



Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Integrated early years systems

**A review of international
evidence**

Chris Pascal, Tony Bertram and Kathryn Peckham
January 2019



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Summary

- This report provides an overview of available international evidence on integrated early years systems. It analyses the early years systems in **Belgium, Denmark, Estonia and the Netherlands** and explores the means by which system change has been achieved.
- Most countries are in the process of creating their integrated early years system, **with no one country having ‘arrived’** and so offering a complete transferable model;
- The review indicates that there is no one country that can offer a fully functioning model of an integrated system that can be replicated in Wales, but **aspects of system development and structural features** drawn from a range of countries in this review **can usefully inform** the development of an integrated early years system in Wales;
- There are various models and levels of integration, from a fully unified or integrated model, to more loosely coupled models, but **a hybrid of approaches** may be pragmatic and workable in the short and medium term;
- **Clarity of vision, sustained government commitment and system leadership** at central and local level are key to the change process, which will take time (more than one parliamentary term to embed) and maybe legislation to achieve;
- The process of change requires **funding and resources** to be used as a lever to incentivise integrated working, even when no additional funding is available;
- Most countries begin the change process with a **targeted programme** or initiative from which **learning can be generated** before wider roll out of the change system-wide;
- The **biggest challenge** is to join up early education, care and family support systems (which seem to be easier to fully integrate) with the health system, especially when there is disconnection between the health services that offer support at different stages in a child’s life (e.g., post-natal to school age);
- Creating an integrated system of early education, health and social care services is **an aspiration that is shared by governments** in many countries. All the evidence provided here should be considered in relation to the specific priorities and goals across Wales; that said, all such programmes of system change require **government commitment, clarity of vision, leadership, time and smart funding** to be successful.

Introduction

The Welsh Government is developing its system of delivering services for children in the early years, which is defined in Wales as from conception to seven years, and is considering all relevant services as within scope for this development. It is looking at international evidence on early years systems that have similar policy challenges, or have already developed an integrated early years system, from which it can learn. To support this work, the Wales Centre for Public Policy commissioned CREC to complete a focused evidence review. This builds on and extends policy comparison work already completed by CREC for various international bodies and the UK Department for Education, which documented and analysed international comparisons between preschool systems in 45 countries. This report has two key aims:

- To review cases of a specified number of countries or regions similar to Wales which have ‘integrated early years systems’, and to explore systemically what has worked and what hasn’t given different policy aims, whilst highlighting the policy choices and trade-offs inherent in the systems they have in place;
- To describe how transformations have been achieved in system delivery towards integrated system delivery models and enhanced access to these integrated services.

The policy context

‘Early years’ is one of five cross-cutting priorities named in the Welsh Government’s national strategy *Prosperity for All* (Welsh Government, 2017). Currently, a wide array of different agencies, bodies, and programmes are involved in early years, including Flying Start, Families First, Healthy Child Wales Programme, and the Children and Youth Support Fund, to name but some. *Prosperity for All* sets out the following:

“We want children from all backgrounds to have the best start in life. Our aim is that everyone will have the opportunity to reach their full potential and lead a healthy, prosperous and fulfilling life, enabling them to participate fully in their communities and contribute to the future economic success of Wales.” (Welsh Government, 2017)

The government also acknowledges that significant gaps in educational performance remain, with ‘*persistent under-achievement by those from more deprived and disadvantaged backgrounds*’ (Welsh Government, 2017, p.23). The strategy sets out the ambition of tackling inequality, investing in early years, prevention and tackling problems early:

- There has to be a “*more joined-up, responsive system that puts the unique needs of each child at its heart*”;

- The early years' provision in **the new curriculum** must build strong key skills, and embed health awareness, well-being and resilience in children from an early stage;
- There must be consistent **regulation and delivery** of pre-school provision;
- Extended, coherent **support for parenting** will be delivered, drawing together family support programmes, and focused on positive parenting and early intervention;
- Working parents of three and four year olds will be provided with 30 hours of **free education and childcare** for up to 48 weeks a year;
- Children First areas will be piloted, to support the **better integration** of services.

(Welsh Government, 2017, p.23)

Outline of our approach

This review was undertaken in two parts. First, we identified relevant reviews and existing data sets and, in partnership with colleagues within Welsh Government and the Wales Centre for Public Policy, identified a long list of ten countries with social, geographical or political similarities to Wales. We drew together brief profiles of these ten countries (which we have called the 'phase one analysis') and selected four countries to interrogate in detail as the core case studies for this report ('phase two analysis'). These are: Belgium, Denmark, Estonia, and the Netherlands. A detailed account of the selection process and selection criteria is provided in the Technical Annex.

Alongside broader literature, the review drew particularly on five international comparative studies of early childhood health, care and education systems:

- Economist Intelligence Unit (EIU) (2012). **Starting Well: Benchmarking Early Education Across the World**. Economist Intelligence Unit: Hong Kong;
- Pascal C., Bertram T., Delaney S., and Nelson C. (2012). **A Comparison of International Childcare Systems: Evidence to Childcare Commission**. London: Department for Education;
- Pascal C. and Bertram T. (2016). **Early Childhood Policies and Systems in Eight Countries: Findings from IEA's Early Childhood Education Study**, The International Association for the Evaluation of Educational Achievement: Hamburg;
- Cullen A., McDaid, D., Wynne R., Matosevic T. and Park, A. (2017). **A wide-angle international review of evidence and developments in mental health policy and practice. Evidence review to inform the parameters for a refresh of A Vision for Change**. Department of Health, Dublin, Ireland;
- Wolfe I. (Ed.) (2014). **European Child Health Services and Systems: Lessons Without Borders**, McGraw Hill Education, UK.

Approaches to integration

When exploring the available evidence on integrated early years systems from countries comparable to Wales, it is important to clarify what is meant by 'integration', what constitutes an 'integrated early years system', and how system change occurs.

What is an integrated system?

The term 'integrated system' is generally used to describe a network of services working together within one system, and is often viewed as a means of improving effectiveness while reducing public costs. In relation to early years, integration primarily concerns a coordinated policy for children under which different sectors such as social welfare, health, education and employment services work together in integrated networks. The evidence indicates that an integrated system can have a number of drivers (Milotay, 2018):

- Simplifying complexity of governance;
- Increasing economic efficiency;
- Efficiency around shared priorities;
- Better quality and outcome.

However, there are also some key challenges to achieving this goal including identifying target groups without stigma, financing the new system, incorporating competition between interests and services, navigating multi-level governance, and changing the structures of existing welfare states (Milotay, 2018).

What constitutes an integrated early years system?

The key structural elements of an integrated early childhood system were identified in a 2010 UNESCO report, 'Caring and Learning Together' and included seven dimensions of service delivery across health, education and social welfare: policy, regulation, curriculum, access, funding, type of provision and workforce, with all seven working cohesively to create a fully integrated system (Kaga, Bennett and Moss, 2010). The authors also argued that a focus on structural dimensions is insufficient, and that full integration also demands conceptual integration, which means thinking and talking about early childhood services in terms other than the care/education/health divide, so that each element is seen as indivisible from the other. It can thus be useful to think of system integration in terms of both conceptual integration (i.e. how we *think about* services in relation to needs), and structural integration (i.e. how we *organise* services) (Bennett and Kaga, 2010).

Furthermore, integration can be vertical or horizontal (Milotay, 2018). When exploring experiences in different countries we therefore need to examine:

- How far the services are integrated vertically (structurally and conceptually), as the child and family develop different needs at each age and stage;
- How far the range of services required to meet these needs at each age and stage are working together horizontally to ensure seamless service experiences.

The extent of integration within a system can be viewed as a continuum, moving from limited to deeper integration (Pascal et al, 2002; Milotay, 2018). In the evaluation of the UK Department for Education's Early Excellence Centre Programme, three models of integration were identified which exemplify degrees of integration in service delivery: a 'unified model', a 'coordinated model' and a 'coalition model' (Bertram and Pascal, 2000). It should be noted that these are not always discrete models. In practice, some systems may have a dominant integration model but, for some smaller part of their services, adopt other forms of integration- for example, a unified education and care service, with a health service coalition (Pascal et al, 2002).

- A **unified model** of service delivery has amalgamated management, training and staffing structures for all its services, which may be delivered by different sectors (e.g., public, private, or third sector) but they are closely united in their operation. An example would be a centre operating out of one site and offering fully integrated early education, child care, social care, family support, adult education and health services organised under one cohesive management structure;
- A **coordinated model** of service delivery has the management, training and staffing structures for all services synchronised, so that they work in harmony but remain individually distinct. An example would be a centre operating out of one site, comprising a relocated nursery school and day care centre working collaboratively with health professionals and social care workers, coordinated by a senior management team with equal status for their respective fields of expertise;
- A **coalition model** of service delivery has the management, training and staffing structures of the various services working in partnership. There is an association and alliance of the various services but they operate discretely. An example would be a network of providers of early education and care within a local area cooperating together and with others, such as a social care centre and a health centre, linked by an appointed network facilitator (Bertram and Pascal, 2000; Bertram et al, 2002).

All of these models can represent joined-up thinking in service delivery to families and children, but they differ in the degree of structural integration. The evidence from these UK studies (Bertram and Pascal, 2000; Pascal et al, 2002) suggests that the process of integration might thus involve a developmental journey which begins with coalition and then moves through coordination to a more fully integrated model of service delivery. However, local circumstances may mean that any of these models might be optimal. Integration is therefore best viewed as a continuum with a range of dimensions and possibilities.

How does system change occur?

For the purposes of this review we have used Kotter's (2012) three-stage model of change as it provides a useful stepped approach to the actions that are required to progress a change in organisational practice or culture. Kotter sets out three stages which he argues are important to consider when initiating any organisational change:

Stage 1: Creating a climate for change

- **Create Urgency.** For change to happen there is a need to develop a sense of urgency, to help spark the initial motivation to get things moving. It requires opening an honest and convincing dialogue about what's happening and why change is necessary.
- **Form a powerful coalition.** Convincing people that change is necessary often takes strong leadership and visible support. Change must be led by effective change leaders throughout the organisation.
- **Create a vision for change.** A clear vision helps everyone understand what you are trying to achieve; shifts in practice then tend to make more sense.

Stage 2: Engaging and enabling the organisation

- **Communicate the vision.** The vision needs to be communicated frequently and powerfully, and embedded within everything that the organisation does. The vision needs to be referred to daily in decision-making.
- **Remove obstacles.** If the vision is highly visible has buy-in from all levels of the organisation then staff will want to achieve the benefits and so remove obstacles to implementation.
- **Create short-term wins. Nothing motivates more than success so some quick wins should** be celebrated so all can see the benefits of the changes. This means creating a trajectory of targets – not just one long-term goal, with each smaller target achievable.

