# CHAPTER 1

# The importance of health and wellbeing

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## Introduction

According to the United Nations, the world population was 7.3 billion in mid-2015 and is projected to increase to over 8.5 billion in 2030 (United Nations, Department of Economic and Social Affairs, Population Division, 2015). In 2015, 26 per cent of the world population was aged between birth and 15 years (United Nations, 2015). It is predicted that by 2050 the relative percentage of young people aged 0–9 will decline – see Figure 1.1 (United Nations, 2015). More than half the global population growth up to 2050 is expected to occur in Africa. These demographic trends result from a combination of increased life expectancy, along with the effects of birth and population controls affecting fertility rates. What is evident is that the proportion of the world population in the birth-through-childhood group is large and, although it will decrease proportionately in the future, it will continue to be a dominant group in the world population (see Figure 1.1).

Children currently aged 0–15 years are all members of Generation Z. A **generation** is typically defined as the average interval of time between the birth of parents and the birth of their offspring with on average a birth generation 20–22 years, and a lifespan four times that generational length (Pendergast & Garvis, 2014). Every person is a member of a generation and this is based on their year of birth. Generational theory seeks to understand and characterise cohorts of people according to their birth generation. It is a dynamic socio-cultural theoretical framework that employs a broad brush-stroke approach, rather than an individual focus (Pendergast, 2008).

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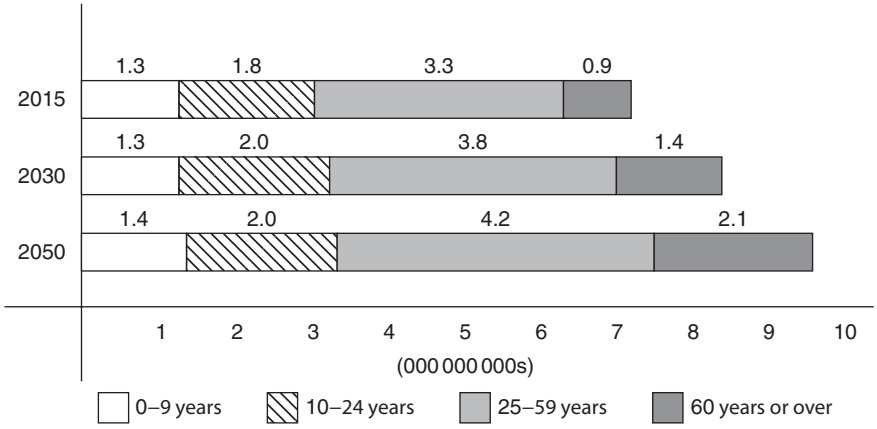


**Figure 1.1** Global population by age group – 2015, 2030, 2050.

Generations are defined not by formal process, but rather by demographers, the press and media, popular culture, market researchers, and by members of the generation themselves (Pendergast, 2007). The basic notion is that as members of a generation, we typically share a birth year range, which is more likely to expose us to experiences that are typical of that time, and to a set of social and economic conditions that shape our generation in particular ways. The effect is the emergence of patterns and influences on collective thinking which leads to the acquisition of broad and common values and beliefs. The acquisition of values and belief systems principally occurs during the formative or childhood years of each generation (Pendergast, 2008).

The birth years for Generation Z commenced in 2002 and in 2017 incorporates our current young people up to the age of 15. The values and beliefs of the emerging generation are being shaped and defined, with contemporary world and local events impacting on this generation in ways never before experienced. According to McCrindle (2013), three words summarise Generation Z: global, visual, digital (see Figure 1.2). He explains that this group of young people are being shaped by the shifts in society resulting from acceleration and rapid change in complex times. Features of these times include the advancement of digital technology into almost every avenue of people's lives, along with a global perspective and visual pedagogies that come with the tools of technology. Peers remain a significant shaping force.

