The impact of social and cultural capital variables on parental rating of child health in Australia

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SUMMARY
The aim of this paper is to study the effects of factors broadly captured under the rubric of parental social and cultural capital on child health. The setting was 11 disadvantaged communities in Victoria, Australia during the conduct and evaluation of Best Start, an early childhood initiative of the Victorian State Government. Questionnaires were sent to parents of 3-year-old children in 2004 and 2006. The principal dependent variable was parental global rating of their child’s health. Social capital variables focussed, for example, on community support for parent’s childrearing practices. Cultural capital variables focussed, for example, on parent’s reading to their child. Socio-economic status and other potential confounding variables were also measured. Stepwise multivariable logistic regression was used. There were consistent independent effects for the cultural capital variables—‘Age started reading to the child’ and ‘Confident being a good parent’, and only one of a number of social capital variables—‘Community support for childrearing’ as well as for some other variables particularly that ‘Child had a chronic health/medical condition’. Dichotomizing parent’s global ratings of their child’s health differently had some effects on results. Cultural capital and, to a lesser extent, social capital variables were associated with parent’s rating of the child’s health. It is now timely to conduct and evaluate programs aimed at improving parents’ cultural capital. Better measures or inventories of parent’s cultural capital will be essential for this.

Key words: children; social capital; social context; Australia

INTRODUCTION
A number of recent studies in the USA, UK, Canada and Australia have demonstrated a positive relationship between socio-economic status (SES) and child health (Case et al., 2002; Starfield et al., 2002; Spurrier et al., 2003; Currie and Stabile, 2003; Chen et al., 2006; Currie et al., 2007). In addition, a systematic review by Galobardes et al. (Galobardes et al., 2008) indicated that childhood SES is associated with adult all-causes mortality. While the magnitude of the effects reported varied, the relationship between SES and child health can now be regarded as well established. The mechanisms underlying this association, however, are not always well understood. Dowd (Dowd, 2007), for example, demonstrated that, while a set of factors relating to maternal pregnancy (e.g. smoking, alcohol, exercise and multivitamins during pregnancy) and early childhood health behaviour (e.g. household smoking, breast-feeding, always use car seat and multivitamins) were significantly related to family income and maternal education, they did not explain the relationship between family income and maternal-assessed child health status.

It is important, therefore, to better understand the mechanisms underlying the relationship between SES and child health if societal initiatives are to be successful in reducing these differentials across SES groups. Fortunately,
some progress in doing this has occurred in recent years and it is now possible to identify four groups of mediating factors that explain the association between poorer health and lower SES. These are the following.

Maternal mental health and depression
A number of papers have studied the mediating role of Maternal mental health and depression including Hollins (Hollins, 2007), Larson et al. (Larson et al., 2008) and Stewart (Stewart, 2007). A UK cohort study is particularly informative about mechanisms for this income–child health relationship (Propper et al., 2007). After controlling for a number of factors, there was almost no direct impact of income. The most important mediating factor was mother’s mental health with maternal anxiety and somaticism apparently being most important.

Parenting practices
Shaw et al. (Shaw et al., 2001) and Fagot and Leve (Fagot and Leve, 1998) have studied the mediating role of Parenting practices. A prospective cohort study in 10 US communities demonstrated that the low socioeconomic status was associated with poor parenting for all indicators of both SES and parenting (Belsky et al., 2007). Maternal warmth was the most predictive of the three measures of parenting. The authors concluded that parenting mediates some, but not all of the detectable effects of socioeconomic risk on health in childhood.

Structural/materialist explanations
Kroenke (Kroenke, 2008) assessed the relative role of Structural/materialist explanations as a mediating factor and specifically psychosocial factors and material influences on the SES–health relationship in children and adolescents. The author concluded that both psychosocial factors and material influences were present in the SES–health relationship in children and adolescents. With regard to material causes, these could have direct and indirect effects on child health. For example, overcrowding, noise, air pollution and lead exposure could have direct effects on child health but also indirect effects through effects on the cognitive and psychosocial development of the child. Du Prel et al. (Du Prel et al., 2006) showed the effects of both the former and the latter. Parental education as well as living conditions, for example, damp housing conditions and living near a busy road had effects on child health. Gokhale et al. demonstrated a number of pathways though which female literacy had effects on child health in India (Gokhale et al., 2004).