Stage 3: Implementing and sustaining

- **Build on the change.** Kotter argues that many change projects fail because victory is declared too early. Real change runs deep so quick wins are only the beginning, and there should be ongoing attention to the required improvements.
- **Anchor the changes in organisational culture.** Finally, to make any change stick, it should become part of the core of the organisation. There should be continuous efforts to ensure that the change is seen in every aspect of the organisation.

Adapted from Kotter (2012).

The evidence from a formative review by Bennett and Kaga (2010) indicates that key factors in system change in early years services specifically are:

- Leadership, alliances with the major stakeholders and advocacy based on strong arguments in order to initiate reform;
- Action at all levels of government to embed change deep into the system, along with the consensual formulation of strong and integrative concepts on which to build substantive reform;
- A strategy is necessary to achieve change in practice, which will include attention to resources and materials, support and training, and time to reflect on current methods.

Achieving such an integrated early years system, *“demands strong political will, government responsibility and a clear awareness of the comprehensiveness of the functions covered”* (Bennett and Kaga, 2010, p.43). The next stage, they suggest, is to engage the whole of society in developing a shared approach to supporting children in their early years; they also note however, that most countries have not yet arrived at this stage (Bennett and Kaga, 2010).

The model of integration appropriate or desirable for a country will vary according to culture and context, so no one country will offer a perfect model for comparison with Wales. For example, citizens of some countries might need predominantly health and parenting support, whilst other governments may be more focused on welfare and employment support, or employment and education. Considering the best option for a country therefore requires a re-thinking of the whole system of support for children and families at all levels, with a consideration of the barriers and enablers for change at each level, and within each structural dimension.

Phase one analysis

In phase one, we conducted an initial, high-level review of ten countries with similarities to Wales and identified key aspects of their early years systems, to assess which might be shortlisted for detailed analysis. The full phase one analysis is included in the Technical Annex. Our key findings from this phase are:

- Most of the review countries are facing a drop in the proportion of young children in their populations, and a rise in the proportion of the elderly. However, even those with well developed economies and social welfare systems are facing increasing numbers of young children who are at risk of poverty and social exclusion. This increase is forecast to continue, with child poverty rates particularly high in Belgium and Germany where there has been a high influx of migrant families with young children,

and in those countries like England where some communities have been hard hit by austerity policies;

- There is wide variation in the proportion of government spending on education, health and social welfare, with some countries preferring to shift the burden of cost onto parents rather than the state bearing the cost, as in the Netherlands. In contrast, Finland, Denmark and Ireland have the highest government spending on children and families. Some countries prefer demand-side funding (where funding is allocated directly to children or parents, or given to settings on the basis of enrolment numbers) whilst others prefer supply-side funding (in which funding is allocated directly to the settings themselves to cover the costs of delivering a service to a required standard);
- Most countries reviewed have integrated their early education and childcare services, bringing them under one department (usually education); however, no country in the review has a single government department responsible for education, health and social care for all children. Most divide responsibility for early education and health between two separate departments, education and health respectively, with social welfare sitting separately again or sometimes within either health or education. In Denmark and Poland there is an integrated body for health and education but only for children under three;
- The majority of countries in the review have both a comprehensive early childhood development (early education) strategy and a health strategy at policy level, and there are policies to combat social exclusion and poverty which are contained within both of these strategies. However, no country in the review currently has an overarching integrated service policy strategy which encompasses education, health and social care. There are examples of integrated service delivery, for example Early Excellence, Sure Start, or Children's Centres in the UK, Pestalozzi Froebel Centres in Germany, and kindergartens in Poland, which were the result of previous national and local governments' attempts to integrate services. These initiatives have been cut back due to austerity, and in these countries, the strategic bodies that delivered them have been discontinued;
- Five of the review countries are now developing programmes with more integrated models of service delivery: Belgium, Denmark, Germany, Ireland and the Netherlands;
- Most countries employ targeted intervention programmes for less advantaged or at risk children, with a focus on early education, social care and health, but usually these intervention strategies are not integrated within the universal service offer;
- There is little published evidence on the processes involved in integrating early education, health and social care at policy or operational level in the review countries, other than in England with the Early Excellence and Sure Start programmes.

Phase two: Case studies

In phase two, we developed detailed case studies of four countries' approaches to integrated early years systems: Belgium, Denmark, Estonia and the Netherlands. Each of the four case studies is presented below in the following structure: national context, extent and nature of system integration, impact of system on child, family, or providers, the cost of the system, and system change processes. The four case study countries were analysed to explore the stage and level of integration in their health, education and social care systems, and for evidence on the processes used to achieve the policy change. A brief background on the geography, demographics, politics and social systems in each of the four case study countries is provided in the Technical Annex.

Early years in Belgium

National context

Belgium is one of the most urbanised and densely inhabited countries in the world, with a population of approximately 11.5 million and its cultural diversity has increased through immigration. The country has an inclusive social security system and wealth is relatively evenly distributed. Most of the population is regarded as middle class, whilst five to six per cent are living close to the poverty line. Less than three per cent of men work part-time, compared to nearly 30 per cent of women, suggesting childcare issues may be hindering women's full-time employment (Eurostat, 2018).

Belgium has three key cultural communities: a Flemish, a French and a small German-speaking community (around 76,000 people) each with its own legislative body and government responsible for education, health and social welfare. This makes the country complex to describe and analyse at a national level. For this review we have focused mainly on the Flemish and French speaking communities and their approaches to early years system integration, both in terms of what is the same, and what is different.

Extent and nature of system integration

The Belgian federal government has a stated policy intention to move towards a more integrated system of early years education, care, health and family support. To this end they have carried out structural reforms to integrate early years policy, types of provision, access, regulation and workforce:

Policy: The Belgian **health care system** is based on a universal social insurance commitment. Health insurance is mandatory and paid for by employers. If self-employed, insurance must be in place and payment is made according to income. Belgium's health

system is comprised of state, university, and private hospitals and a network of independent general practices.

Belgium has had a legal framework for **early education and care** (ECEC) in place since 2012, making ECEC a universal and free provision for children from the age of two and a half; attendance is not compulsory but is nearly universal by the age of three (Montero, 2016; OECD, 2017a). Early education services have a statutory responsibility to work with parents and children and **parenting programmes and support** are offered as well as early learning or childcare in all early childhood settings.

Administrative responsibility: Departmental responsibility for implementing this policy varies between the French and Flemish parts of Belgium. In the **French community**, education and care is administratively divided, but brought together under the Minister of Childhood (Ministre de l'Enfance), responsible for early care and basic education for children from the age of two and a half (OECD, 2006). At a local level, authorities organise these services and provide additional funding. Responsibility for child care policy and provision for children up to three years falls under the governmental agency, the **Office de la Naissance et de l'Enfance (ONE)**. Authorisation for all settings providing care to children under six years of age must be obtained from ONE, which ensures that their programmes conform with quality standards, issued as the "*Code de qualité de l'accueil*" (OECD, 2006). ONE's aims are:

- *"To support children's development within their family and social environment; to advise and support pregnant women, parents and families medically and socially to ensure the global wellbeing of their children. Most services offered by ONE are free;*
- *To organise (that is, to control and sometimes to finance) day care centres for children outside of the home environment. ONE's role is to ensure that these structures operate correctly and provide quality care for children."* (ONE, 2010)

ONE also has cross-disciplinary guidelines to support parenting, which require child care settings to work with parents and take their views into account.

In the **Flemish community**, responsibilities for education and care are separated between the Ministry of Education, which has responsibility for most educational provision and sets overall objectives, and local authorities and non-profit organisations which oversee child care provision (OECD, 2006). The Flemish Ministry for Welfare, Family and Equal Opportunities oversees the Kind en Gezin agency, which is responsible for child care and out-of-school care provision, setting policy and regulation, funding, and planning places. Their focus is on preventative care. Kind en Gezin consists of 63 regional teams of nurses, and reaches around 98 per cent of new-born babies, providing parental support, administering vaccinations, and screening children's development up to six years of age (Montero, 2016).

Kind en Gezin also determines, monitors and promotes minimum levels of quality and care in consultation with the sector (OECD, 2006).

Types of provision: In the **French Community** there is a range of health, education and social care providers which are coordinated through ONE and include:

- **Prenatal care:** a network of prenatal centres providing services during pregnancy and at birth. Prenatal consultations take place either in local hospitals or in specialised 'prenatal centres'. ONE adopts targeted strategies to ensure vulnerable groups have easy access to these services, aiming to support safe and successful pregnancies, and to minimise the risk of premature births and underweight babies. All pregnant women receive a Mother's Notebook (Carnet de la Mère), in which all health information for the child is documented and which is available to all health professionals who work with the child and family. Check-ups are scheduled regularly, during which women receive health and lifestyle advice;
- **Consultation points for children up to six years:** ONE also provides free post-natal care, available to every parent with children between zero and six years of age. The focus of the consultation is on preventative health care;
- **Day care settings:** ONE regulates, and occasionally provides funding to support, an extensive network of day care centres (nurseries, kindergartens and childminders), for babies and children aged between three months and three years. The daily rate for these facilities is based on the parents' income. Flexible day care centres ('haltes accueil'), are also available for parents who need secure professional care for a few hours (ONE, 2010).

In the **Flemish Community**, the approach became more integrated after local networks of services for families were brought together through the creation of **Houses of the Child** in 2013. These networks offer a wide range of health, education, social welfare, youth care, and child day care services, and operate in approximately 55 per cent of cities and communities in Flanders (Montero, 2016). A locally-centred approach to improving childhood opportunities is also reflected in the Public Social Welfare Centres, multi-agency local networks which focus on poverty. All Flemish communities with high child poverty prevalence receive additional funding from the Government for network co-ordination, to encourage an integrated approach. The 2013 National Child Poverty Reduction plan requires Public Social Welfare Centres to either work in partnership with local organisations such as schools and day care centres, or to strengthen existing partnerships to pro-actively and jointly identify, prevent or tackle child poverty (Frazer, 2016). The Belgian government also launched the 'Children First' initiative in 2014 as part of the national drive to reduce child poverty in all three regions. This programme funded pilot projects involving local 'consultation platforms' to engage a range of local stakeholders, including local child care centres, schools and family support services, with the aim of improving coordination between local services and

encouraging the exchange of good practice to support children from impoverished families (Montero, 2016).¹

Access: For children under the age of two and a half, access to child care is patchy, while access to education after this age is good. By European standards, parental leave is short, with a possible 15 weeks of maternity leave. However, parental leave of three months (with a fourth month unpaid) per child up to the time a child turns 12 years is also available to both parents. (OECD, 2016a). Most children under one year of age are cared for in the family home, with between 12 per cent in the French region and 30 per cent in the Flemish region enrolled in public crèches. Demand for care provision outweighs supply, despite increased capacity over the past five years. Such care services are predominantly used by families in which both parents are employed, although single-parent families also make strong use of this provision (OECD, 2006; PERFAR, 2014). Strategies are in place to balance access for children from different backgrounds. Through working with employers and piloting crèches, access to free public education is now guaranteed to all children aged two-and-a-half and above (OECD, 2006; PERFAR, 2014).