Along with the establishment of values and belief systems, the early years from birth to 12 years are increasingly recognised as the crucial time for laying the foundations for life with significant consequences for ongoing educational success, resilience and future participation in society. The formative years are the years where the capacity to make a difference can and does have profound effects. Carers and educators need specialist preparation as they are required to promote and teach health and wellbeing and to have the skills and knowledge to understand and manage the plethora of issues related to young children. Around the world, including in Australia, **early years** education is undergoing significant reform

**Early years** include preschool and the first two years of formal schooling.

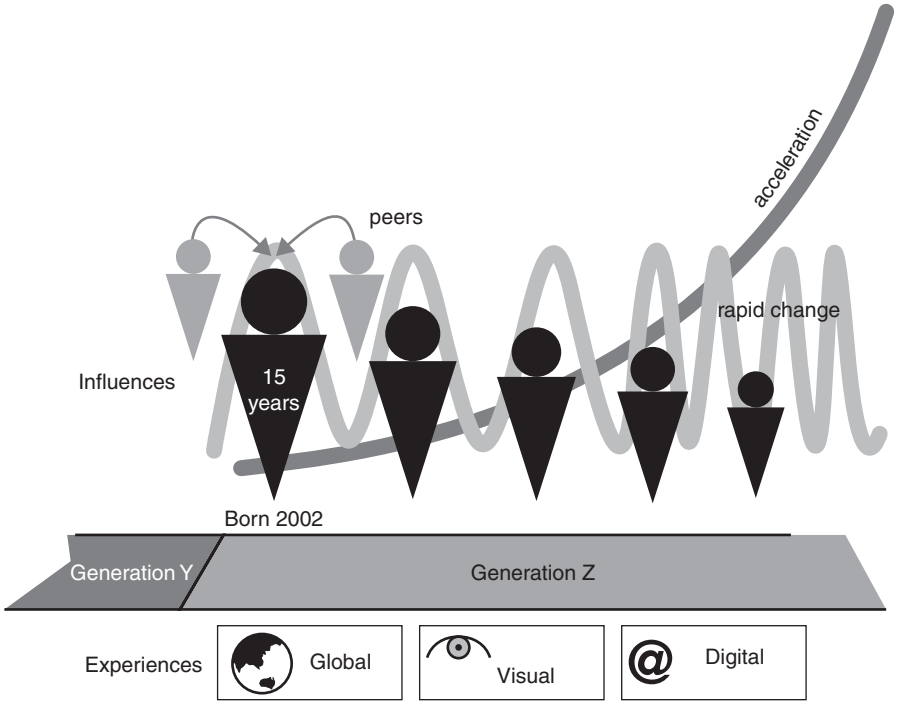


**Figure 1.2** Snapshot of Generation Z.

as the potential to improve quality of life is better understood. These reforms place health and wellbeing as central constructs of this agenda. This chapter will explore the concepts of health and wellbeing and will share some of the initiatives that have put health and wellbeing on the agenda for early years learners in contemporary times.

## Health

According to the World Health Organization (WHO), in a definition that has stood the test of time and remains unamended since 1948, '**health** is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1948). The first international conference for the promotion of health was held in 1986, and it was here that the *Ottawa Charter for Health Promotion* (*The Charter*) to encourage action to achieve health for all by the year 2000 and beyond was formalised, and the public health agendas around health promotion were shaped globally for the first time. According to *The Charter*, the fundamental conditions and resources for health are: peace; shelter; education; food; income; a stable ecosystem; sustainable resources; social justice; and equity. Improvement in health requires a secure foundation in these basic prerequisites (WHO, 1986).

**Health** is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (World Health Organization, 1948).

Consistent with this view, the Australian Institute of Health and Welfare (AIHW) (2012) notes that a person's health and wellbeing result from a complex interplay between biological, lifestyle, socio-economic, societal and environmental factors, many of which can be modified to some extent by health care and other interventions. Given the scope and complexity of these fundamental conditions and resources, the challenge of achieving health for all is patently obvious. For early years learners, who are reliant upon others for the provision of these conditions and resources, the challenges are even greater.

## Wellbeing

The definition of health is dependent upon an understanding of the concept of 'physical, mental and social wellbeing'. The term **wellbeing** is a ubiquitous term that is used widely in the full range of discourses in society, including in policy and legal arenas, in education and the academy, in the workplace, in commercial settings and in media discourses such as television and magazines. However, there is no single definition of this commonly used term, which is in use around the world.