Parental social and cultural capital
Social capital, as defined by Putnam (Putnam, 2000), refers to the institutions, relationships and norms that shape the quality and quantity of a society’s social interactions. There is a dearth of research addressing this issue in relation to child health. Social capital is, however, increasingly informing theoretical frameworks aimed at better understanding childhood disadvantage.

The authors of Health for all children 4 adopted both a community-focused and an individual-perspective on social capital and defined it as the social cohesion of a community, and the sense of belonging and the level of involvement in community affairs (Elliman and Hall, 2003). Some evidence exists that social capital has effects on child health through both perspectives. In support of the former, rates of child abuse and child abuse fatalities were found to be higher in socially disorganized neighbourhoods and lack of social coherence, in contrast to low-risk areas which show evidence of a stronger social fabric (Garbarino and Kostelny, 1992). In support of the latter, mortality from a number of causes, including infant mortality, have been shown to be strongly associated with perceptions of lack of helpfulness, lack of fairness and social mistrust in a community (Kawachi et al., 1997). The application of the concept of social capital to child health remains controversial—it has been argued, for example, that social capital is a vague term that does not accurately specify social phenomena (Earls and Carlson, 2001).

Cultural capital is less well known as a concept than social capital. Bourdieu (Bourdieu, 1986), who developed the concept, describes cultural capital as forms of personal knowledge, skills, education and advantages which give those persons a higher status in the society. The author specifically notes that parents provide their children with cultural capital by transmitting the attitudes and knowledge needed to succeed in the current educational system.
Khawaja et al. demonstrated that two indicators of maternal cultural participation, namely watching television and attending movies/art exhibitions, were significantly associated with child health status (Khawaja et al., 2007). The study was conducted in impoverished neighbourhoods in Beirut. The findings controlled for the effects of other risk factors. Some of these though—quality of water, the quality of local health services and maternal education (though not household income) also had significant associations with child health. Two Swedish studies have shown effects of cultural capital (measured by attendance at cultural venues outside the home) on both survival and self-reported health in adult populations (Bygren et al., 1996; Johansson et al., 2001). The concept of cultural capital in the context of child health has also been subject to methodological challenge (Spencer, 2006).

The operationalization of these two constructs remains challenging and is discussed further in the Methodology section.

Study aims

The aim of this paper is to study the effects of factors broadly captured under the rubric of parental social and cultural capital on child health as a way of better understanding this SES–child health relationship. Whether these variables mediate the relationship between SES and child health or have separate independent effects on child health will become clearer.

It was possible to study these parameters and their possible association within data sets generated as part of the evaluation of Best Start, an early childhood initiative of the Victorian State Government in 11 disadvantaged communities (Victorian Department of Human Services, 2002; Raban et al., 2006). Some other relevant socio-economic variables including family income and parental education which may have independent effects on parental rating of child’s health were also collected in these data sets.

METHODS

Best start program

A partnership with representatives from the Victorian State Government and local government, non-government agencies as well as local community groups and local parents supported by a facilitator was established in each of the Best Start sites. All sites were disadvantaged in comparison with all Victorian Local Government Areas (LGAs)—see Table 1 (Victorian Department of Human Services, 2005). Projects, developed and delivered on behalf of the partnerships, were largely designed to add value by increasing co-ordination, co-operation and linkages between existing services rather than introduce new services or expand existing services.