For children aged zero to three, a number of databases have been developed which enable the Ministry of Education and to be interlinked with provider databases to collect more systematic and robust data on young children and early years settings for topics such as enrolments, attendance and child characteristics (Persoons, 2015). These new information systems facilitate more accurate calculation of actual coverage, taking capacity and filled as well as unfilled places into account. As a result of the new systems, indicators for a universal service, and imbalances between sub-regions, between subsidised and non-subsidised services and between crèche services and family day care have been identified, leading to positive discrimination in certain communities. Similar initiatives exist in the education sector, leading to increased accuracy and individualisation of data on children and places (OECD, 2006). For example:

“In Flanders various databases are being developed and interlinked to collect data on pupils and schools. In turn these data can contribute directly to the development of educational policy. Since 1 September 2013 all schools and Centres for Part-time Education... provide data in real time to the ministry of education by use of the "Discimus" database. This project allows for a central collecting of data on enrolments,

¹ The European Commission published a peer review of the pilot in 2015
https://www.eurochild.org/fileadmin/public/05_Library/Thematic_priorities/02_Child_Poverty/European_Union/BE2-2014_synthesis_report_EN.pdf

deregistration, attendance, pupil characteristics, etc... Discimus has already been recognised as an example of best practice.” (Persoons, 2015, p19)

Regulation: In the **French Community** changes to regulation since 2004 dictate that any form of child care for those under 12 years of age must be reported to ONE, with providers required to conform with the quality code. ONE created the role of “child care co-ordinators” (coordinateurs accueil), who inspect child care services for compliance, and support pedagogical practice. Inspections are required for certification and receipt of subsidies (OECD, 2006; PERFAR, 2014).

Workforce: A continuing quality challenge for early years services in the **Flemish Community** (also evident in the French Community) has been the relatively low government investment in professionals, resulting in a weak, poorly-qualified family day-care sector. Universities and training centres now include child care as a separate discipline. Whilst there has been movement towards a coherent national quality system (Urban et al., 2012), it is still significantly under-financed (OECD, 2018a). In recent years, increasing multiculturalism in Flanders has created the added expectation that providers reflect local ethnic balances.

Impact of system on child/family/providers

Assessing the impact of the early years system on the child, family and providers is complex and there is a lack of comparable evidence both from within countries and internationally. International organisations such as UNICEF have outlined the challenges in assessing impact, not least since this requires agreed measures to assess child and family outcomes (UNICEF, 2013). Some progress is being made with international comparator studies such as the OECD International Early Learning and Child Well-being Study (OECD, 2018d), but this work is at an early stage and the final report is yet to be made available. The UNICEF Child Wellbeing Study (UNICEF, 2013) gives an insight into early years systems in 29 of the worlds’ most advanced economies, including the four case study countries included here, to create conditions for children to thrive. The study reported that in 2013 Belgium performed well, ranking ninth out of 29 countries against these criteria, indicating that the comprehensive framework of services for children in Belgium has a positive effect on the overall well-being of children.

There is little published evidence of the direct impact of the Belgium government’s actions to create an integrated early years system for children and families, as the government has taken a deliberate stance not to measure child outcomes at this point. However, there is some evidence on the educational performance of older children. According to the latest PISA reports on children’s educational performance at age 15, Belgium achieved above average scores in science, mathematics and reading but also has one of the largest educational gaps of the countries studied. It is argued that this can be linked to the children’s home situations (OECD, 2018b; van Laere, 2017). There is also an attainment gap between

children with high and low socioeconomic status, and between those who are from migrant backgrounds and those who are not. This is despite government investing in early years services with the explicit aim of closing the educational gap (van Laere, 2017). Recent research also links this poor performance to a lack of congruence across providers of education, care, health and social welfare services in their understanding of the conditions which best enable children's learning and development in early years (van Laere, 2017). In sum, there appears to be growing *structural integration* but a lack of *conceptual integration*.

Cost of system

There is little published evidence on the cost of the system in Belgium. Funding is complex and divided between three communities and national, federal and local administrative bodies. It is beyond the scope of this review to untangle this complexity of funding and costs. The OECD education statistics for 2016 (OECD, 2017c) show that annual expenditure on pre-primary education in Belgium was 0.7 per cent of GDP although this excludes expenditure on early childhood education and care (the OECD country average is 0.08 per cent for early childhood education and care and pre-primary education). This suggests Belgium's funding for early years education and care is above the OECD average. The OECD health statistics for 2017 (OECD, 2017b) show that annual expenditure on health in Belgium was 10 per cent of GDP (OECD average was 8.9 per cent), again suggesting a higher than average spend.

System change processes

Belgium is recognised as having one of Europe's most comprehensive and integrated early education and care systems and is making further progress in developing the scope and range of this system. Historically, Belgium has not integrated early education and care with health and wider family services, but progress is being made to develop a service delivery offer for all children and families which includes education, care, health, parenting support and social welfare. However, it should be pointed out that this is largely preventative health care and not linked in with universal healthcare services. At government level, the desire to improve both accessibility and quality of services through a more integrated approach has given rise to change processes (Eurydice, 2018; van Laere, 2017) which include:

- **Concertation**, which is a form of decision-making which encourages dialogue and cooperation between various bodies;
- **Management reform** and training to support new leadership models, implementation of change, and ensuring local leadership is in place to make change happen;
- The creation of **new municipal posts** to join up early childhood services in the various coordinating bodies;
- **The development of coordinated planning** across service providers at a local level;
- An emphasis on **training and professional development**.

A high level of commitment from university researchers to the early childhood sector is addressing workforce and practice quality issues through **action-research projects** in collaboration with teachers and staff (OECD, 2006).

Summary

In this analysis, Belgium can be viewed as a country which is making good progress towards developing an integrated early years system but there is still work to be done. At this point this review would classify Belgium as being at an early point in **Kotter's Stage 3:**

Implementing and sustaining. The evidence indicates that it has managed to *create a climate for change* and has *engaged and enabled the system, by communicating the vision and removing structural obstacles*, but now has work to do to *build on the change* and, which is more challenging, to *anchor the changes in organisational culture* through developing a more coherent conceptualisation of what they are trying to achieve, especially for the less advantaged families and communities.

The Flemish community can be viewed as currently working to establish a **'unified' model** of integration at service delivery level through its creation of the Houses of the Child. At policy level, however, responsibility remains divided between departments of education, welfare and health, coordinated by Kind en Gezin (Child and Family) which is overseen by the Flemish Ministry for Welfare, Family and Equal Opportunities. Thus at this level we view them as embodying a **'coordinated' model** of integration.

Similarly, in the French community policy level responsibility remains divided between education, welfare/care and health departments. Their early years initiatives are coordinated by ONE, the governmental agency responsible for mother and child health and protection, with overall child care policy and provision overseen by a Minister for Childhood. Thus at this level we view them as embodying a **'coordinated' model**. At service delivery level, ONE coordinates the local delivery of education, care, health and welfare services which may be offered by a range of different providers. Again, this appears to be realising a **'coordinated' model** of integration.

In both Belgian communities we can see progress is being made on **structural integration**, through collective action on policy, service delivery, access, regulation and workforce, but further work is needed to ensure conceptual as well as structural integration. This has been identified as a key reason for the lack of progress in closing educational gaps for children with low socioeconomic status or migrant backgrounds (van Laere, 2017).

Early years in Denmark

National context

Denmark is a small nation, consisting of more than four hundred islands, eighty of which are inhabited by a population of approximately 5.7 million. Whilst immigration, mainly from other Scandinavian and northern European countries, has increased, immigrants from southern Europe and the Middle East are also now more evident. Denmark is an industrialized society and only 15 per cent live in rural areas. Education is the primary motivating factor for migration to urban areas. Denmark has high living standards and low inequality by international measures and also has the highest percentage of women in the labour market in Europe, at almost 80 per cent (Eurostat, 2018).

Extent and nature of system integration

In Denmark, like other Nordic countries, services for young children are seen as an essential aspect of the social welfare system, alongside tax-financed public health, education, and social systems. These systems reflect a high public commitment to provision and funding. Universalism is a central principle, and in education the integration of 'education' and 'child care' is prioritised; however, this is not the case with health. The early education and care system operates largely separately from the health system. There are however the early beginnings of structural reforms to integrate health services more fully with the early education and care systems, including some initiatives around policy, types of provision, access, regulation and workforce, as detailed below.

Policy: All children from zero to five years of age have a legal entitlement to early education and care and early health services, with high enrolment rates in early childhood or primary education (OECD, 2017c). There are wide ranging policy aims for the free, universal **early childhood education and care system**; these seek to balance child care and early education priorities and provide support for parental employment, work/life balance, parental education and training. Early education is provided to address children's development, preparedness for school, citizenship, special need, safeguarding the vulnerable, supporting children where their home language is different to the national language, and reducing inequality. More recently, aims have included children's health and wellbeing (Bertram and Pascal, 2016).

Denmark has historically had a decentralized **health system** but in recent years, policy initiatives have progressively introduced a more centralised approach to planning and regulation. There is also an expressed aim to improve inter-sectoral cooperation but several challenges remain in the Danish health care system. Denmark performs less well than other Nordic countries on indicators such as health inequalities and life expectancy (OECD, 2016b).

In 2012, in response to rising deprivation and social inequalities, partially brought about by the global economic crisis, the government introduced a four-year national prevention strategy, investing DKK 100 million of social funds (Blades, 2012). It comprised two main initiatives aimed at children and young people at risk of poverty:

- “*Strengthening provision for, and the inclusion of, **children with welfare and learning difficulties** in day-care, schools and leisure activities by sharing best practice, improving guidance for local authorities on key transitions (e.g. between school stages) and developing better links with local health services;*
- *Strengthening **targeted support for families**, particularly those with school age children, children who have been in contact with the youth justice system and children with behavioural difficulties [...] through the establishment of local action teams, more support and better education.”* (Blades, 2012, pp. 6-7)

During recent years there have also been policy changes regarding expenditure, staff qualifications and child assessments (Bertram and Pascal, 2016). New legislation and strategies now also take cultural diversity into account in early childhood service delivery. Recent strategies include an improved early childhood and education curriculum, additional training and pedagogical consultancy to settings and pedagogical support given at home or through outreach programmes (Eurydice, 2018). Early intervention programmes also encourage the participation of children from low income families and minority ethnic groups, and of children with special needs.

Administrative responsibility: The Ministry of Health is responsible for health legislation and guidelines but delivering and managing health services is devolved to regional and municipality level. The legal framework for healthcare is decided by the national government, where regional and municipal service delivery is also coordinated. There are also democratically elected assemblies at all levels of the Danish health care system.

