Health Inequalities - Early Years

Prof Philip Wilson, University of Aberdeen

I am grateful for the opportunity to submit evidence on this matter to the Health and Sport Committee. I am professor of primary care and rural health at the University of Aberdeen before which I was a senior lecturer in infant mental health at the University of Glasgow with 25 years relevant clinical experience as a GP. While in Glasgow I led a population-based programme of research into the mental health of children aged 1-10 years, and I continue to act as senior academic advisor on this work. In this written response I would like to focus on the role of general practitioners and health visitors as well as on the importance of standardised assessment approaches.

1. How effective are early years interventions in addressing health inequalities?

The Scottish Collaboration for Public Health Research and Policy produced an excellent scoping document on this subject three years ago\(^1\). I have little to add to the findings in this document except to say that there is very strong evidence for the benefits of nurse home visiting programmes (eg the Family Nurse Partnership), for high quality preschool education (eg the HighScope Perry project) and for some targeted parenting programmes (eg Incredible Years). Each of these programmes has substantial potential for reducing social inequalities, if appropriately targeted. Nevertheless, claims for some interventions (eg the Triple P Parenting programme) have been over-inflated\(^2\) and it is very important to examine the quality of evidence before committing substantial public funds.

2. What are your views on current early years policy in Scotland in terms of addressing health inequalities?

Following the Hall 4 guidance in 2005\(^3\) a number of important problems became apparent. This guidance assumed that vulnerability could be predicted very early in a child’s life, and where problems emerged that were not predicted, that families would seek help. The end result was the abandonment of routine child health surveillance beyond the age of six weeks. The work we undertook in Glasgow made it clear that important developmental problems such as language delay can not be predicted\(^4,6\) and parents often do not seek help when important problems emerge\(^4,5\). The Scottish Government wisely reintroduced a universal assessment focussed on language and social development at 27-30 months last year.

The work of the Early Years Collaborative is to be commended. The Stretch Aims relating to attainment of developmental milestones at 27-30 months and at school entry are excellent but there is a lack of clarity about how these should be achieved and, worse, there is no clear guidance on how the milestones should be defined. I would like to make the following three recommendations to deal with these deficits:
• Introduction of a universal child health assessment at 13 months, around the time of the MMR. Our research in Glasgow showed that this was a highly successful and acceptable contact performed by health visitors, and the content of the visit ensured that the more vulnerable families received more care.

• Introduction of standardised instruments for assessment of achievement of milestones at 27-30 months and school entry across Scotland. I would suggest the Strengths and Difficulties Questionnaire (SDQ) and the Sure Start Language Measure, as used in Glasgow, would be most suitable and acceptable.

• To allow the concept of "small tests of change" to be developed further in order to inform tests of change of sufficient statistical power (ie trials) to establish beyond reasonable doubt that interventions have actually worked.

3. What role can the health service play in addressing health inequalities through interventions in the early years?

There is no doubt that early intervention with vulnerable families by nurses is highly effective, and cost-effective. For example, David Olds’ landmark randomised trials of the Nurse Family Partnership in the US have demonstrated that about 30 hours of input between mid pregnancy and the age of two years can halve criminal behaviour, substance use, smoking, running away and high risk sexual behaviour by age 15. Nurses are much more effective in this work than paraprofessionals, and continuity of care is crucial.

There have been continued attempts to replicate Olds’ work in Scotland, and much resource allocated, but the model is not directly transferrable. In the US, there is no universal health visiting service and consequently no mechanism for identifying actual need in individual families in the community. Offering the Nurse Family Partnership intervention to all families is clearly impractical, expensive and unjustified. The current policy of directing attention to families on the basis of predicted vulnerability (ie to teenagers who book early enough in their pregnancy) without actual assessment appears highly inefficient: it gives resources to families who do not need them, and misses many children with substantial need who do not fall into the ‘right’ demographic group. We have the potential for an efficient and flexible use of resources through use of an ‘active filtering’ approach in which professionals and families together determine level of need with reference to standardised assessment tools. Resources should be directed towards those most in need. In other words we need an intelligent system for ‘case-finding’ and resource allocation.