The Victorian State Government identified seven health outcome areas as well as four educational and two housing/child protection outcome areas that Best Start programs could choose to target. As a result, the portfolio of projects offered by Best Start sites varied considerably. Strategies underlying interventions at Best Start sites included social marketing, cross-service promotion and coordination, reminders

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Best Start</th>
<th>Rest of Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>All families with children aged 0–8 years within each LGA (median family income per month)</td>
<td>$1743.5</td>
<td>1948</td>
</tr>
<tr>
<td>All families with children aged 0–8 years where parent(s) highest school qualification is less than year 12 or equivalent within LGA</td>
<td>% 43.5</td>
<td>33.9</td>
</tr>
<tr>
<td>All families with children aged 0–8 years where parent(s) have a non-school qualification within each LGA</td>
<td>% 12.3</td>
<td>21.2</td>
</tr>
<tr>
<td>Indigenous children aged 0–8 years within LGA</td>
<td>% 1.4</td>
<td>1.0</td>
</tr>
<tr>
<td>All families with children aged 0–8 years where both parent(s) not fluent in English within LGA</td>
<td>% 1.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Couple families with children aged 0–8 years where both parents not fluent in English within LGA</td>
<td>% 1.3</td>
<td>1.8</td>
</tr>
</tbody>
</table>

and the development of playgroups. The projects had a particular focus on targeting vulnerable and underserved groups. A detailed description of the survey and its implementation is included in the evaluation report (Raban et al., 2006).

**Instruments and procedure**

Questionnaire surveys were conducted in the LGAs involved in Best Start. Questionnaires were sent to parents of 3-year-old children attached to the official form for preschool enrolment in the following year. Distribution methods varied slightly between sites. Questionnaires were sent to parents at the commencement and conclusion of the Best Start program. In this way, two cross-sectional samples of parents of 3-year-old children were surveyed. These samples were then combined for the purposes of this study.

**Sample**

One thousand six hundred and sixty-six completed questionnaires were returned in the first wave of data collection and 1838 in the second wave. While efforts were made to establish exact tallies of questionnaire sent/handed to parents by sites, this was difficult to achieve because of unavoidable variation in their methods of disseminations between sites. The estimated response rate in the first wave was 37.3%. This assumed 25% wastage of questionnaire based on reports of upper limits of wastage provided by Best Start facilitators who were responsible for their distribution and is therefore likely to be conservative. In the second wave when tally numbers were more accurately estimated, the response rate was estimated to be 34.9%.

Characteristics of the survey sample and the LGA of which they are a part were similar in terms of parents born overseas (OR 95% CI = 0.96, 0.62–1.48, p = 0.86), parents born in non-English-speaking countries (OR 95% CI = 0.98, 0.57–1.69, p = 0.95) and families with indigenous children (0.94, 0.53–1.69, p = 0.85) (Table 1). However, there was an under-representation of one parent families (OR 95% CI = 0.52, 0.38–0.71, p = 0.00) in the survey compared to LGA samples. Thirteen sociodemographic characteristics of wave 1 and wave 2 survey respondents were compared and only one (reading literacy in English) was significantly different (data not shown) (Table 2).

**Questionnaire content and key variables**

**Child health**

The principal dependent variable was child health. This was assessed by parental global rating of their child’s health. This involves the use of a 5-point Likert scale at child age 2–3 years. The descriptors on the 5-point scale were excellent, very good, good, fair and poor. This variable has been used to study socio-economic effects on child health in the USA, Canada and the UK (Case et al., 2002; Currie and Stabile, 2003; Currie et al., 2007; Dowd, 2007). Parental global rating is known to be a powerful predictor of future mortality and functional decline in adults (Idler and Benyamini, 1997; Idler et al., 2000). Scholle et al. (Scholle et al., 1995) have reported that parental global rating is also associated with concurrent childhood behaviour problems and health care utilization. These authors, however, concluded that parental global rating is better regarded as a measure of mother’s concern than a proxy measure for wider health outcomes and health service utilization. Dowd has sounded a warning that differences in subjective child health status between higher- and lower-income parents might not correspond to differences in objective child health status between these parental groups (Dowd, 2007). In summary, parental rating of child health is simple to administer and measures important aspects of the child’s

| Table 2: Comparison of selected characteristics of populations in Parent’s survey samples and Best Start Local Government sites |
|-----------------|----------------—|----------------|-----------------|
|                  | Parent’s survey samples | Best Start sites |
|                  | n       | % yes | n       | % yes |
| People born overseas | 3309 | 22.0 | 1105001 | 21.4 |
| People born overseas in countries where the language spoken is not English | 3309 | 15.3 | 1105001 | 15.5 |
| Families with indigenous children | 3009 | 1.4 | 91990 | 1.5 |
| Families with one parent | 3009 | 10.6 | 91990 | 18.5 |
present and future health. It requires further study though to better understand these effects.