**Wellbeing** is a way of considering an overall state of being that might be measured using a range of indicators that are typically context specific.

### SPOTLIGHT 1.1: DEVELOPING AN EVIDENCE BASE ABOUT HEALTH AND WELLBEING

In the last two decades the Organisation for Economic Co-operation and Development (OECD) has worked with a number of researchers to develop a sound evidence base that can inform policy makers and citizens to better understand the notion of wellbeing and to develop measures in order to improve wellbeing. For example, recent work on subjective wellbeing links the concept with happiness and quality of life (OECD, 2013). The OECD's Better Life Initiative, launched in 2011, aims to measure society's progress across 11 domains of wellbeing, ranging from income, jobs, health, skills and housing, through to civic engagement and the environment.

In a study conducted by Ereaut and Whiting (2008) titled *What do we mean by well being? And why might it matter?* the researchers concluded that 'we can see the complexity of definition and possible meaning for contemporary ideas of wellbeing … in fact, the research showed that the word "wellbeing" behaves somewhat strangely, and contains many anomalies and puzzles' (p. 6). The researchers settled on six key discourses that each hold a place in our understanding and use of the term wellbeing:

- *Wellbeing and the medical heritage*. This is where wellbeing is regarded as being closely aligned with the notion of health. This version of wellbeing is considered to be the dominant discourse for the term wellbeing.
- *Wellbeing as an operationalised discourse*. This is where wellbeing is formalised into measures which can be used as indicators of wellbeing, including desired outcomes and indicators of achievement.
- *Wellbeing as sustainability discourse*. This notion of wellbeing incorporates the idea of responsible society and the capacity to be replicable and more widely available for people; not just the individual.
- *Wellbeing within a discourse of holism*. The notion that not only the mind and body are the focus but also the social, environmental and other facets of life.
- *Wellbeing and philosophy*. In this understanding of wellbeing the notion of aiming for an ideal state, with a vision of what is best and desirable for a person, is the core meaning.
- *Wellbeing, consumer culture and self-responsibility*. This is a discourse where people are encouraged to strive for resilience, independence and achievement and to take personal responsibility for decision-making, their health and ultimately their sense of wellbeing.

For the purposes of this book, we are taking the multiple meanings of wellbeing, along with the dominant discourse connecting it to the health agenda, thereby incorporating the broad discourses of wellbeing and considering these in terms of early years learners. Bradshaw, Hoelscher and Richardson (2007) assist in honing the definition of wellbeing for the early years. They define child wellbeing as 'the realisation of children's rights and the fulfilment of the opportunity for every child to be all she or he can be in the light of a child's abilities, potential and skills' (p. 8). So, what are children's rights?

## Global context: Health and wellbeing

The Convention on the Rights of the Child (CRC) is the most recognised international treaty setting out the basic rights of children, along with the obligations of governments to fulfil those rights. It has been accepted and ratified by almost every country in the world. The treaty was adopted by the United Nations General Assembly in 1989 and ratified by Australia in 1990 but is yet to be incorporated into Australian law. The Convention has 54 articles, with numbers 43–54 specifying how adults and governments should work together to make sure that all children realise their rights. The articles have four fundamental principles:

1. *Non-discrimination.* Children should neither benefit nor suffer because of their race, colour, gender, language, religion, national, social or ethnic origin, or because of any political or other opinion; because of their caste, property or birth status; or because they are disabled.
2. *The best interests of the child*. Laws and actions affecting children should put their best interests first and benefit them in the best possible way.

3. *Survival, development and protection*. The authorities in each country must protect children and help ensure their full development – physically, spiritually, morally and socially.
4. *Participation*. Children have a right to have their say in decisions that affect them and to have their opinions taken into account (UNICEF, 2013).

The United Nations Committee on the Rights of the Child monitors compliance with the CRC, with governments reporting every five years on what they are doing to ensure that children's rights are being met.