In Scotland, the only professions in routine contact with all children under the age of three years are general practitioners (GPs) and health visitors (HVs) as well as midwives in the first few days of life. In the past ten years, a number of policy developments have progressively undermined the involvement of GPs and HVs with children to the extent that most Scottish children (apart from seeing an HV at 27-30 months) do not see either profession except on
an opportunistic basis after the age of four months. Because we can learn from past mistakes it is worth enumerating these policy initiatives:

- **Nursing for Health.** This shifted the focus of health visiting from work with individual children towards community development and other public health responsibilities. Training in child development disappeared from the curriculum.

- **The Review of Nursing in the Community.** This development proposed the end of health visiting as a profession in favour of the introduction of a generic community nurse role. Although now abandoned, the damage to professional morale was grave. Health visiting courses were cut and many HVs left the profession, never to return.

- **The Scottish implementation of Health for All Children** (Hall 4). This report was interpreted erroneously by many health boards as supporting the view that families considered to be at “low risk” did not require any health visiting input after 8-16 weeks. There is now robust evidence that no more than half of vulnerable families can be reliably identified by that time, even in the context of an intensive home visiting programme. Not only health visitors, but also general practitioners, now do less preventative work with children than they did a few years ago.

- **The Glasgow review of health visiting.** In its original form, this set of policies advocated removal of health visiting from attachment to general practices (a process which has sadly already taken place in many areas), management of the profession by social work services, ending of HV involvement in immunisation, and introduction of skill-mix teams. This policy caused great damage to the profession despite never being fully implemented. Many HVs took early retirement, moved to other areas or left the profession.

- **The new GP contract introduced in 2004** focussed almost entirely on chronic disease management (many of these diseases, incidentally, are more likely after adverse early childhood experiences). The Quality and Outcomes Framework has produced substantial improvements in chronic disease outcomes and has effectively reduced social inequality in health. It was a missed opportunity rather than an actively damaging policy development, but a substantial component of GPs’ pay is now determined by quality indicators, none of which, apart from immunisation rates, are anything to do with children.

The development of HV skill mix teams, while appearing to offer a rational approach to cost containment, appears not been handled well in Scotland and has tended to pay insufficient regard to the importance of continuity of relationships, both between HVs and families and between HVs and primary care teams including GPs. These relationships are crucial, not only in the process of assessment of family needs but also in the process of inter-professional communication about the needs of children.

4. **What barriers and challenges do early years services face when working to reduce health inequalities?**
We have a very demoralised and understaffed health visiting workforce and a GP workforce that has forgotten the importance of preventive child health work. Scottish Government has, to its great credit, begun to turn the tide by recognising the status of health visiting and in general allocating the health visitor to the role of named person. Nevertheless, a whole generation of health visitors has been trained without any in-depth knowledge of child development and this is a serious deficit. In my view health visitors should be universally acknowledged as the experts in normal child development, at least for preschool children.

Although it could be seen as a specific personal plea from an academic, I would like to make the point that it is very difficult to get research funding for work in the field of child development compared with say, cardiovascular disease. Given that social development in early childhood is one of the most powerful determinants of mortality and morbidity\textsuperscript{17}, this situation appears to me at least to be perverse.

5. Are there any specific initiatives or research evidence from Scotland, UK or internationally that you would wish to highlight to the Health and Sport Committee?

My research group in Glasgow has been measuring the social and emotional wellbeing of all children in the city at the ages of 30 months and 5, 7 and 10 years. We have uncovered clear evidence of social differentials in mental wellbeing, and these differentials widen when children start primary school. The map below illustrates the differences in SDQ scores for the most affluent parts of Glasgow compared to the most deprived: scores in Springburn are twice as high as those in Hillhead.
I believe that these social differentials in childhood mental health underlie the differences in adult morbidity and mortality attributable to deprivation.

Philip Wilson DPhil MRCPCH FRCGP,
Professor of Primary Care and Rural Health, University of Aberdeen (and general practitioner).
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Reference List


(3) Scottish Executive. Health for all Children 4 - Guidance to implementation in Scotland 2005


