

The health effects of Sure Start

Executive summary

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Executive summary

From lagging well behind most European countries in the early 1990s, the UK is now one of the highest spenders on the under-5s in Europe (OECD, 2014). One of the biggest programmes for this age group is Sure Start. It offers families with children under the age of 5 a 'one-stop shop' for childcare and early education, health services, parenting support, and employment advice, with the aim of improving children's school readiness, health, and social and emotional development.

Sure Start has had a turbulent history. The programme was first introduced in 1999 as Sure Start Local Programmes, targeted at highly disadvantaged neighbourhoods. Five years later, the 10-Year Strategy for Childcare called for 'a children's centre in every community', transforming the initiative into a universal service. At its peak in 2009–10, Sure Start accounted for £1.8 billion of public spending (in 2018–19 prices), about a third of overall spending on programmes for the under-5s (Belfield, Farquharson and Sibieta, 2018). But in the decade since, the context has been one of funding cuts, consolidation and centre closures, with funding falling by two-thirds to £600 million in 2017–18.

Despite its rapid expansion and the subsequent cuts, evidence on the impact Sure Start has had on the health of children and their families is still relatively scarce. The initial evaluation of the programme focused on the earliest years of Sure Start and found some health benefits for children living in neighbourhoods with access to the earliest Sure Start Local Programmes. A subsequent evaluation centred on describing and assessing different patterns of family use in the early 2010s and found little evidence of a link between more frequent use of services and children's health.

In this report, we take a step back to consider the overall impacts on health of the Sure Start programme as a whole between its inception in 1999 and its peak in the late 2000s. Our focus on health outcomes is motivated by the fact that, while Sure Start's services were multifaceted and varied between centres and over time, one of its objectives was to improve children's health and an important component of its offer was health services. These include both direct provision of new services (e.g. baby-weighing clinics) and outreach to signpost parents to existing healthcare.

Data and methodology

We use a new data set that gives the location and opening date of all Sure Start centres (both Children's Centres and their predecessor Local Programmes) combined with big data sets that cover children across England and collect outcomes (on hospitalisations and obesity) over many years. The scale of these data makes it possible for us to generate more precise estimates of the programme impacts and to investigate how these effects differ for different groups.

These big data sets also make it possible for us to look at the impacts of Sure Start for children born over the entire period from its inception in 1999 to its peak in 2009–10. We focus on their medium-run health outcomes to see whether the programme has any impacts that last after children start school (and stop visiting Sure Start centres). We explore the impact that Sure Start has on hospitalisations throughout primary school (ages 5–11). We also provide exploratory evidence about the programme's impacts on child obesity and on maternal mental health.

We use statistical techniques to robustly estimate the *causal* impact that Sure Start has on children's outcomes. We use new data on the precise location and opening date of Sure Start Local Programmes and Children's Centres to define a measure of 'access to' Sure Start, which changed over time as the programme was rolled out. Using a difference-in-differences methodology, we compare the outcomes of children in the same neighbourhood with more or less access to Sure Start, after accounting for both permanent differences between neighbourhoods and nationwide differences between years. This strategy lets us isolate the causal impact of *having access* to Sure Start during the first five years of life on children's later-life health and the health of their mothers.

The measure of 'access' that we use is the number of centres per thousand children of Sure Start age in each local authority. Sure Start centres were designed to serve local children and families, so from a policy perspective benefits should be measured across all the children they were intended to serve (and not only those who use them). For each child, we calculate their access to Sure Start each month for their first five years of life, then calculate an average level of coverage over the ages 0–4.

Key findings

- **Sure Start reduced the likelihood of hospitalisation among children of primary school age. These benefits get bigger as children get older.** We measure the impact of providing greater access to Sure Start – equivalent to boosting Sure Start coverage from nothing to the average level of coverage at the programme's peak, around one centre per thousand children – on the probability that there is at least one hospital admission among the boys or girls born in a particular month and year in a particular neighbourhood. At age 5, greater Sure Start coverage reduced this probability by 4% of its baseline level (though we cannot be statistically confident that this effect is not a result of chance). By age 11 – the last age we look at – the impact has grown to 18% and is strongly statistically significant. This effect is equivalent to averting 5,500 hospitalisations of 11-year-olds each year.
- **At younger ages, a reduction in infection-related hospitalisations plays a big role in driving these effects. At older ages, the biggest impacts are felt in admissions for injuries.** This could suggest that Sure Start is helping young children to develop their immune systems, perhaps through supporting immunisations or exposing children to other children's illnesses (e.g. in childcare). Sure Start drives a significant fall in injuries at every age we consider, with the probability of an injury-related hospitalisation falling by around 17% at the younger ages and by 30% at ages 10 and 11.
- **Sure Start benefits children living in disadvantaged areas most.** While the poorest 30% of areas saw the probability of any hospitalisation fall by 11% at age 10 and 19% at age 11, those in more affluent neighbourhoods saw smaller benefits, and those in the richest 30% of neighbourhoods saw practically no impact at all. The bigger benefits in the poorest neighbourhoods could come about because disadvantaged children are more able to benefit from Sure Start, because the types of services Sure Start offers in poorer areas are more helpful, or because children in disadvantaged areas were more likely to attend a centre.
- **We find no evidence that Sure Start has impacted child obesity at age 5, or maternal mental health.** However, given data limitations, the lack of evidence for Sure Start's impacts should not be taken as evidence that there is in reality no effect.