It was not possible to use a number of the well-established early childhood development (ECD) instruments. These were consulted in constructing the questionnaire to be used in the study, for example, home observation for measurement of the environment, parents’ evaluation of developmental status and early development instrument (Caldwell and Bradley, 1984; Glascoe, 1997; Offord Centre for Child Studies, undated). All were either unsuitable for a questionnaire-based survey or needed to be substantially modified given the limited educational background of residents in Best Start sites, many of whom were also not born in Australia and had limited English-reading ability. A separate study was made of hard-to-reach groups using observational and informal interviewing methods.

The final questionnaire was worded to assume very limited educational background of respondents. The questionnaire was also translated into the three most common community languages across Best Start sites (Turkish, Vietnamese and Cantonese). Translated surveys were then back translated for verification of the precision of the questions in relation to the original survey.

Other key variables included were the following.

**Social capital**
Inventories or measures for this construct are not well developed, particularly in regard to ECD. Our measures were developed to be consistent with the individual focus component of the definition of social capital for children’s health developed by Elliman and Hall (Elliman and Hall, 2003). This is parent’s sense of belonging and the level of involvement in community affairs specifically. Rating of the community support for parent’s childrearing practices captures the former of these. Perceptions about the access to, and information about early childhood services and community facilities captures the latter. These include maternal and child health services (MCH), preschools, playgroups, playgrounds and libraries. Access to the information about best age to start reading was also specifically included.

**Cultural capital**
Inventories or measures for this construct are similarly not well developed. The principal measures of cultural capital we chose differed from the measures of Khawaja et al. (Khawaja et al., 2007), which focused on watching television and attending movies/art exhibitions. We chose otherwise because of the negative association between socioeconomic status and television watching in western countries (Johnson et al., 2002). We chose instead child literacy activities (frequency of reading to child and age of child when started reading). This is because literacy reflects that component of the parent’s cultural capital that is most important in transmitting to the child. We also selected the parent’s self-rated level of self-efficacy as self-efficacy has been identified as a key component of cultural capital (Knott et al., 2008).

**Financial disadvantage**
This principal measure of SES was measured by possession or otherwise, of a Health Care Card. This Card entitles the cardholder to cheaper medicines under the Australian Government’s Pharmaceutical Benefits Scheme as well as other concessions. Low-income earners as well as recipients of a number of government welfare allowances, payments and benefits are eligible. Highest level of schooling achieved was also used to measure SES. Questions relating to ethnic background included country of birth, aboriginal and Torres Strait Islander status, reading and writing in English.

**Other potential confounding variables**
Questions included long-term health problems in the index child, number of children and partner/spouse living at home were also measured. All of the independent variables that were studied are set down in Tables 3 and 4.

The overall evaluation study was approved by Ethics committees at the Victorian Government’s Department of Human Services and The University of Melbourne.

**Analysis**
Parental global rating of their child’s health was dichotomized principally ‘Excellent/Very Good versus Other ratings’. It was also classified as ‘Excellent versus Other’ in a
subsidiary analysis in order to test for differences in the way higher- and lower-income parents' global ratings of their child's health might vary as a result of their reporting styles. The independent variables, like the principal dependent variable, also took the form of 5-point Likert scales and were also dichotomized as indicated in Tables 3 and 4. The second dichotomized category for all variable forms the reference category.