Since 2011, overall responsibility for early education and care has lain with the Ministry of Children and Education. Governance and system management for education and care is split between national and sub-national (regional and municipality) levels. As in the health system, early education and care is highly decentralised (OECD, 2001; Pascal and Bertram, 2012); the Government defines the legal framework for day-care facilities (Dagtilbud), within which local authorities set guidelines for operating those services. This division of responsibility means achieving an integrated model of health, education and care delivery is challenging.

Types of provision: Most Danish **education and care services** are publicly funded and administered by local municipalities. The most common types are day-care settings (Dagtilbud) which cater for children from birth to six years and provide educational and social care. Home-based care (Dagleje) is also used, nurseries (Vuggestuer) provide part-time and extended day places to children up to three years old while Integrated Centres

(Integreret daginstitution) cater to children up to six years of age. Kindertagesinstitutioner (Børnehaver) also provide places for children between three and six years of age (Blades, 2012). Municipalities cover at least 75 per cent of the operating costs for day-care services for children from 26 weeks to age six; parents pay a maximum of 25 per cent and can also receive additional discounts such as a sibling discount, or an 'aided place' subsidy (Japsen, 2016).

The Danish national **health care system** is universal and free at the point of use, financed by local and state taxes (Blades, 2012). Municipalities provide universal preventive health examinations for children, as well as child nursing, school nursing and dental care. A minimum of five health visits by a nurse is offered to all families during the child's first year to support general wellbeing, development and early bonding between the child and parents. GPs also carry out seven scheduled preventive health examinations under the Danish childhood immunisation programme; at five weeks, five months, and then annually until five years of age (Ministry of Health, 2016). Recently, several municipalities and regions have established joint multi-speciality facilities, known as **Health Houses**, which generally bring together GPs, specialists and physiotherapists, as well as other healthcare professionals. Integration within the healthcare sector also occurs through various formal and informal networks that GPs participate in, alongside health service agreements established between regions and municipalities to facilitate cooperation and improve patient pathways (Mossialos et al, 2016).

In recent years, there has been public debate on issues related to ideas of cohesion and coherence in children's daily life (The Children's Society, 2018; UNICEF, 2013). This is linked to a desire to establish common objectives and vision across all municipal services for children, including education, care and health services. Many municipalities have established a single administration responsible for all matters relating to young children, schools, and out-of-school activities. A seminal comparative study by Kaga, Bennett and Moss (2013) revealed that countries that have adopted a unified administrative department for all early childhood services have benefited from a more coherent policy, greater quality and consistency across sectors, enhanced management of services, greater coherence in children's experiences and more investment in services for young children. These organisational changes demonstrate a movement towards structural integration around the early years, but as Kaga, Bennett, and Moss (2010) point out, increased collaboration across ministerial boundaries, including mutual understanding as to the values and norms held by different Government departments, is required to fully realise this aim and Denmark, as in other countries may still need to work on this (Kaga, Bennett, and Moss, 2010; Bertram and Pascal, 2016; OECD, 2001).

Access: Universal entitlement and guaranteed access to early education and care has led to high enrolment rates: 97.7 per cent of three to five year olds and 65.7 per cent of under threes attend a form of day care institution (OECD, 2018a). Local municipalities have a

statutory responsibility to ensure sufficiency of places. Strategies are also in place to support children from poorer families, those with special needs or a disability, minority ethnic groups, and children who do not have Danish as their first language. More than 90 per cent of children attend the first three health examinations (OECD, 2017b). Danish Red Cross clinics offer services to undocumented individuals who are not able to access routine care or basic prescription medicines.

Regulation: National guidance for early education and care services encourages a broad and balanced learning programme, and provides expectations of outcomes at set stages between birth and primary school age. Local municipalities are responsible for ensuring that all centres meet these national requirements. There is also a national inspectorate which assesses compliance, leadership and management, the curriculum, staff performance, children's learning outcomes, health and well-being, parental satisfaction, financial sustainability and value for money (Bertram and Pascal, 2016). Results are reported to parents, providers and local and regional ECE bodies, and are used to inform policy and practice. A similar system applies to health services, with the government setting national guidelines and local municipalities taking responsibility for confirming compliance (Bertram and Pascal, 2016).

Workforce: The education, care and health workforces are highly trained. Danish teachers are educated to degree level, including training in care and supporting development. In an average municipality, 59 per cent of education professionals hold a degree in pedagogy, while 41 per cent are assistants with limited or no formal teacher training (Urban et al, 2012). In the health system, GPs are required to complete six years of training, and there is a separate training programme for health visitors. There is no move yet to develop an integrated approach to workforce training across services.

Impact of system on child/family/providers

The aforementioned UNICEF Child Wellbeing Study (UNICEF, 2013) revealed that in 2013 Denmark ranked 11th out of 29 countries studied, indicating that its framework of services for children has a largely positive effect on the well-being of children. There is little published evidence of the direct impact of the Danish government's actions to create an integrated early years system for children and families, as like others in this report, the government has taken a deliberate stance not to measure child outcomes at this point. There are no nationwide assessments of young children; although some local municipalities stipulate that their early years providers assess children under three years there is no national reporting of this data. PISA evidence on the educational performance of children at age 15 shows that Denmark achieved just below the OECD average scores in science, mathematics and reading (OECD, 2018b).

Cost of system

There is little published evidence on the specific cost of the early education and health system in Denmark and expenditure on early childhood education and care as a proportion of GDP is not reported in the latest OECD report (OECD, 2018a). Most costs are covered publicly and expenditure is large, primarily due both to high demand and high salaries for staff in education, care and health. To illustrate, the municipalities alone are estimated to spend just under £3 billion a year on ECEC (Japsen 2016). The overall funding picture is complex and divided between a range of national, regional and local administrative bodies and it is beyond the scope of this review to untangle this complex situation. Health spending is higher in Denmark than in most other EU countries, and in 2017 was at 10.2 per cent of GDP compared to the EU average of 8.9 per cent (OECD 2017b).

System change processes

Denmark established a fully integrated education and care system for young children, alongside a universal healthcare system in the 1970's. Departmental responsibility is with the Ministry for Children and Social Affairs, including welfare and parenting support responsibilities. The government has also set out requirements to local municipalities that day care centres should offer education, childcare and parenting and family support. More recently change processes have included:

- **Incentivising day care centres** to make a particular effort to support less advantaged children;
- Bringing together **preventative social care services** with **universal education** and **parenting support**;
- Developing GP-run **health centres** within local communities and home-visiting health visitors to adopt a more cohesive approach;
- Establishing a dialogue about the **concept** of more joined-up education and health services and moving towards local collaborative planning.

As yet, there has been little action in terms of integrating service delivery.

Summary

Our analysis shows that Denmark has well established models of integration within its education and care systems and is in the process of developing models of integration within its health system. However, there has not been significant progress in integrating these two systems to form a fully integrated early years system. At this point we would classify Denmark as being at Kotter's **Stage 2: Engaging and enabling the organisation(s)** since it is at an intermediate stage in the development of a fully integrated early years system. Evidence indicates that work remains to *engage and enable the system by communicating*

the vision and removing structural obstacles. Notably, the Danish Government has begun a dialogue to *anchor the changes in organisational culture* through developing a more coherent conceptualisation of what they are trying to achieve, especially for less advantaged families and communities. However, this is still at an early stage and the two systems are currently functioning largely as separate entities.

In terms of education, care and social welfare systems, Denmark can be viewed as having a well-established **'unified' model** of integration at both government and service delivery level under the Ministry for Children and Social Affairs and through its universally available day care centres. Denmark is also making progress towards creating a **'unified' model** of integration in health through its local Health Houses, which are under the strategic responsibility of the Ministry of Health. However, integration of the education and care system with the health system is at an early formative phase and currently embodies a **'coalition' model**.

There is some progress on **structural integration** within the two separate systems, through collective action on policy, service delivery, access, regulation and workforce, but further structural elements are required of a fully integrated early years system. Considerable work and political will is needed to take forward the early dialogue about coherence in children's daily life to achieve **conceptual integration** across these two systems, and to establish the groundwork for structural integration. However, Denmark is one of the few countries which has started this conceptual dialogue before structural integration between the two systems has begun, which may prove advantageous in the long term.

Early years in Estonia

National context

Estonia is the most northerly Baltic state, consisting of a mainland and 2,222 islands in the Baltic Sea. With a population of 1.3 million, it is one of the least populous European Union (EU) member states. Since regaining its independence in 1991, the country has become one of the most economically successful of the newer eastern EU members, and one of the most digitally advanced societies internationally (Eurostat, 2018).

Extent and nature of system integration

Owing to Estonia's turbulent political history, services for young children and families have experienced repeated shifts in organisation and structure. Development of the education, care and health systems continues, as the country positions itself as a modern European society with a strong social welfare system. To this end, a range of structural reforms and initiatives are planned or already underway in the early education, care and health systems

with the intention to provide a more cohesive early years system. These include initiatives addressing policy, types of provision, access, regulation, and workforce.

Policy: Estonian citizens are provided with universal health care, free integrated education and care from eighteen months to seven years of age, and the longest paid maternity leave in the OECD. However, there remain challenges in terms of access and coverage of these services, a shortage of both health and education staff to meet demand, and a failure of these systems to handle increasing levels of social care, child mental health and family health needs. Government policy is being developed to address these challenges (Eurydice, 2018).

The Child Protection Act of 2014 established a strategy to promote child development and support, to see the best interests of children as a primary consideration and to improve their quality of life. The 2014 Act led to the establishment of the State Child Protection Service in 2016 and a number of national strategies to regulate early intervention services:

- The **'Strategy of Children and Families 2012-2020'**, the main objective of which is to improve well-being and quality of life for children through child and family policy, positive parenting, child rights and protection systems, family benefits and services, and reconciling work with private life (Frazer, 2016);
- The **'Children and Youth at Risk' programme** aims to improve cross-sectoral support, including healthcare, legal protection, education, and the welfare system, for children and young people at risk;
- In cooperation with the National Institute for Health Development, the Ministry of Social Affairs piloted the evidence-based **'The Incredible Years' Preschool Basic Parent Programme and Advance Programme'** among Estonian and Russian speaking parents from 2014-2017 (Frazer, 2016). Since then the Programme has been institutionalised in the National Institute for Health Development and an advanced programme pilot is ongoing, working with the Child Mental Health Centres;
- The **'Circle of Security'** programme sees two educated trainers working in collaboration with local governments and midwives to support parents in enhancing attachment security with their children;
- The **'Developing a Concept of Integrated Services to Improve Children's Mental Health'** programme was a public health programme that aimed to support child wellbeing and mental health through the integration of social, healthcare and educational services, funded by the Norway Grant 2009-2014.

This last initiative was an ambitious programme which aimed to map existing services, develop a less fragmented system of children's mental health services, and to provide better regional health and social care coverage for children and families. It encouraged a family-centred approach predicated on cooperation, which considers the child's needs along with

existing services and aims for measurable results. This concept work has been the basis for improving the quality of interventions and service coordination reforms in Estonia and continues to inform the further integration of services in the healthcare, social, child welfare and educational system.

