The 18-month well-baby visit: A commentary

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Canadians working in early child development often ask themselves, 'Why don't we just give up and move to Sweden?' As Williams et al (1) point out, Canada is currently ranked 12th among 21 economically advanced countries on UNICEF's Child Well-Being Scale (2). Furthermore, despite nominal 100% literacy rates, we continue to send 30% to 40% of Canadian children into adulthood without the reading and numeracy skills they need to cope in an information-based society (3). Meanwhile, Sweden and the other Nordic countries go from strength to strength, outdoing us in every measurable category of child health and development. They have even eliminated virtually all measurable inequalities for their indigenous populations – the northern Sámi (4).

Sweden consciously began a process of investing in the early years back in the 1960s and, over the following four decades, put in place a comprehensive system of income supports, parental work leave, high-quality early child development and parenting centres (for which they use the term 'preschool'), neighbourhood strengthening policies and flexible transition from preschool to school. They can demonstrate that their levels of public spending are highest at the ages of greatest synaptic development in the brain, and less thereafter, whereas in Canada, investment is inversely proportional to synaptic development. One crucial element of the Swedish system is monthly developmental follow-up during the first 18 months of life, concurrent with the period of funded parental leave. In practice, Bremberg (5) reports that Swedish children end up with 13 to 18 visits, such that, by the time they enter preschool, virtually all developmental delays have been identified and addressed. When I pointed out to Bremberg that, in Canada, a large proportion of vision, hearing, dental and speech/language problems are not detected until school age, he gave me the sort of pitying look that I suppose we give to those whose homeland is mired in poverty or strife.

And yet, Canada has its own traditions of sustained progressive change, reflected in international ranking systems that do not weigh children heavily, such as the Human Development Index (6). Now it is time to bring to Canadian childhood the spirit that has gone into multiculturalism, universal medicare and income security for the elderly. Unlike Sweden, progressive change in Canada has not followed a straight line from planning to policy to action. It has come about through a diverse set of 'actors' (as the political scientists like to say) from different walks of life working in ways that, over time, converge on a common goal. Not surprisingly, then, all of the elements that would make up a world-class system of supports for early child development have already been proposed for Canada. But we have not had the vital element of convergence, and so progressive proposals have been left scattered about the policy landscape akin to hotdog wrappers after a hockey game. In this context, civil society leaders (for example, primary care physicians) have a very important role to play – to find and exploit the prospects for convergence where and when they exist.

This is why I am very enthusiastic about the articles in the present issue.

These articles describe the rationale, content and implementation of the enhanced 18-month developmental screening model, which is a paragon of convergence. It fills an important gap because, in most provinces, the 18-month well-child visit is when the last scheduled immunization is given until the child is four years of age and, therefore, is an important time to thoroughly evaluate the child's physical and social development. The primary care model described here builds on a strong evidence base and is, thus, defensible and ready for scaling up. It has the potential to be highly efficient because family physicians, paediatricians, public health nurses and other primary health care providers are well positioned to provide identification and intervention for developmental delay in early childhood (7). Furthermore, it is proposed that primary health care providers use the platform as an opportunity to understand and address the broader social determinants of health – poverty, unemployment, illiteracy and mental illness – as they apply to individual families.

Most important, however, is the fact that community development and family strengthening are at the core of the model. An underlying premise is that when there is collaboration among parents, primary care, community health and child development services, outcomes for children will be improved. Indeed, we already have an extensive evidentiary base showing that children in a community can benefit from early infant and child intervention programs at family resource centres, good and high-quality day care facilities, play groups and nursery schools. Thus, the recommended model not only aims to find and treat developmental problems, it is designed to strengthen primary care as a delivery

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Accepted for publication October 14, 2008

system, enhance the role of the public health nurse, and convert primary health care into a credible point of entry into the bewildering array of community-based programs and services available to help young children thrive. Pilot studies have shown that the model may, in fact, deliver on its promise. Williams et al (1) provide data and observations from two pilot sites showing increased parental exposure to information on child development, increased parental consciousness of community resources, increased use of community programs and services, increased reading to young children and increased referrals to speech and language services.

Canada has a long way to go to meet the developmental needs of its youngest children, but the 18-month screening model proposed here is an important step. It is time to seriously think about bringing it to scale in communities across the country.

CONFLICT OF INTEREST: Dr Williams and Dr Hertzman work together at the Council for Early Child Development.

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