers (FaFT)

Year commenced: 2009

Delivered by: Office of Children and Families, Northern Territory Government, Australia

Location: Remote Indigenous communities in the Northern Territory, Australia

Description: An early learning and family support program delivered exclusively for Aboriginal and Torres Strait Islander families with children from birth to school age. The Abecedarian teaching and learning strategies were adapted for cultural appropriateness and delivered to groups of Indigenous children living in remote areas who were attending playgroup and preschool.

To formally assess the level of dosage for Conversational Reading and Learning Games received in the FaFT playgroups by young Aboriginal children and the impact of that dosage on language and early learning outcomes

All eligible children from the two participating communities; average age 37.8 months (SD = 6.2), ranging from 18.6 to 58.3 months

The implementation through early childhood playgroups was positively associated with Aboriginal children's language and other developmental outcomes (Page et al., 2019). The degree of exposure to Conversational Reading and Learning Games predicted stronger language and overall outcomes for young children.

necessarily located nor concentrated in areas of greatest need. The design and delivery of services occur in an increasingly dynamic environment with ever-changing community expectations, government priorities and technological advances. In this context, it is essential that child language services are well planned and have the capability to respond to evolving changes in order to meet needs. Thus, there is an urgent need to re-examine how we ensure services are available to our most vulnerable children. We are not suggesting that all services for children need to be reorganised, but that it is timely to consider how we can lay the foundation for equitable access to services and thereby improve population language outcomes.

Principles to Guide Service Design and Planning

What principles should guide this reorganisation? In Figure 23.2 we attempt to capture these and propose a way forward. The steps align in part with the recommendations made in the *Bercow: Ten years on* report (Bercow, 2018), including: the use of tools to provide local areas with data on the estimated number of children with language needs in their local population (see recommendation 3.1); the utilisation of available data to inform community vulnerability (see recommendation 3.2); and working collaboratively with stakeholders to determine and meet these needs (a key principle of place-based approaches). The six steps in our proposal are suggested as a precursor to consider when planning/relocating services to places that meet the needs of the population.

Step one, 'know your population', is of critical importance. Understanding language from a population perspective, their health status, and the services they access: this has been a key theme in this book, but what does it mean in the context of planning services? Put simply, speech and language therapists who have intimate knowledge of the target population, and the (in)adequacy of existing services to support needs, must do more than manage the wait-list that presents to any single clinic – because it is certain that these children and families are just the tip of the iceberg. Further, speech and language therapists cannot tackle this alone, particularly in the context of broader place-based initiatives. 'Knowing your population' also means understanding the birth rate, community demographics (acknowledging these can change), the degree of child developmental vulnerability in the location and the current vs future availability of services. If a preventative model forms the basis of a public health approach to child language, then the analysis of population demographics, including the social and environmental determinants of language outcomes, is essential. If we know where our most vulnerable children reside, then placing services where they are most needed makes sense; a place-based approach goes some way to addressing this.