Univariate analysis was first conducted using a Fisher’s two-sided exact test. A Likelihood ratio Chi-square test, with selection cut-off levels set at 15%, was used in progressing through the stepwise multivariable model those variables that had independent effects after adjusting simultaneously for the effects of other variables. Logistic regression was used for multivariable analysis. Variables were eliminated in the forward selection stepwise process if they were not statistically significant. These analyses were carried out separately for parents whose country of birth was English speaking and non-English speaking to provide insight into the impact of reporting styles in English-speaking and non-English-speaking groups. No interaction effects between variables were discovered.

A total of 3038 returned questionnaires from 10 Best Start sites were entered into the analysis. Parents who did not disclose whether their country of birth was or was not English speaking (n = 237) or their aboriginal status (n = 42) were subsequently excluded.

Table 3: Parent’s global rating of child’s health and selected parent/child characteristics: univariate analysis (95% confidence intervals of odds ratio)

<table>
<thead>
<tr>
<th>Parental and child characteristics</th>
<th>Parent’s global rating of child’s health</th>
<th>Attribute being compared with reference</th>
<th>Excellent/very good count (%)</th>
<th>Other ratings count (%)</th>
<th>Odds ratio, 95% confidence intervalsa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures of cultural capital</td>
<td></td>
<td>Confident being a good parent (strongly agree/agree versus others)</td>
<td>Strongly agree/agree</td>
<td>1758 (98.0%)</td>
<td>1290 (93.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age started reading to child (&lt;12 months versus others)</td>
<td>Less than 12 months</td>
<td>1489 (83.2%)</td>
<td>977 (71.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequency read to child (daily versus others)</td>
<td>Daily</td>
<td>1291 (72.5%)</td>
<td>843 (61.2%)</td>
</tr>
<tr>
<td>Other characteristics</td>
<td></td>
<td>Child has worrying health or medical condition and expected/to last/has lasted &gt; 12 months (yes versus no)</td>
<td>Yes</td>
<td>139 (7.7%)</td>
<td>351 (25.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health care cardholder (yes versus no)</td>
<td>Yes</td>
<td>473 (26.9%)</td>
<td>479 (5.8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aboriginal/Torres Strait Islander (yes versus no)</td>
<td>Aboriginal/Torres Strait Islanders</td>
<td>12 (0.7%)</td>
<td>27 (2.0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First child (yes versus no)</td>
<td>Yes</td>
<td>273 (15.6%)</td>
<td>259 (19.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of children &lt;18 years in household</td>
<td>1</td>
<td>266 (15.2%)</td>
<td>250 (18.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parental relationship (mother versus others)</td>
<td>Mother</td>
<td>1711 (97.1%)</td>
<td>1270 (94.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education level (&lt;9 years versus ≥ 9 years)</td>
<td>≤9 Years</td>
<td>276 (15.7%)</td>
<td>282 (21.2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reading English (no problems versus others)</td>
<td>No problem</td>
<td>1691 (95.8%)</td>
<td>1216 (90.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Writing English (no problems versus others)</td>
<td>No problem</td>
<td>1674 (95.6%)</td>
<td>1186 (88.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Country of birth (non-English speaking versus English speaking)</td>
<td>Non-English-speaking COB</td>
<td>183 (10.6%)</td>
<td>261 (20.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parent’s country of birth (not Australia versus Australia)</td>
<td>Not Australia</td>
<td>285 (16.6%)</td>
<td>347 (26.8%)</td>
</tr>
</tbody>
</table>

a Asymptotic 95% confidence interval.
**<0.01.
***<0.001.
RESULTS

Univariate analysis

The effects of all independent variables on parent’s global rating of their child’s health are set down in Tables 3 and 4—measures of cultural capital and other characteristics in Table 3 and measures of social capital in Table 4. All measures of cultural capital and other characteristics had likelihood ratios less than 0.15 and progressed into subsequent stages of the stepwise multivariable analysis. The largest magnitude of effects on parent’s global rating of their child’s health were for ‘Child has a health/medical condition that is worrying & lasted/expected to last more than 12 months’, ‘Confident being a good parent’ and ‘Aboriginal or Torres Strait Islander’.

