Health Inequalities - Early Years

Sarah Burton

This is my personal response to the call for evidence on health inequalities in the early years. This is my individual response, based on my experience working in early years policy and research in Scotland over the last 5 years.

Specific questions

*How effective are early years interventions in addressing health inequalities?*

As with all interventions they vary. Efforts to address health inequality should start with thinking about inequalities in access to: - housing, income, high quality early childhood education and care, and support from high quality health professionals pre-birth onwards.

I do not believe that interventions that focus on health alone, focusing on traditional health professions such as health visitors, GPs and midwives will have the impact hoped for.

Countries with generally greater equality, for example Norway, Denmark etc, have better health equality.

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

There are many great intentions and commitments and that must be supported. However, a fundamental change is needed to really push the issue on.

Scottish policy on early years is severely hampered by the way policymakers continue to think about children's lives from pre-birth to 3 as a matter of health, and from 3 a matter of education. Legislation such as the additional support for learning Act, and the currently expanding provision on early childhood education and care are all based on this way of thinking.

This reflects the way we have created professions and systems that suit adult life, and are not built around children and their families. It also continues to assume that the standard for family life is that children will be at home with their mother, their father at work, until they start part-time nursery, which their mother brings them to for short periods.

Lone unemployed parents and parents of children with disabilities for whom there is inadequate daycare available are then likely to be stuck in low pay or poverty, which is linked to poorer health and wellbeing.

Poor quality or simply satisfactory early childhood education and care does nothing to improve child health and wellbeing. We should be aiming much higher in our early years provision - offering better food, better support to all
parents, natural outdoor environments where children can be physically active. While poverty is a large contributor to poor health, this does not mean that children in wealthier families have higher levels of wellbeing, we need to think more broadly about what we mean by good health, and consider emotional and cognitive health as well as physical health and the absence of disease.

A recent example of attention being skewed away from young children is the publication of BETTER EATING, BETTER LEARNING - A NEW CONTEXT FOR SCHOOL FOOD http://www.scotland.gov.uk/Publications/2014/03/1606/1, which is concerned with children’s experience in the statutory education system. Services for children under 5 or in out of school care have guidance and inspection in relation to food, but local authorities do not have duties to ensure the food they are offered match the aspirations of this publication. The reason why this publication is not about all children, is because it is linked to the education system, and leaves out the non-statutory ‘care’ system.

Children’s needs do not change because of adults’ systems of laws and professions. Adults providing food for children regardless of statutory/private etc should be tasked with the same high standards. There should be a strategy for all children when they are in places of education and care - systems of education and existing statutory provision mean that less attention is given to supporting good food for young children.

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

A health service that recognises the importance of providing high quality support will make a difference. That means universal services that are sensitive to individuals. This means better support from pre-conception, pregnancy, birth, post birth. It is positive relationships with professionals that makes the difference.

Services should focus on ways to cultivate consistent care with women, so that they can get to know midwives and health visitors, 1 or 2, and develop trusting relationships. They are then more like to seek advice and trust it. Health staff are then better likely to understand and become more sensitive to individuals, which should then improve their general approach and ability to respond to individuals. The lack of progress in promoting breastfeeding is linked particularly to the failure of maternity services to provide the one to one support for women in the lead up to and post birth and provide ‘mother-centred’ support rather than ‘breast-feeding centred support. I would draw
attention to work by the NCT reviewing the effectiveness of peer support in promoting breastfeeding as an illustration of how it is not enough to think about a mechanical 'what works' approach, but to think about individuals and the full context of each experience. Improving breastfeeding rates is not easy without a big investment in the time required to build trusting relationships. Peer support for breastfeeding continuation: an overview of research

Health services should work alongside and in an integrated way with early childhood education and care services. Some families will have no idea who their health visitor is, but will have good relationships with childminders or nursery staff and they will turn to these people for health support and advice. There are not enough health visitors, certainly, but in recruiting more the focus should be on how to join up to other early years services.

What barriers and challenges do early years services face when working to reduce health inequalities?

The above structures and systems that divide young children's lives up into education and health.

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?

There is overwhelming evidence to support investing in services for the early years, and there are pockets of great practice, so that it's a puzzle as to why it's so hard to do. I think it's the lack of statutory requirements, and the focus on short-term 'interventions' rather than long term high quality services and structural change. The idea that children are lifestyle choice and are not a shared responsibility still pervades people's thinking.

Part of the mystery is that because there is so much positive talk, ambition and rhetoric, it is easy to think that more money is spent and more resources are being directed to support families and children in the early weeks, months and years. Money, time, and resources do no yet match intention.

I suggest the following documents, which emphasise a focus on building relationships with families and providing practical services that families want.

I would support the work of the WAVE Trust and its submission 'Putting the Baby IN the Bath Water' which was sent to all MSPs in relation to the Children and Young People's Bill. I would also supports the need to level the system by changing the ASL Act to include assessment of all children aged under 5 with additional support needs.


These are positive examples of early years provision in Scotland - outlined by an IRISS study: http://www.iriss.org.uk/resources/where-it-starts-collection

"What resonates through the case studies is that relationships are the key to improving lives in the early years - relationships between teams within and across agencies, between individual practitioners and parents and, crucially, between parents and their children."


And highlight this report looking into family food practices with young children, to highlight the complexity of choices about ‘healthy’ eating: Food and finance: mothers’ food practices with young children, on a low income http://ssphr.files.wordpress.com/2013/08/ssphr_briefing_4.pdf

*Sarah Burton*

*March 2014*