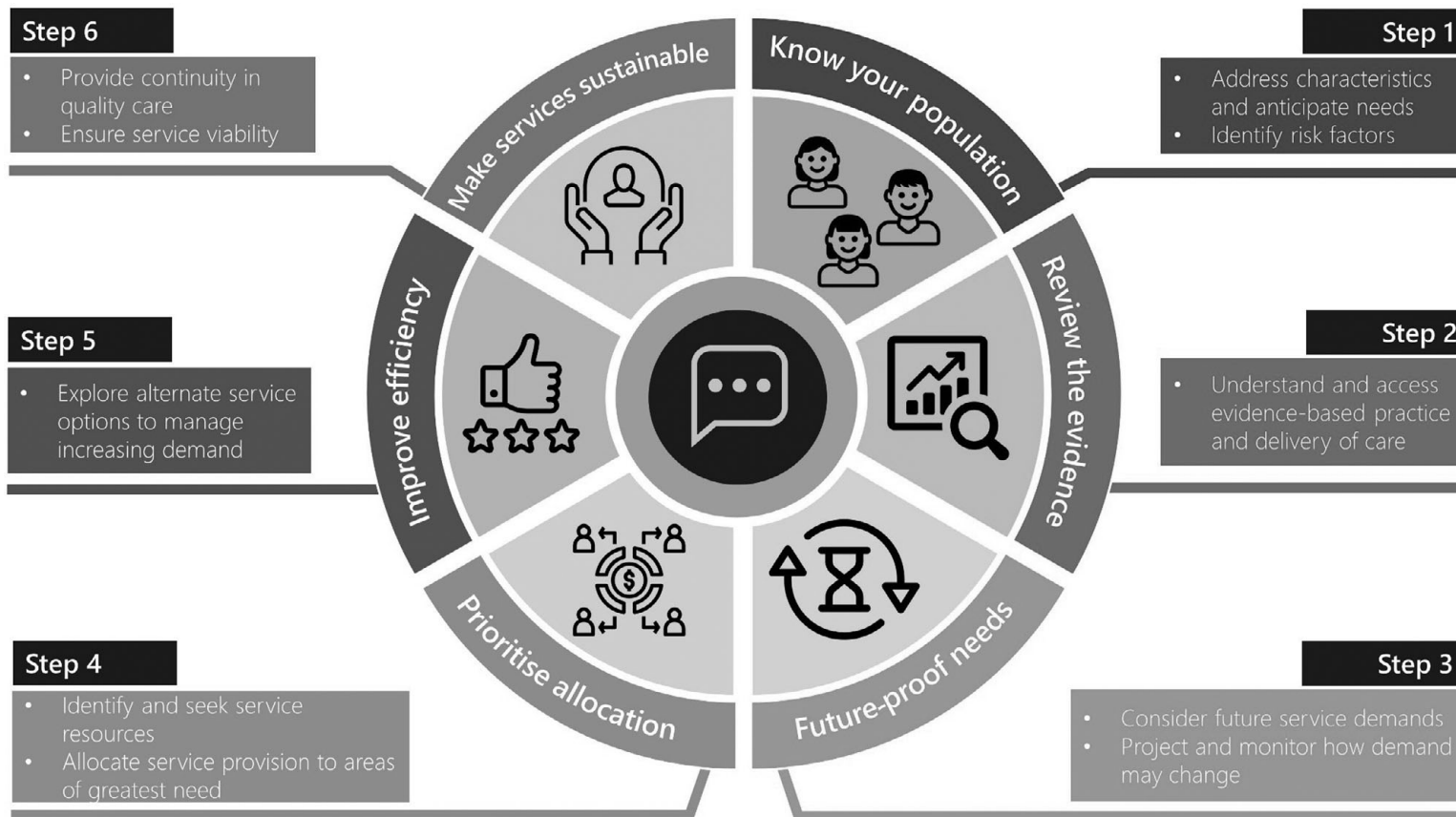


Figure 23.2 Planning for the delivery of speech-language therapy services to meet the future needs of the population

Step two emphasises the need to ‘review the evidence’, which will be recognised by all speech and language therapists who are well versed in accessing and appraising the literature for the best evidence. The purpose of this is to understand not only the best clinical evidence, but also information about the population, their health status and the services they access. For example, a comprehensive profiling of speech-language services within the broader place-based approach, such as the environment, the population, geographical context, health status, service arrangement and activity, will ensure that all relevant evidence informs the development of strategies and planning activities.

Step three, ‘future-proof needs’, builds on the findings from steps one and two and concerns the gap between services currently provided and what will be required in the future to improve the health status of the target population. It is important to consider the evidence to substantiate unmet needs, factoring for population growth, health issues, service networks and partnerships. For example, the demographics of areas can change in relatively short periods; some areas can quickly become gentrified and others change as economic pressures shift locally and globally.

Step four concerns ‘prioritising resource allocation’ to guide future services solutions. Place-based approaches are often jointly created, and a key premise is the identification of local resources, capability and capacity, as well as the validation of need, government direction, urgency and feasibility. Whilst we acknowledge that service delivery often occurs within a resource-constrained system, consideration should be given to ensuring they are distributed equitably. Addressing inequities may require prevention/intervention to be delivered with greater intensity in line with the level of social need (Marmot, 2010), where expenditure is influenced by social gradient, deployed in a time-sensitive manner and sustained in early childhood (Heckman, 2007).

Step five explores ‘improving efficiency’ through alternate service options to manage, optimise and direct demand. The prioritisation completed in step four will provide a platform for determining this direction by aligning service delivery with changing patterns of need. The third example in Table 23.1 illustrates how a broader approach aimed at improving developmental outcomes also achieved strong language outcomes via specific approaches. These outcomes were probably not achievable without this place-based approach, which required coordination and integration across service providers and local community stakeholders.

Step six addresses the need to provide continuity in the quality of care and ensure long-term service viability, such that ‘services are sustainable’. They must be capable of sustaining the provision of high-quality care and adapt to changing elements. Both these steps depend on a cycle in which place-based measures of language vulnerability are regularly collected and outcomes are measured.

Challenges of Measuring Effectiveness of Place-based Approaches

Place-based approaches are often regarded as challenging to evaluate because they deal with complex issues over a longer-term period than traditional ‘interventions’ and with a broad range of stakeholders. The first challenge is in determining what the outcomes might have been in the absence of the initiative and requires an assumption that the outcomes would have been the same. Thus, the baseline in terms of child development, or specifically child language, would be the relevant available measure(s). In Australian communities this might commence with the population snapshot obtained by the AEDC, and in the UK the National Child Measurement Programme, both of which would be supplemented by specific language outcome measures of interest. However, demonstrating the effectiveness of place-based approaches also includes measurement of a range of broader concepts that relate to the features outlined earlier. For example, data on the number and type of services being provided, the coordination and co-operation between services as well as the number of broad demographic and family characteristics are usually included.

Conclusion

In summary, what we have suggested in this chapter is not straightforward. In the opening pages we emphasised that the early years matter and in Shonkoff’s words they are either a ‘sturdy or fragile state’ (National Research Council and Institute of Medicine, 2000) on which the child’s development is built. We refer to the ‘postcode lottery’, a situation that arises when service availability is directly related to where one resides, and to services being less accessible for those living in the areas of greatest disadvantage. We have argued and demonstrated that access to services for children with language difficulties is not equitably distributed and that disparities in health and educational outcomes will continue to be greater for children with language difficulties living in disadvantaged circumstances. We propose it is timely to rethink not only the location of services and their alignment with areas of greatest need in the community, but also the framework within which they are delivered to our most disadvantaged communities.

Place-based approaches are appealing because they locate resources where they are most needed, involve consultation with communities and incorporate an agile cycle of integrated learning to ensure they continue to meet the needs of the community. If we accept that there is inequity for children with language difficulties defined by social, economic, geographic and demographic factors that limit access to services, then some disruption to current service provision is surely warranted.

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