In their working paper developed for the United Nations Children's Fund (UNICEF) *Child Well-being in Advanced Economics in the Late 2000's,* Martorano et al. (2013) set out to develop a Child Well-Being Index in order to rank countries according to their performance in advancing child wellbeing, as underpinned by the framework of the Convention on the Rights of the Child. This is a challenging undertaking, as there is no consensus on how to operationalise and measure the concept of child wellbeing, although there have been many attempts to construct indexes over recent years. Most of these attempts are fraught with problems due to the lack of generalisability beyond country contexts or other factors such as a lack of measureable indicators. Utilising the Bradshaw et al. (2007) aforementioned definition of child wellbeing, Martorano et al. (2013) captured data for 13 components aggregated into five dimensions which they regard as representing child wellbeing, these being: material wellbeing; health; education; behaviour and risks; and housing and environment (see Table 1.1). Thirty-five countries received a score on the indicators and combinations of variables. Several did not have enough data for each indicator so were excluded from comprehensive analysis and commentary, including the countries of Australia, Japan and New Zealand.

Martorano et al. (2013, p. 41) concluded that:

> *most countries have at least some or several dimensions or components that show a relatively disappointing performance. Some countries do relatively well on most dimensions (the Netherlands and the Scandinavian countries, except Denmark) and some countries perform relatively badly on most dimensions and components (Bulgaria, Romania, the United States). The Child Well-Being Index and the results on its dimensions, components and indicators reveal that serious differences across countries exist; suggesting that in many countries improvement could be made in the quality of children's lives.*

An important initiative that set out to make substantial progress against the global problems of poverty, health, education and the environment was the establishment in the year 2000 of the United Nations Millennium Development Goals (MDGs) for 2015 (United Nations, 2000). All 189 member states of the United Nations including Australia committed to eight goals and targets, as outlined in Table 1.2.

Without exception the MDGs have the potential to impact on the health and wellbeing of early years learners around the world. In particular, Goal 2 – to achieve universal primary education – is particularly pertinent to health and wellbeing as

**Table 1.1:** Child Well-Being Index – dimensions, components and performance.

| Dimension | Component | Examples of indicators used | Best performers | Worst performers |
|---|---|---|---|---|
| **Material wellbeing** | Monetary deprivation | Relative child poverty<br>Child poverty gap | Netherlands and Nordic regions | Romania, Eastern European countries, United States |
| | Material deprivation | Deprivation index<br>Family affluence scale | | |
| **Child health** | Health at birth | Birth rate<br>Infant mortality rate | Finland, Iceland, Luxembourg, the Netherlands and Sweden | United States, Romania, Latvia and Lithuania |
| | Child mortality | Child death rate | | |
| | Preventive health services | Immunisation against DPT3, measles and polio | | |
| **Education** | Educational achievement | OECD PISA reading, maths and science literacy | Nordic European countries, Belgium, Germany and the Netherlands | Romania, Greece and the United States |
| | Participation | Early childhood education<br>Youth education<br>Neither employment nor education | | |
| **Behaviour and risks** | Experience of violence | Fighting in schools<br>Bullying in schools | Nordic and Western European countries | Southern, Central and Eastern European countries |
| | Health behaviour | Eat breakfast daily<br>Eat fruit daily<br>1 hour physical activity daily<br>Overweight according to body mass index | | |
| | Risk behaviour | Cigarettes, alcohol and cannabis consumption<br>Teenage fertility rate | | |
| **Housing and environment** | Overcrowding | Number of rooms / person / household with children | Switzerland, Ireland and Norway | Central and Eastern European countries, Greece, Italy and the United States |
| | Environment | Homicide rates<br>Outdoor air pollution measure | | |
| | Housing problems | Moisture<br>Darkness<br>No bath or shower<br>No flush toilet | | |

Source: Developed from Martorano et al. (2013).