Ten of the 12 measures of social capital had likelihood ratio less than 0.15 and progressed into subsequent stages of the stepwise multivariable analysis. The largest magnitude of effects for the community characteristics on parent’s global rating of their child’s health were for ‘Ease in locating information about maternal and child health centre’. Magnitudes of effects for measures of social capital were generally less than for cultural capital and other characteristics.

Multivariable analysis

In the larger English-speaking country of birth group, associations with parent’s global rating of their child’s health existed for the social capital variable ‘Community support for child-rearing’ and with cultural capital variables for ‘Age started reading to the child’ and ‘Confident being a good parent’. For other characteristics variables, associations existed for ‘Child has a health/medical condition that is worrying & lasted/expected to last more than 12 months’, ‘Can write English’ and ‘Educational status (Table 5).

In the smaller non-English-speaking country of birth group, associations again existed for the social capital variable ‘Community support for...
childrearing’ and for cultural capital, they again existed for ‘Age started reading to the child’ and ‘Confident being a good parent’. Associations existed for other characteristics variables ‘Child has a health or medical condition that is worrying & lasted/expected to last more than 12 months’.

The SES variable ‘Healthcard holder’ had no significant effect on parent’s global rating of their child’s health in both non-English and English-speaking country of birth groups. ‘Educational status’ had a weak effect judged by magnitude of its odds ratio in the English-speaking country of birth group and no effect in the non-English-speaking country of birth group.

Alternatively, dichotomizing parent’s global ratings of their child’s health, excellent versus other ratings had some effects on results (Table 6). In the larger English-speaking country of birth group, effects were consistent in the two sets of analyses for the cultural capital variables ‘Age started reading to child’ and ‘Confident being a good parent’. They were also consistent for other characteristic variables, ‘Child has a health or medical condition that is worrying & lasted/expected to last more than 12 months’, and ‘Can write English’. Effects were inconsistent for the social capital variable, ‘Community support for childrearing’ and ‘Enough information about what age to start reading’. They were also inconsistent for the other characteristic variable ‘Educational status’.

In the non-English-speaking country of birth group, effects on parent’s global rating of their child’s health were consistent in the two sets of analyses for the other characteristic variable ‘Child has a health or medical condition that is worrying & lasted/expected to last more than 12 months’. Effects were inconsistent for the social capital variable ‘Community support for childrearing’ and the cultural capital variables ‘Confident being a good parent’ and ‘Age started reading to child’ and the other characteristic variable ‘Parental relationship’.

The SES variable ‘Healthcard holder’ continued to have no significant effect in both non-English and English-speaking country of birth groups. As noted, ‘Educational status’ continued to have no significant effect in the non-English-speaking country of birth group but now also no effect in the English-speaking country of birth group.

**DISCUSSION**

**Overview of results**

In summary, the results demonstrated some independent effects for both social and cultural
capital variables on parent’s global rating of their child’s health and these were fairly similar in both the English-speaking and non-English-speaking country of birth groups. However, these independent effects were present in only 1 of the 12 social capital variables—‘Community support for childrearing’. They were present though for two of the three cultural capital considered—‘Age started reading to the child’ and ‘Confident being a good parent’.

For other characteristics, these effects were for both groups ‘Child has a health/medical condition that is worrying and lasted/expected to last >12 months (no versus yes)’. Significantly, important SES variables had limited independent effects on parent’s global rating of their child’s health. ‘Healthcard holder’, a measure of poverty, had no independent effects in either group or either analysis considered in Tables 3 and 6. Educational status had an independent effect in the English-speaking group only and only in one of the two analyses. ‘Can write English’ also had an independent effect in the English-speaking group only but was present in both analyses. These results suggest that these cultural and social capital variables partly but not entirely mediate the relationship between SES and child health.