In Estonia, links have been forged between health care, the social system and education sectors as processes have been amalgamated and problems tackled that each sector could not adequately address working independently. For example, by restoring the 'home visit for every new-born' system in Estonia, data from first home visits could be utilised and interventions planned for children at risk from a need-based approach, creating contact between the health care system and family whilst assessing family resources and empowering parents. This mirrors the coordination mechanisms being developed through their 'Children and Youth at Risk' (CYAR) programme and reform of the child protection system.

Administrative responsibility: Until 2018, Estonia had a partially unified system of early childhood education and care under the Ministry of Education and the Ministry of Social Welfare, reflecting a multi-level governance model, with governance and system management distributed between national and sub-national levels. From 2018, all early education and care institutions have been brought under the Ministry of Education and Research which reflects a move to integrate and unify administrative responsibility for all education and care services from birth. There is also a central state agency – the Social Insurance Board - which co-ordinates social care support for children with complex health conditions or disabilities.

From the early 1990's the Estonian health system has operated as a decentralised model funded through social insurance. Responsibility for the health system currently lies with the Ministry of Social Affairs (MoSA) and its agencies, including the independent Estonian Health Insurance Fund (EHIF).

“The Ministry of Social Affairs and its agencies perform the main stewardship role for the Estonian health care system.... The Estonian Health Insurance Fund (EHIF), operates the national, mandatory health insurance scheme and performs some quality assurance activities. The national health insurance scheme covers approximately 95% of the population with a broad range of curative and preventive services.” (Kurowski et al, 2015, p.9),

However, the experience of decentralisation in the 1990's has not been as successful as hoped in delivering an efficient and effective system and Estonia is now moving to establish more centralising planning and regulatory functions (Lai et al, 2013). The main policy document is the National Health Plan (NHP) which integrates existing sectoral plans to

support linkages between the various stakeholders of the health system and other sectors. In 2017, (OECD, 2017a) the Estonian government increased its funding for the health system and its new NHP sets out to define more measurable targets, and hold providers more accountable.

Types of provision: Parents are universally entitled to 62 weeks paid maternity or paternity leave, which can be taken by either parent (Bertram and Pascal, 2016).

Under the responsibility of the Ministry and Education and Research, Estonia has a unitary **childcare and education system** with two main structures; child care centers and fully integrated educational institutions for children aged from eighteen months to seven years of age, both offering daycare and education. Both are fully publicly funded, receiving supply side funding in the form of staff salary and place subsidies, resource and capital grants, and demand side funding via reduced tax credits or relief, fees, and family allowances (Bertram and Pascal, 2016).

A 1992 health insurance law established a decentralised system of medical funding that operates primarily at a regional or municipal level (Aruja et al, 2018). However, a gradual return to a centralised model of planning and regulation has followed the less than successful deregulation during the 1990s (Lai et al, 2013). The Ministry of Social Affairs, supported by the National Institute for Health Development, is responsible for the health system (OECD, 2017a). All health care providers are independent and family physicians who practice either as private entrepreneurs or employees of private companies, some of which are owned by family doctors and other by local municipalities. Structural reforms in the 1990s saw family physicians become the centre of the health service delivery system, providing a core package of primary health services (Kurowski, 2015). This description reveals that the health system in Estonia is largely operating as separate to early childhood and care provision and has been managed as a market system, although recent reforms have shifted the approach back towards more centralised planning which might facilitate a more integrated approach.

Children in Estonia have access to regular health checks and vaccinations. Monitoring of a child's growth, development and overall health, including eyesight and hearing, is overseen by family physicians, who also provide developmental advice on issues such as hygiene, diet, and physical exercise (Julge, 2016). Children are examined monthly during their first year, and annually after this point. At six or seven, the child receives a preschool medical examination from the family physician, who assesses development, readiness for school, eyesight, hearing, and speech development. If any potential concerns are identified, the child is referred to a relevant specialist (Julge, 2016).

Municipalities and cities also have their own **social care systems** and contact with primary care doctors and nurses begins when a child is born. Disabled children receive significant additional support. The 2012 National Health Plan aimed to integrate all health and

development strategies and plans, as well as link stakeholders from the health system and other sectors (OECD, 2017a).

Access: Enrolment levels to early education and care are relatively high and increase with age; 13.2 per cent of under-threes and 90.7 per cent of three to five-year-olds enrolled in formal education and care provision (OECD, 2017c). Strategies exist to encourage the participation of children from low income families and to extend coverage in rural areas. There are also a range of early intervention programmes to support the participation of children from low income families, children with special needs or a disability, minority ethnic groups and where the home language is different to national language (Bertram and Pascal, 2016). However, there remains a shortage of provision, particularly in rural areas, for low income families and for children with special needs or a disability. These initiatives are specifically designed to ensure better integration and access to children with higher levels of need (Bertram and Pascal, 2016).

Regulation: The Ministry of Social Affairs, which is responsible for the Estonian health sector, has passed several acts and regulations which set out structural requirements for facilities, installations and equipment, quality requirements for specific medical procedures, and the designation of provider responsibilities for the accessibility and quality of health services. A single national body is responsible for accrediting all early education and care and the system incorporates compliance, curriculum, financial sustainability and a national system for inspection. A range of outcome expectations are set, covering educational, health and wellbeing outcomes, which support the move towards more integrated service delivery. In the health sector, the different health stakeholders carry out specific quality assurance activities; however, there is no single national institution responsible for coordinating and assessing these independent quality assurance activities.

Workforce: People working in ECEC in Estonia are expected to have graduate or postgraduate qualifications. There are three main staff categories - teacher, assistant and nurse - and two categories of leaders - director and lead teacher. Assistants must have an International Standard Classification of Education (ISCED) Level three qualification, and nurses are required to have an ISCED Level 4 qualification. Teachers, directors and lead teachers are required to have an ISCED Level 5 qualification (Bertram and Pascal, 2016). In health, the picture is more varied owing to the shortage of qualified health professionals, especially in family health. GPs are required to have six years of training, in line with most European countries and they have the opportunity to specialise in family medicine during their training. This is hoped to increase the supply of specialist expertise. There are no current initiatives to encourage cross system training for early education and care and health professionals, even at leadership level.

Impact of system on child/family/providers

As stated previously, assessing the impact of the early years system on child and family and providers is complex and there is limited evidence. Whilst programmes such as the Circle of Security and the Integrated Concept adopt a collaborative, targeted approach, it is unclear how successful these have been owing to a lack of measurement. This is due in part to insufficient collaboration between services (Tõemets and Põllumaa, 2016). Universal home visits specifically have been shown to achieve positive outcomes - creating early contact between the health care system and family, assessing family resources and empowering parents. That said, time delays when targeted support for disadvantaged children or when special needs or safeguarding issues are involved, prevent this holistic, evidence-based approach from working well for everyone (Tõemets and Põllumaa, 2016).

There is currently a significant – and possibly unnecessarily high - number of databases in use, for example the Social Services and Benefits Registry, the Social Insurance Board Information System, e-Health, and Estonian Education Information System, amongst others. These databases are not interfaced, and large scale impact studies are problematic due to duplicate information and uncertainties regarding data validity. Further, information relating to children's well-being, mental health, and risk group status is not regularly gathered on a national level (Tõemets, 2015).

The UNICEF Child Wellbeing Study (UNICEF, 2013) revealed that in 2013 Estonia did not perform well, coming 23rd in the table of 29 countries, with poor results particularly on the dimension of child poverty. Based on this, it may be concluded that the framework of services for children in Estonia at that time at least was not working well for the poor and less advantaged. More up-to-date insight may be revealed in the forthcoming OECD International Early Learning and Child Well-being Study (OECD, 2018d) in which Estonia is a participant.

There is however positive evidence on the educational performance of older children in Estonia; Estonia was 3rd in the most recent PISA study of children's educational performance at age 15, and was well above the OECD average scores in science, mathematics and reading (OECD, 2018b). This gives some indication that aspects of the Estonian system for children and families are working well.

Cost of system

There is a lack of evidence on the specific cost of the early education and health system in Estonia but OECD data reveals that in 2017 Estonia spent 1.2 per cent of GDP on early education and care, higher than the OECD average (2018a). The funding situation in Estonia is complex, divided between a range of national, regional and local administrative bodies, and partially comes from external funding, including the Norway Fund.

By contrast, health spending is lower in Estonia than in most other EU countries, and in 2017 was at 6.7 per cent of GDP compared to the EU average of 8.9 per cent. According to the OECD: “*There is a strong reliance on payroll contributions that makes the system vulnerable but three quarters of health spending is publicly funded, which gives the population more protection than in neighbouring countries*” (2017a, p.3).

System change processes

There have been four main ways in which system change has been encouraged in Estonia:

- The government has stimulated a range of change initiatives through securing funding for **specific projects** aimed at developing a more integrated education, care and health system. This funding for focused, time-limited projects has acted as a lever to pilot changes and encourage the development of new practices;
- The Estonian Social Insurance Board has piloted and implemented **regional support units** to build strong links between state and local level, channelling national policy related to children, youth and families to the local level with advice and support for local governments in planning changes towards more integrated service delivery. The capability of the local governments has improved in both evidence-based policy making and providing more effective and integrated assistance for children and families and evidence-based intervention;
- **Supervision, co-vision and coaching** have been found to be integral to supporting frontline specialists working with families, enabling them to operate in a more coordinated way;
- A **conceptualisation programme** to enhance the understanding of integrated system delivery has been launched to support cross sector thinking about how an integrated system might be developed and delivered.

Summary

Our analysis shows that Estonia has well established and integrated models within its education and care systems, and has made a good start of integration within its health system. It is progressing the integration of these two systems to form a fully integrated early years system across the education, care and health divide. At this point this review would classify Estonia as being at a middle stage in the development of a fully integrated early years system which encompasses education, health and social care, being at Kotter’s **Stage 2: Engaging and enabling the organisation**. The evidence indicates that it has begun to *engage and enable the system by communicating the vision and removing structural obstacles and creating short term wins* through its projects. It has also begun a dialogue to *anchor the changes in organisational culture* as it moves to Stage 3, by developing a more coherent conceptualisation of what they are trying to achieve, especially for less advantaged

families, but this is just beginning and currently the two systems (education and care, and health) remain separately constituted.

In terms of education, care and social welfare, Estonia can be viewed as having a well-established **'unified' model** at both government and service delivery levels through its universally-available day-care centres. With regard to health services, Estonia is making some progress towards creating a **'coordinated' model** of integration through its local multi-specialist GP centres, which are under the strategic responsibility of the Ministry of Health but which work with the integrated education and care centres, plus a range of service delivery partners. However, the integration of the education and care system with the health system remains at an early stage of development and is making progress to establish a **'coordinated model'** of integration rather than a fully unified model given that the services are synchronised so that the various services work together but remain individually separate.