**Table 1.2:** The United Nations Millennium Development Goals (MDGs) for 2015.

| Goals | Targets |
|---|---|
| Eradicate extreme poverty | • Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day<br>• Achieve full and productive employment and decent work for all, including women and young people<br>• Halve, between 1990 and 2015, the proportion of people who suffer from hunger |
| Achieve universal primary education | • Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling |
| Promote gender equality | • Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015 |
| Reduce child mortality | • Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate |
| Improve maternal health | • Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio<br>• Achieve universal access to reproductive health |
| Combat HIV/AIDS, malaria, other diseases | • Have halted by 2015 and begun to reverse the spread of HIV/AIDS<br>• Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it<br>• Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases |
| Ensure environmental sustainability | • Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources<br>• Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss<br>• Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation<br>• Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers |
| Develop a global partnership for development | • Address the special needs of least developed countries, landlocked countries and small island developing states<br>• Develop further an open, rule-based, predictable, non-discriminatory trading and financial system<br>• Deal comprehensively with developing countries' debt<br>• In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries<br>• In cooperation with the private sector, make available benefits of new technologies, especially information and communications |

Source: United Nations (2000).

the notion of a minimum global attainment for all children by 2015 would serve to lift the levels of literacy, numeracy and scientific literacy, thereby improving health and wellbeing status globally.

## Australian context: Health and wellbeing

### SPOTLIGHT 1.2: AUSTRALIA'S CHILDHOOD POPULATION

On 8 April 2016 the resident population of Australia was projected to be 24 039 377 (Australian Bureau of Statistics, 2016). Children aged 0–9 years make up 12.6 per cent of the population, and is a total of 18.8 per cent if the age group is extended to include all children up to 14 years of age (AIHW, 2012).

There are many agencies in Australia that provide updates of indicators related to children's health, development and wellbeing. A report compiled by the AIHW (2014) set out to map the indicators and reporting frameworks and their possible intersections, revealing that the Key Child National Indicators reported by the AIHW is the most comprehensive with 56 indicators. For that reason we will turn to these indicators to consider the current state of play for child health and wellbeing in Australia (see Table 1.3).

What these data indicate is a wide range of variability in the health, development and wellbeing of young Australians aged 0–14 years, and a lack of comprehensive knowledge in some core areas where we might expect to have a clear understanding of our practices, especially with regard to proportion of children attending early childhood education programs. The variability is geographic and between some population groups. New South Wales, Victoria, Western Australia, South Australia and the Australian Capital Territory had results better than, or similar to, the national average across either all or most of the indicators, with available data. Queensland, Tasmania and the Northern Territory had poorer results than the national average on several indicators, with Queensland's and the Northern Territory's results on all education-related indicators less favourable than the national average and with higher teenage birth rates. Aboriginal and Torres Strait Islander children, children living in remote areas and children living in socio-economically disadvantaged areas were all markedly extremely less favourable on many of the indicators, especially when the compounding effects were taken into effect.

Australia's child vulnerability in 2013 was reported to be 22 per cent (Australian Government, 2013), which refers to the percentage of young people who are developmentally vulnerable on one or more domains, as measured using the Australian Early Development Index (AEDI). The AEDI measures five areas of early childhood development from information collected through a teacher-completed checklist for children in their first year of formal full-time school.

**Table 1.3**: Trends for Australia's children aged 0–14 years: Health, development and wellbeing.

| Priority area | Indicator | Explanation | Trend<br>✓ = favourable<br>X = unfavourable<br>= = no change or clear trend<br>? = no trend data available |
|---|---|---|---|
| **Healthy** | Mortality | Infant and child mortality is a key indicator of the hygiene and health conditions prevailing in a country, and the effectiveness of the health system in maternal and perinatal health. | ✓ |
| | Morbidity | Chronic conditions can affect normal growth and social, emotional and physical wellbeing. | ✓ |
| | Disability | Disability can have diverse effects that may restrict children's full involvement in society. | = |
| **Promotion of healthy child development** | Breastfeeding | Breastmilk provides the best nutritional start for infants and promotes their healthy growth and development. | ? |
| | Dental health | The dental health of children affects their wellbeing and self-esteem. Untreated dental decay is a risk factor for infection and chronic disease in adult life. Most dental diseases are, however, preventable. | ? |
| | Early learning | Children who attend early childhood educational programs 0–2 show better performance and progress in their early school years in both intellectual and social domains. | ? |
| **Learning and development** | Transition to primary school | Children entering school with basic skills for life and learning have higher levels of social competence and academic achievement, increasing their likelihood of achieving their full potential. | ? |