**Limitations and challenges**

A number of limitations of this study need to be acknowledged. First, as noted previously, there are no suitable scales available to measure social and cultural capital and the particular measures used were those that were available from a study designed for a different purpose. Second, it is possible that the association between the independent and dependent variable flows in two directions. For example, the association between the child’s health (as measured by parent’s global rating) may be an independent factor for parent being confident they are a good parent, as much as vice versa. Against this, the association is independent of the child having or not a health/medical condition that is worrying and lasting/expected to last more than 12 months. Third, as always, there may be unmeasured confounding variables that may explain the associations between the independent and dependent variables that were observed.
Finally, while the dependent variable, parental global rating of their child’s health can be considered to be a useful and valuable measure of child health UK (Case et al., 2002; Currie and Stabile, 2003; Currie et al., 2007; Dowd, 2007), other measures of child health were not available in this data set to support its associations with social and cultural capital. Being a subjective rating, there are necessarily residual concerns that it are not an ‘objective’ measure of child health. As noted, Dowd warned that differences in subjective health status between higher- and lower-income parents might not correspond to differences in objective health status between these parents (Dowd, 2007). In other words, the styles of reporting on the health of their child may be different in higher and lower SES parents. This is confirmed in this study by the somewhat different estimates of effects on parent’s global rating of their child’s health when the dependent variable parental global rating of their child’s health was dichotomized differently.

While acknowledging these different estimates of effects on parent’s global rating of their child’s health, social and cultural capital variables demonstrated independent parent’s global rating of the child’s health of equivalent orders of magnitude as the other well-established SES variables considered. Effects of social capital were restricted though to parent’s sense of belonging and did not occur for level of involvement in community affairs using the categorization of social capital used by Elliman and Hall (Elliman and Hall, 2003). Independent effects of cultural capital were more apparent. In so doing, the study adds to the limited knowledge that currently exists of the effects of parental social and cultural capital on child health. It will have some relevance to an understanding of SES effects on child health.

Next steps and policy implications
Parental social and cultural capital remain the least well developed in terms of strength of evidence of the four groups of mediating factors discussed in the Introduction section that may explain the effect of parent’s SES on their child’s health (maternal mental health and depression, parenting practices, structural/materialist explanations and parental social and cultural capital). Complicating this though, there may indeed be overlap in some of the constructs and parameters considered under these four groups of mediating factors. Parental self-efficacy may involve parental warmth which is important in parenting practices. Parental self-efficacy could also be seen as a manifestation of maternal mental health. Reading to one’s child could be related to literacy and educational levels (noting that the educational level did not have consistent effects on rating of child health).

However, strength of evidence is not the only factor to consider in choosing future policy directions. Issues of cost and effectiveness are also highly relevant, particularly in regard to lower SES parents. It will be necessary to demonstrate, for example, that psychotherapy for maternal mental health problems and parenting programs for parenting problems that may be effective for most parents may not be effective in lower SES parents (Sanders et al., 2003; Hiscock et al., 2008). More recently, beneficial effects of community-based Early Childhood Development programs such as Sure Start local programs in the UK on the social development of the child as well as parenting behaviour have been noted including for lower SES parents (Melhuish et al., 2008). These were better child social development, more positive social behaviour and greater independence, less negative parenting and better home-learning environment.

Given the overlap in the relevant constructs noted above, a number of effective programs, addressing one or several of the group of mediating factors considered in the Introduction will indirectly impact on the parent’s social and cultural capital. It would be useful though to have a program specifically aimed at improving the parent’s cultural capital to further investigate the importance of parent’s social and cultural capital on their child’s health. To do this and indeed engage in further research on the effects of parent’s social and cultural capital on child health, there need to be better developed and validated measures or inventories of parent’s cultural capital.

ACKNOWLEDGEMENTS
The Statewide evaluation team Evaluation team would like to thank the Steering committee and Best Start projects, particularly the community facilitators, for their assistance and advice in the
development of methods for the evaluation and the collection of the data which form the basis of this report. Their enthusiasm and support is truly valued. Indeed the report could not have been produced without their inputs.

**FUNDING**

The evaluation was commissioned by the Victorian Government’s Department of Human Services and the Department of Education and Training with support from the Community Support Fund. M.K. was supported in part by an Australian National Health and Medical Research Council Career Development award and VicHealth.

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