- **A simple cost-benefit analysis shows that the benefits from hospitalisations are able to offset approximately 6% of the programme costs.** We consider the costs of giving access to Sure Start to a cohort of children, and the corresponding benefits of reducing hospitalisations for injuries and infections, in terms of averted direct healthcare costs, averted indirect (parental and societal) costs, and the financial impacts of their consequences over the life course.

Conclusions

Sure Start is one of the biggest early years programmes in England, and one of the most controversial. Since the removal of ring-fenced funding in 2011, local authorities have had to make decisions about whether – or to what extent – to protect their Children’s Centre services. Their choices have been starkly different; some authorities have closed most or all of their centres, while their neighbours have chosen not to officially close any. Instead, many local authorities have delivered cuts in other ways, such as curtailing opening hours or cutting back on services delivered through the centres (Smith et al., 2018), or merging them.

These decisions have been made in the context of limited evidence about the impact that Sure Start has had on children and their families. Our research suggests that the Sure Start programme has had significant benefits for children’s health, preventing hospitalisations throughout primary school. But these benefits are only felt in the most disadvantaged areas. Of course, these findings relate only to health outcomes; Sure Start might have different effects on other outcomes, such as children’s school readiness or parents’ employment decisions. Nevertheless, our findings about the health impacts of Sure Start raise two questions for policymakers.

The first question is about Sure Start’s total level of resources: given the substantial benefits for children’s health that we find, is the current level of cuts to Sure Start’s budget appropriate? Measured on a purely financial basis, the reduction in hospitalisations at ages 5–11 saves the NHS approximately £5 million, about 0.4% of average annual spending on Sure Start. But the types of hospitalisations avoided – especially those for injuries – also have big lifetime costs both for the individual and the public purse (e.g. through healthcare costs and the tax and benefit system). Including these savings as well, the financial benefits of Sure Start’s effects on hospitalisations amount to 6% of its budget.

Of course, it is crucial to emphasise that we are considering the financial impacts of only a narrow set of potential outcomes and setting them against the total cost of Sure Start. Further research is needed (and some is already under way) to determine whether the programme has had other effects – for example, on academic and behavioural outcomes and on the demand for social care. As well, society might value the improvement in children’s health on its own merits, particularly since these benefits are concentrated in the most disadvantaged areas.

But even if some of the cuts to Sure Start are reversed, it would be a long journey back to the funding levels the programme enjoyed in 2009–10. So in a context where spending is cut back from its peak, how should these cuts be delivered? Our results suggest that one way to deliver more value for money would be to focus on providing services to the disadvantaged areas, which are more likely to benefit from them, and to consider which types of services and models of provision could most effectively help this group.

More broadly, all interested parties – politicians, policymakers and practitioners – should continue to assess how the resources targeted at early intervention can best be used to improve outcomes for children and their families, and how they can best encourage the families who would benefit the most to use the centres.

The government has recently commissioned the Early Intervention Foundation to review the existing evidence on Children’s Centres and other early years services and to develop practical materials for local authorities to use in producing a model for Children’s Centres in their area.

The government has been clear that it believes that decisions about Sure Start should be taken at the local level, with local authorities free to decide how to fund their Children’s Centres and which services the centres should deliver. It is crucial that both local authorities and central government consider the effectiveness of Sure Start for different groups when deciding how services should be delivered going forward. Our research clearly shows that the majority of the benefit of Sure Start has been felt in the most disadvantaged neighbourhoods – so policymakers at both the central and local levels should think about how Sure Start spending can be targeted to deliver the best value for money.

Our research cannot say why children in disadvantaged areas benefit so much more from access to Sure Start than their better-off peers. Children in disadvantaged areas may be more likely to use these services. The types of services or the longevity of centres in disadvantaged areas might differ from those in richer neighbourhoods. There might also be more scope for Sure Start to improve health in more disadvantaged areas, since on average they have more hospitalisations. Unpicking the extent to which each of these possibilities holds will be crucial for deciding how to draw lessons from the success of Sure Start in the most disadvantaged neighbourhoods. To do so, researchers must have access to data on the take-up of services. These data are already being collected by local authorities, but it is very difficult for researchers to access.

More broadly, as Sure Start enters its 20th year, the government has an opportunity to set out a vision of the purpose of Children’s Centres based on the best available evidence.

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