In sum, while some progress is being made towards **structural integration** within the two separate systems, it has yet to tackle the structural elements required of a fully integrated early years system. Considerable work and political will is needed to take forward work on establishing a common concept of integrated system delivery and achieve **conceptual integration** - but Estonia is one of the few countries that has started this conceptual dialogue.

Early years in the Netherlands

National context

The Netherlands is a densely populated country with a population of just over 17 million which is growing, due mainly to migration (Eurostat, 2018). The Netherlands operates a liberal, free market economy balanced with a desire to be a social democracy with a welfare state that gives all citizens a universal right to a minimum standard of living. Income inequality has historically been relatively small when compared to other EU countries due to progressive taxation and redistribution, but in recent years wealth inequality has increased significantly (Eurostat, 2018; OECD, 2018c).

Extent and nature of system integration

In the Netherlands, changing demographics and economic demands have brought new challenges to the education, care and health systems. These have driven structural reforms to integrate systems more fully, including initiatives around policy, types of provision, access, regulation and the workforce.

Policy: The Netherlands provides universal, free education to children from a young age, emphasising social support for families and children within youth and social integration

policy, at both the national and municipal levels. There is a strong relationship between business and ECEC in the Netherlands, with businesses setting up and funding places for workers in much of the available provision, which is largely provided by the private and voluntary sectors. Social cohesion and parental support is offered in pre-school playgroups within neighbourhoods, and is fundamental to reaching socially isolated families. Overall, the Netherlands has developed a comprehensive system of services aimed at securing the well-being of children, which operates on both a central and a decentralised level (van Riel and van der Kooi, 2016). The Dutch national government retains responsibility for developing national regulations and standards and monitoring the quality of provision but there is an ongoing process of decentralisation of responsibilities from the national government to provincial and local authorities, through which the government aims to move responsibilities back to those directly involved in providing early years services and those who benefit from them. In this context, the role of employers is becoming increasingly prominent and organisations of parents, labour unions and supporting institutes are becoming more involved in shared decision-making and self-regulation (OECD, 2016c).

Administrative responsibility: In the Netherlands, there is no overarching legislation or single government department that coordinates all aspects of support for children, young people and families. The country has a partially unified early childhood education and care system with the involvement of several ministries:

- The **Ministry of Social Affairs and Employment** is responsible for the governance of child care at the national level (ECEC settings for children 0–4 years; after school care 4–13 years; family day care, 0–13 years);
- The **Ministry of Education, Culture and Science** is responsible both for the governance of early childhood education for disadvantaged children 2½–4 years at national level and for the early education of 4 to 5 year olds in the Basisschool;
- The **Ministry of Social Affairs and Employment** is responsible for the overall social protection system, which includes child care; (van Reil and van der Kooi, 2016);
- The **Ministry of Health, Welfare and Sports** coordinates the overall well-being of children and young people and encourages exercise as a way of preventing health problems and facilitating social inclusion; (van Reil and van der Kooi, 2016);
- The **Ministry of Education, Culture and Science** is responsible for education and culture; (van Reil and van der Kooi, 2016); The **Ministry of Security and Justice** stipulates the legal basis for child protection, including parental responsibility and ordered supervision (van Reil and van der Kooi, 2016);
- The municipal health offices, under the responsibility of the **National Inspection of Health** monitor all childcare and child minding settings, including playgroups (OECD, 2016);

- Pre-primary education is monitored by the **Inspectorate of Education** (OECD,2016).

Co-ordination, co-operation and integration is a matter of urgency due to the split responsibilities and multi-sectoral system. In 2010 a law was introduced for harmonising and integrating preschool facilities and child care resulting in both sectors now being covered by the same laws and regulations.

Types of provision: Parental leave is amongst the lowest across the EU and OECD countries (OECD, 2017c). There are 16 weeks of parental leave available at 100 per cent of earnings, together with an additional unpaid, partial leave of six months for those working at least 20 hours per week. However, since the early 1990s the Dutch government has funded **day-care** for children from three months to stimulate women's participation in the labour market. These policy changes were consolidated in the 2005 Dutch Childcare Act, which provided a means-tested child care entitlement to working parents (Montero, 2016). Children often enter playgroups, the most common form of provision, at age 2. Other types of provision are used to a lesser extent, depending on the needs of children and parents (OECD, 2018a). This suggests that children in the Netherlands are more likely to be in formal childcare from a much earlier age than in other comparator countries but for fewer hours, which may be linked to parental leave entitlements which are comparatively low.

Participation in formal child care (**pre-school playgroups and nurseries**) is higher in the Netherlands than most OECD countries, with 55 per cent of children under two years of age in provision, compared with 33 per cent OECD average. However, it should be noted that this is for shorter hours (17 hours a week) compared to other countries. For 3 year olds participation rates in formal provision are 71 per cent, 86 per cent for 4 year olds, and 96 percent of 5 year olds (OECD, 2016c).

Playgroups are set up by parents with funding input and certification from municipalities and are an integral part of local policy. The need for parental support is also recognised in assisting social cohesion and socialising children and pre-school playgroups organised at the neighbourhood level are seen as intrinsic in reaching parents (particularly from ethnic minority backgrounds) that have a low participation rate in other facilities, and function as meeting places for families at risk of social isolation (OECD, 2001). Playgroups tend to be integrated into day care services or are part of early education services for children, which focus on children's education development (Montero, 2016). Early education (as opposed to child care) for children aged two and a half to six years of age focuses on cases where there is a risk of developing a language or educational deficit. Montero (2016) suggests that this demonstrates the Dutch interpretation of early education as a targeted rather than a universal service, utilised by local authorities to intervene early to aid development; child care levies are imposed by the government on all employers and day care centres, and playgroups are primarily financed by the municipalities through funds received from the central state.

In 2006, Dutch **healthcare** was reformed through the creation of a single compulsory insurance scheme involving a range of private health insurers (Schäfer et al, 2010). Insurance premiums are the same for everyone, and it is illegal to refuse coverage on the basis of someone's health (Stoelwinder, 2014). Free preventive child healthcare is universally available from birth to 19 years (Fleuren, Dommelen and Dunnink, 2015). These services are divided into three parts: perinatal healthcare (maternity home help), pre-school healthcare and, school healthcare. Pre-school healthcare for children up to three years old is provided by nurses and doctors specialising in mother and child healthcare (OECD, 2000; Kroneman et al., 2016). This service is delivered in child health clinics/centres and municipal health care centres with responsibility for administering vaccinations (among other things), screening the health and development of young children, and advising parents on health, nutrition, child development and education (OECD, 2001; Kroneman et al., 2016).

Child health centres maintain area-based, preventive health provision. Contact with these centres is frequent, and nearly all children and their parents visit during the first year, if only to receive the required vaccinations (OECD, 2001; Kroneman et al., 2016). The changes in the Dutch system for child and youth social care that were introduced in 2015 foresaw a system change in which child and youth social care, mental health services and care for children with chronic conditions became more integrated (Montero, 2016).

The Netherlands has historically offered one of the most expensive but generous social security systems worldwide but since the 1980s its costs have become progressively prohibitive and it has recently undergone significant revisions, such as cost-sharing provisions and restrictions involving non-Dutch nationals, temporary workers, and the self-employed. The evidence indicates that despite cost restrictions the system remains relatively expensive and continues to perform well on international comparisons (OECD, 2017d; Meijer et al, 2018).

Access: Healthcare reforms since 2006 have significantly improved access to health services and they are now viewed as fulfilling aspirations of universality, transparency, relative simplicity and engagement with the whole community. It is nonetheless expensive, despite active competition between health insurance providers. The comprehensive and universal system of early education and care from birth to school age means that enrolment levels throughout the birth to school system are high and there is sufficiency of places.

Regulation: In the Netherlands, regulation and monitoring is achieved through a complex partnership between central and municipal government, sector-based partners and inspection services. Most municipalities are required by national government to adhere to national child care regulations to ensure the quality of provision in child care centres. Inspections are usually carried out annually by the Municipal Health Care Service inspectors and involve feedback from service users, to assess whether child care centres meet the national quality requirements as stated in the 2005 Dutch Childcare Act (OECD, 2000;

OECD, 2017c). These national quality requirements cover seven different domains: parental participation, personnel, health and safety, buildings and interior design, group size and child-caregiver ratio, pedagogical policy and practice, and complaint settlement. The findings of the inspection are registered in a public report which is sent to the municipal authority and includes advice on whether to carry out legal compliance procedures. Pre-school playgroups can also participate in a certification process for child care services on a voluntary basis (OECD, 2001; OECD, 2017c).

Workforce: The majority of personnel working in the child care sector for those under four years of age have a certificate awarded for the vocational training for childcare at intermediate level which is low compared with other EU countries. The minimum requirement is a vocational qualification at ISCED Level 3, but the number of caregivers with a certificate at ISCED Level 4 appears to be slowly increasing (OECD, 2016c). Teachers in Basisschools (for four to five year olds) need a bachelor or degree level qualification. Training for the health workforce is broadly comparable to that in other European countries; GPs train for between eight to 12 years to achieve a specialist status and other health workers training for two to four years. There is no evidence of any integrated workforce training initiatives.

Impact of system on child/family/providers

As stated earlier, assessing the impact of the early years system on child/family and providers is very complex and there is a lack of evidence from within the country as well as internationally comparable evidence on this. However, the UNICEF Child Wellbeing Study (UNICEF, 2013) reports that in 2013, *“the Netherlands retains its position as the clear leader and is the only country ranked among the top five countries in all dimensions of child wellbeing. The Netherlands is also the clear leader when well-being is evaluated by children themselves.”* Based on this, it can be concluded that the overall framework of services for children in the Netherlands has a positive effect on the well-being of its children.

The Netherlands gathers data on child outcomes for preschool children, but this is not made available nationally so no inference as to the impact of the system on these can be drawn (OECD, 2016c). There is however, some evidence on the educational performance of older children; according to the latest PISA reports on children’s educational performance at age 15, the Netherlands performed well, obtaining scores above the OECD average in science, mathematics and reading (OECD, 2018b).

Cost of system

There is a lack of published evidence on the specific cost of the early education and care system, due mainly to its complex structure and market based system which shifts much of the costs onto parents and businesses. The OECD data reflects this and reveals that in 2017 the Netherlands spent 0.4 per cent of GDP on early education and care, considerably lower than the OECD average (OECD, 2018a).

By contrast, the Netherlands spends considerably more on health care than many other countries as a share of GDP at 10.1 per cent and above the OECD average of 8.9 per cent (OECD, 2017b).

System change processes

System change has been encouraged in four main ways in the Netherlands:

- Establishing national system requirements for both health and early education and care within a **legislative framework**, and ensuring that funding for local municipalities and private and voluntary service providers is dependent on meeting these requirements;
- Requiring **business and families to make a significant financial contribution** to child care, working in partnership with public funding, thus securing their involvement and commitment to a cohesive system which meets the needs of children and families locally;
- Involving parents and local communities in the **evaluation and assessment** of the services to ensure that they work collaboratively to meet their needs;
- Keeping a clear focus on an agreed **conceptualisation of a system** that is shaped around the needs and wellbeing of children and ensuring all providers understand this concept.

Summary

Our analysis shows that the Netherlands has well established models of integration within its education and care system, but this is delivered entirely separately from health services. At this point we would classify the Netherlands as being at the first stage in the development of a fully integrated early years system which encompasses education, health and social care, being at Kotter's **Stage 1: Creating a climate for change**. There has been a sustained dialogue regarding securing conceptual integration between the two systems, with a clear view of a service which should focus on the needs of the child now and for the future but there has been little progress in structurally integrating the two systems.

In terms of education, care and social welfare, the Netherlands can be viewed as having a well-established '**unified**' model at both government and service delivery levels, through its universally-available day care centres and playgroups. With regard to health services, the Netherlands has a conceptually unified model of integrated service planning, but this is delivered structurally through a health system which works through a '**coalition**' model of integration rather than a unified one.

While some progress is being made at achieving **structural integration** within the two separate systems through collective action on policy, service delivery, access, regulation and

the workforce, it has yet to tackle the structural change required to become a fully integrated early years system. However, evidence indicates that the Netherlands has achieved **conceptual integration** which appears to enable the different systems to work effectively to secure good outcomes for children and families.

Phase 2: Key findings

This chapter highlights the integrated system models emerging from the evidence that may be helpful in translating ‘what works’ to Wales (while avoiding what doesn’t); it also reflects upon the change process as a country moves to establish a more integrated early years system, and what factors or actions might enable or inhibit the desired changes.

Alternative models of integrated systems

The four case studies in this review reveal governments at different stages in their progress towards achieving an integrated early years system. Belgium offers the most developed model of integration (Kotter Stage 3) and the Netherlands the least (Kotter Stage 1), with Denmark and Estonia making significant progress in the development of their integrated systems (Kotter Stage 2). This spread of maturity in the development of a unified and fully integrated early years system enables the identification of key steps at each stage to implement the policy and practice changes required as Wales develops its system.

Table 1: Model of integration and stages of change, whole system

	Model of integration			Stage of change
	Unified	Coordinated	Coalition	
Belgium		x		Stage 3
Denmark		x		Stage 2
Estonia		x		Stage 2
Netherlands			X	Stage 1

None of the case study countries has yet achieved a fully unified model for all their early years services (which includes education, care, social welfare and health) at policy or delivery level, with Belgium the closest to achieving that goal. Yet in all the case study countries education, child care and social welfare/child protection services have been integrated into one delivery system (see Table 2 below), with shared structures for workforce, admissions, regulation and funding, thus reflecting a unified model of integration for these aspects of their early years offer.

Table 2: Model of integration and stage of change – service delivery only (excluding health)

	Model of integration			Stage of change
	Unified	Coordinated	Coalition	
Belgium	X			Stage 3
Denmark	X			Stage 2
Estonia	X			Stage 2
Netherlands	X			Stage 1

In all cases, the health system remains distinct and separate at government and delivery levels, reflecting the historic evolution of health with its own system and professional identity in many countries. Education, child care and social welfare/child protection have been more easily viewed as linked and there has been much work internationally over recent years that has encouraged governments to view these services (education and care from birth) as an indivisible offer.

Such impetus for integration has not been evident to the same extent with health services. However, this is changing and three of the case study countries are working to bring their health services into a much closer systemic partnership with their education, care and social care services (which are already unified), through developing more coordinated planning and service delivery (explored later). The Netherlands is the least integrated, owing to its privatised and decentralised health service delivery model which inevitably makes closer alignment difficult due to market restrictions. It seems at government level, all case study countries view merging the child health system with the education, care and welfare systems at government level a step too far, and so all are currently adopting a coordinated model for this aspect of their early years offer, facilitated by a dedicated central agency.

Features of integrated early years systems

The UNESCO (2010) report provides a useful framework for analysing the key structural and conceptual features of an integrated early years system. The key relevant features are: policy, administrative/departmental integration, types of provision, access, regulation and workforce.

In all the case study countries there is **strong political commitment** to enhancing support for young children and families, particularly those who are less advantaged, with special educational needs or disability, or with a first language that differs from the local language - and to seeing this as a state responsibility and an essential part of the social welfare system. Investing in early years provision is viewed as a key aspect of government commitment to equality, social solidarity, social justice and social mobility; to enabling all children to have the benefits of accessing free, affordable and high-quality early education and child care,

enhancing child health and wellbeing; and to enabling parents of young children to access employment more easily and more equitably.

Political commitment has led the governments in this review to develop **statutory frameworks** for their early years services which are comprehensive and generous, giving young children and their parents statutory entitlements covering education, child care, health, child protection and family support from birth to school age. For example, in 2012 Belgium put in place a legal framework for early education and care with the aim of making this service universal and free for all children from 2.5 years, with an accompanying statutory responsibility for services to offer child care, early learning and parenting programmes in all settings. A similar legal framework for universal entitlement to health services is also in place in all of the case study countries.

In three of the countries, Belgium, Denmark and Estonia, the governments have also committed large amounts of **public funding** to these services, viewing it as a public good. In the Netherlands and Estonia, there is more expectation that the costs of early years services will be shared with parents and the business community, including for some health services.

Where there is a clear and articulated commitment at policy level, some countries' policy statements have a **stronger conceptualisation** about how an integrated system might work and what it might mean for service delivery - affording clarity to service providers. For example, Estonia and Denmark have both invested in focused initiatives to explore what the concept of an integrated early years system means, and how this might shape the future development of their system.

Administrative/departmental integration

There is international consensus that splitting responsibilities between different government ministries is a barrier to the development of an integrated system (OECD, 2017c). In all the case study countries, national level responsibilities for overseeing the full range of services for young children (education, care, health, social welfare) continue to lie across a number of departments or ministries; however, they have all either designated or created an **agency or department to coordinate policy across administrative divides**. Particular examples are Estonia's Health Insurance Fund for the health system, and Belgium's Office de la Naissance et de l'Enfance (ONE) in the French community and Kind en Gezin in the Flemish community, which have been created to coordinate all aspects of policy and provision for young children from birth, including education, child care, health and social welfare.

Despite this continued division of responsibilities at government level, in all cases the **ministries responsible for early education, child care and social welfare/child protection are working closely together or have merged**. Health ministries predominantly continue to work autonomously, but with an increasing commitment to coordinate with the other bodies responsible for services for young children. At this point there does not appear

to be an intent in any of the case study countries to merge child health policy with other early years policy responsibilities.

In all the case study countries there is significant decentralisation of administrative arrangements for early years and health services, with **multi-governance arrangements** being common. Responsibility for early years and health services is generally split between central and local government levels, with central government setting policy and delivery priorities, and local governments overseeing the delivery of these services. The commitment to decentralisation is particularly evident in Denmark and the Netherlands; these governments are actively moving responsibilities back to those who directly deliver early years and health services and also those who benefit from them, so sharing responsibility for self-regulation between providers and users of the systems. For example, in Denmark we can see that central government defines the overall legal framework applying to day care facilities, but individual municipalities have responsibility for developing operational guidelines for day care providers. Similarly, in the Netherlands decentralisation of regulatory responsibilities to local authorities is an ongoing process, where they are being given back to those directly involved in providing early years services and also those who benefit from them (OECD, 2017c).

Types of provision

In all the case study countries there is a mix of provision and providers of centre and home based services for young children and their families, and the mix changes as the child moves from babyhood through to school age, and through both universal and targeted services. Typically, universal services include free or subsidised access to early education and child care from birth to school age, and universal free access to maternity and child health checks. Some also include universal family and parenting support. Targeted services typically include specialist services to address particular needs - such as child protection and welfare, additional language support programmes, specialist support for children or parents with Special Educational Needs or Disability (SEND), or for newly-arrived families, which would be directed at certain sub-populations within a community. These targeted services might be provided within a universal service or at an additional location.

There are differing entitlements for **parental leave** following the birth of a child, with the most generous in Estonia and the least generous in the Netherlands (OECD, 2017c). This entitlement is improving for both fathers and mothers as the importance of the first few months of a child's life for attachment and social-emotional development are recognised.

In all countries there is access for parents to **free and universal pre- and post-natal care and support**, and then continuing regular **preventative child health checks** (usually annually). These child health checks are usually at specialist clinics, health centres or GP surgeries during the preschool years and then at school once the child enters the school system. Only in Belgium are these annual health checks increasingly carried out as part of

the services offered in fully integrated early years centres (Houses of the Child) and there appears to be good take up, enabling monitoring, and active and continuous preventative health practices throughout the child's early and school years. These continuous annual health checks address the gap between post-natal and school system health checks which can be the result of separate systems' lack of alignment.

Increasingly, **centre-based day care provision** is available, in some countries from the first few weeks after birth, to school age. Where parental leave is generous, such as in Estonia, this offer starts around 18 months to 2 years of age, or before should the child be identified as having particular needs (for example, a low-income family, a child with additional needs, a working parent or a parent with risk factors). In other countries such as Denmark or Belgium, it is seen as a right for all families to choose to send their child to a day care service from a very early age. In the Netherlands, it is seen as particularly important to encourage less advantaged children, children from migrant backgrounds, or children with additional needs, to help with their developmental progress and language proficiency - with the Netherlands seeing very early day care provision primarily as a targeted service. In the case study countries, day care services are increasingly offered as a free or subsidised universal entitlement as governments see the social, educational and economic benefits for children and families.

There is a **range of home-based and centre-based provision** in all countries, with some countries having a more diverse set of providers than others. The Netherlands predominantly has playgroups, which operate as day care centres, and can be run privately, by the local community or by the municipality according to local conditions; in Estonia and Denmark there are state-funded, integrated education, care and social welfare centres for children from birth to school age; and in Belgium there is a wider range of provision but all offer education and care, with increasingly a wider array of social care and health services offered. **Child protection** and **social care services** are generally offered as part of education and care services, are also delivered through these centres, and are universal and free.

In most cases, **annual health checks** and **specialist health services** operate separately from these education and care settings, although enhancing children's health and wellbeing would be seen as a key aspect of education and care provision. Distinctively, Estonia has a significant initiative to support children's mental health in all settings by linking parents with specialist mental health teams, including working within early education and care centres.

Access

In all the case study countries, there is a **stated aspiration for universal access** to early years and health services for all children and families. There are also relatively high levels of service coverage and high levels of enrolment of children from 3 to 5 years of age. For example, in 2016 Estonia had 90.7 per cent of three year olds accessing early education and care, and Denmark had 97.7 per cent of three year olds accessing early education and care

and 90% of children attending their preventative health checks. However, there was much lower enrolment of under-twos in both cases (OECD, 2017c). Even in countries where the aspiration for universal access exists, **availability of services can be patchy**, especially in rural areas, for younger children, where demand is high or if the child has particular needs. Further, some families, especially those from less advantaged backgrounds, do not take up entitlements to services even when available.

As finances become more restricted in these countries, there is a debate about whether resources should be targeted more clearly on children – for example towards low income families, to special needs and disability, to those displaying developmental delay, to those with a different home language to the local one, and/or to those in need of child protection.

All the case study countries were implementing **some form of targeted services alongside their universal offer**. This is a significant shift in policy, as countries like Denmark and Estonia have traditionally seen their universal offer as able to meet all needs. These targeted services were offered *on top of* the existing universal offer to increase access for these low participation groups: a policy of progressive universalism, except in the Netherlands which appears to be shifting to a more wholesale focus on targeted groups of children. Some countries target geographically, and others target children and families with particular characteristics. For example, in Belgium, there are incentives for increasing services in regions where there is an imbalance in service availability as well as targeted interventions to support newly arrived families, low income families, and children with special educational needs or disabilities. Belgium is also working to **improve its data information systems** in the early years and health sector, using individualised data to better track system imbalances and inequalities in access and availability.

Regulation

A further feature of structural integration is the development of a **common regulatory framework for all early years and health services**. In the case study countries there remains work to do to achieve a common regulatory framework but there is progress, at least across education, care and welfare services. The health system in all countries has its own regulatory framework, although in some cases, such as Estonia and the Netherlands this does not cover all health providers. In Belgium, the coordinating agencies responsible for child care and health (ONE and Kind en Gezin) require all service providers to sign up to a quality code, and host teams whose main function is to inspect compliance and support quality improvement in all settings. Denmark, Estonia and the Netherlands have national inspection services for education and care who check compliance with national guidelines, with a similar system for health services. Denmark also has a voluntary quality assurance/accreditation system, which encourages providers to move beyond minimum standards.

Workforce

Recruiting and retaining a high quality workforce for early years services remains a challenge - particularly in those countries where historically there has been little investment in the workforce, as in Belgium and the Netherlands. Early years staff can have a wide range of professional training, roles, responsibilities, pay scales and professional career routes, with a **complex and under-qualified workforce being common**. In Denmark and Estonia there is an historical expectation that early years and health professionals will be very well qualified (graduate and above) and professionalised, but other countries have a long way to go to achieve this. Training across the system can therefore remain fragmented. In terms of workforce training, development and deployment, an integrated workforce system is slowly developing for those who work in education, care and social welfare, but health professionals remain within their own workforce strategy in all the study countries.

Approaches to integration

This review offers some evidence that can provide an indication of the processes of change undertaken as countries move towards more integrated systems of early education, care, health and social welfare. This analysis has been complemented with insights from the authors' professional experience of early years system change in the UK.

Actions at Kotter Stage 1: Creating a climate for change

In the first stage of developing an integrated early years system it is evident that there must be an agreed, top level, **government commitment** to an integrated approach from all departments/ministries with a stake in the services. This may involve **reconfiguring departmental responsibilities** or identifying a central agency or body to coordinate the work of different departments. At this stage, the government should set out a **clear and coherent vision** of what an integrated early years system should look like, which informs the development of an integrated early years policy. It should also set out how progress towards it will be made with a short, medium and long term plan of action. This vision then needs to be powerfully communicated to inspire and engage all key stakeholders. Even if additional **funding** is not available, existing funding should be used as a lever to incentivise the required changes. Any required **legislative actions** need to be enacted.

In the case study countries these actions can be seen to be underway:

- Establishing national system requirements for both health and early education and care within a **legislative framework** and ensuring funding for local municipalities and private and voluntary service providers is dependent on meeting these requirements. (the Netherlands);
- Requiring business and families to make a significant **financial contribution** to the systems, working in partnership with public funding which has secured their

involvement and commitment to a cohesive system which meets the needs of children and families locally. (the Netherlands);

- Keeping a clear focus on an agreed **conceptualisation of a system** that is shaped around the needs and wellbeing of children and ensuring all providers understand this concept. (the Netherlands);
- Dialogue about the **conceptualisation** of more cohesive and joined up services across the education and health systems. (Denmark);
- A **conceptualisation programme** to enhance the understanding of integrated system delivery has been launched to support cross sector thinking about how an integrated system might be developed and delivered. (Estonia).

Actions at Kotter Stage 2: Enabling organisation(s)

In the intermediate stage, there is a need to work on structural integration. It is important to continue to **communicate the vision** to achieve buy-in from a wider group of stakeholders and system leaders. As change requires leadership at all levels from those who really understand what an integrated system means and how to work within this new context, a shared programme of **system leadership training** is beneficial for senior leads across the different services, including education, care and health. Changes at delivery level may be best achieved through resourcing innovative and **targeted programmes** that embody an integrated approach, which can generate new knowledge and disseminate their experience of working in this way. The **active participation of service providers and users** in developing new models of service delivery can also ensure the changes are viewed as realistic, beneficial and viable.

In the case study countries these actions can be seen to be underway:

- The Estonian government has provided funding for **specific projects** aimed at developing a more integrated education, care and health system. This funding for focused and time limited projects has acted as a lever to pilot changes and encourage the development of new system practices. (Estonia);
- **Incentivising day care centres** to support less advantaged children, children with special needs, and migrant children. (Denmark);
- Bringing together **preventative social care services with universal education and parenting support**. (Denmark);
- Developing GP-run **health centres** within local communities and home-visiting health visitors to adopt a more cohesive, joined up approach throughout a child's life. (Denmark);

- **Involving parents and local communities** in **evaluating and assessing** the services to ensure that they work collaboratively to meet their needs. (the Netherlands);
- The Estonian Social Insurance Board has piloted and implemented **regional support units** to build strong links between state and local level, channelling national policy related to children, youth and families to the local level with advice and support for local governments in planning changes towards more integrated service delivery. (Estonia);
- **Supervision, co-vision and coaching** have been found to be integral in supporting frontline specialists to work in a more integrated way (Estonia).

Actions at Kotter Stage 3: Implementing and sustaining

In the final stage, there is a need to embed the vision and required system changes alongside an ongoing commitment to learn from what works and make ongoing adjustments to achieve the desired model of integration. This requires **continued government commitment** to the integrated model and high levels of **policy visibility** to keep the change momentum going. System leaders at department and service delivery levels need training and support to commit **management time** to both sustaining the change process and securing the detailed changes required to make it work. All existing and new **funding** needs to be used as a lever for further integrated working. As the system develops, the policy implementation plan needs to adopt a **flexible and adaptable approach** to ensure it can be locally contextualised and adjusted to ongoing wider societal changes. The functioning and impact of the system change should be carefully **documented and evaluated** to enable organisational learning.

In the case study countries these actions can be seen to be underway:

- **Concertation**, which is a form of decision-making which encourages dialogue and cooperation between various bodies; . (Belgium);
- **Management reform** and training to ensure local system leadership can be provided to make change happen. (Belgium);
- Efforts to form **new positions** that co-ordinate early childhood services across various bodies. (Belgium);
- **The development of coordinated planning** across service providers at a local level. (Belgium);
- Strong commitment from university researchers to the early childhood sector, resulting in many **action-research projects** in collaboration with teachers and staff (OECD, 2017), helping to address workforce and practice quality issues. (Belgium).

Gaps in the evidence

Alongside the issues discussed above, this review also set out to explore evidence of the effectiveness of integrated early years systems, the impact of these systems on outcomes for children and families, for provider services and outputs, and the cost effectiveness and relative cost of each model for the outcomes achieved.

The review found very limited robust evidence to address these questions in the case studies or the wider review of evidence. Even data on broad spending as a proportion of GDP was difficult to disentangle from other spending in a comparable way. This review sets out what evidence there is within each of the four case studies, but we do not feel there is enough evidence to draw any conclusions or making any wider recommendations on the basis of this very limited data. It is clear to us that the impact and cost effectiveness of early years policies are under-researched owing to the complexity of these systems, the dynamic nature of provision, the lack of an evaluative and outcomes based culture in many early years settings, methodological challenges, and also ethical concerns about introducing performativity frameworks around young children and vulnerable families.

Final reflections

This review set out to explore the available evidence on integrated early years systems from countries comparable to Wales. Our analysis offers a range of alternative approaches and models of integrated systems, and explores the development process to be undertaken, and the structural and conceptual changes required, as countries set out to realise this vision. It is hoped that this evidence can help to inform the Welsh Government as it sets out to develop an integrated early years system for Wales.

Reflecting on this evidence a number of overarching lessons can be drawn:

- There is **no 'one size fits all' approach** to developing an integrated system of early education, health and social care. Local circumstances and contexts need to be considered as starting places for change to occur which has to be locally situated and flexibly implemented;
- Most countries are in the process of creating their integrated early years system, **with no one country having 'arrived'** and so offering a complete transferable model;
- The review indicates that there is no one country that can offer a fully functioning model of an integrated system that can be replicated in Wales, but **aspects of system development and structural features** drawn from a range of countries in this review **can usefully inform** the development of an integrated early years system in Wales;

- There are various models and levels of integration, from a fully unified or integrated model, to more loosely coupled models, but a **hybrid of approaches** may be pragmatic and workable in the short and medium term;
- **Clarity of vision, sustained government commitment and system leadership** at central and local level are key to the change process, which will take time (more than one parliamentary term to embed) and maybe legislation to achieve;
- The process of change requires **funding and resources** to be used as a lever to incentivise integrated working, even when no additional funding is available;
- Most countries begin the change process with a **targeted programme** or initiative from which **learning can be generated** before wider roll out of the change system-wide;
- The **biggest challenge** is to join up early education, care and family support systems (which seem to be easier to fully integrate) with the health system, especially when there is disconnection between the health services that offer support at different stages in a child's life (e.g., post-natal to school age);
- The system change undertaken should be **documented and evaluated** to generate learning which can be shared.

Creating an integrated system of early education, health and social care services is a valid and worthwhile aspiration that is shared by governments in many countries. All the evidence provided here should be considered in relation to the specific priorities and goals across Wales. That said, what is evident from this review is that all such programmes of system change require government commitment, clarity of vision, leadership, time and smart funding to be successful.

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Author Details

Chris Pascal is Professor of Early Childhood Education and Director at the Centre for Research in Early Childhood in Birmingham, England. She also holds Professorial posts at Birmingham City University, The University of Birmingham and Wolverhampton University. She is a Co-Founder and President of the European Early Childhood Education Research Association.

Tony Bertram is Professor of International Early Childhood Education and Director at the Centre for Research in Early Childhood in Birmingham, England. He holds Professorial posts at Birmingham City University, The University of Birmingham and Wolverhampton University. He is a Co-Founder and Coordinating Editor of the European Early Childhood Education Research Association.

Kathryn Peckham is an independent early childhood consultant, researcher, trainer and author who works with the Centre for Research in Early Childhood where she is undertaking her doctorate.

For further information please contact:

Paul Worthington

Wales Centre for Public Policy

+44 (0) 29 2087 5345

info@wcpp.org.uk

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