Health Inequalities - Early Years

WAVE Trust

As the twig is bent, the tree’s inclined
(Alexander Pope)

All happy families are alike; each unhappy family is unhappy in its own way.
(Leo Tolstoy, Anna Karenina)

Introduction

Not long after a child starts pre-school or primary school, experienced staff can predict -- with depressing accuracy -- which children are most likely and least likely to succeed . . . in school, in society and in life. We will know that health inequalities have largely disappeared when it becomes impossible to predict young children’s futures correctly.

It is never too late to help children in meaningful ways. For example, there is abundant evidence (from EPPE and Sure Start in the UK to Abecedarian and High/Scope in the States) that high quality early childhood education makes a difference, especially for those children who are furthest behind. The evidence is clear that high quality early learning and childcare reduces inequalities.

However, as do the Growing up in Scotland research findings, this evidence also underlines the point that even very young children are already exhibiting major -- and growing -- discrepancies in their wellbeing and readiness for school. Therefore, WAVE recommends that the Committee’s ‘early years’ inquiry and its eventual recommendations focus on the period from pre-birth to pre-school. This should include preconception health/care.

For more than a decade, WAVE Trust has reviewed and analysed the best available research -- and evidence from practice -- from Scotland, the UK, Europe and internationally from a variety of disciplines. The latest major WAVE report (2013) -- Conception to age 2; the age of opportunity -- consolidates the findings and translates the science into practical recommendations for policy and practice. Although produced in collaboration with the UK Departments of Education and Health, the extensive international evidence base cited within that report -- and undergirding this brief submission -- is relevant to the Scottish Parliament Health and Sport Committee’s inquiry. See:

Given the space limits for submissions to this inquiry, WAVE has not specifically highlighted and cited the excellent work undertaken by other Scottish organisations – from the Scottish Collaboration for Public Health Research and Policy (SCPHRP) to the Glasgow Centre for Population Health – as it is anticipated that these researchers will provide their own evidence to this Inquiry.
1. **Primary prevention of health inequalities** – that is, keeping them from happening in the first place – must become a far higher priority in terms of the allocation of Scotland’s public resources. From the Christie Commission to numerous research studies, the evidence is compelling about the imbalance in favour of intervening after the fact, while too little is done in the earliest years to prevent health inequalities from beginning. Remedial intervention will always be necessary, but it is not a sufficient or wise national strategy for reducing health inequalities. This point has been widely accepted and agreed, but not yet acted upon robustly.

2. Reducing health inequalities means according as much priority to social, emotional and intellectual development, as to physical milestones. Health encompasses far more than not being ill, injured or incapacitated. Advances in neuroscience, genetics/epigenetics and other relevant fields have confirmed the lifelong importance of relationships and communications during the earliest weeks, months and years in shaping brains, predispositions and behaviours for life. Promoting positive/secure attachment between babies and their parents/carers – and preventing negative/insecure (especially ‘disorganised’ attachment) -- is as crucial to their long-term mental/emotional health as breastfeeding and good nutrition is to their physical wellbeing.

3. *What matters most is what children actually experience during the first 1,001 days of life.* While understandable, there has been an over-reliance on using poverty and postcodes as proxies for health inequalities. And yet, there are children in higher socioeconomic families/communities who are suffering lives of pain and adversity, just as there are poorer children who are thriving in loving, competent, stable families. Universal, robust and frequent early years screening and services (with extra help for those children and parents who need it) are the best way of discovering, and dealing with, what is actually true -- rather than making decisions based upon assumptions, instead of individual realities. Making significant health improvements (and reducing health inequalities) becomes more difficult and more costly to achieve over time.

4. *Child maltreatment* – that is, abuse, neglect and living with domestic and community violence – is a root cause of enduring health inequalities. The long-term (often life-long) negative consequences of multiple adverse childhood experiences (ACEs) on mental and physical health can be profound. By contrast, positive/secure attachment, the absence of maltreatment and the consistent nurturing (emotional and physical) are the foundations upon which good health is built. Dramatically reducing health inequalities cannot occur unless and until child maltreatment is dramatically reduced, too. Preventing child maltreatment – and thereby, reducing health inequalities -- requires a serious, sustained governmental and societal commitment to a Scotland in which: *Every baby is nurtured; Every child is thriving; and, Every parent is prepared and supported.*
5. **Eliminating health inequalities during the early years also requires consistent, positive, two-way relationships of trust between professionals/practitioners and mothers/fathers/carers.** There is evidence that some good public health advice and assistance initiatives have unintentionally exacerbated health inequalities because they did not operate within the context of a respectful relationship. The parents whose behaviours were influenced most have too often been the ones least in need of assistance. And yet, research indicates that many parents/carers previously (and erroneously) regarded as ‘hard to reach’ are much more likely to hear and heed the exact same information and advice when help is offered in the context of a positive relationship with the providers. Thus, the real need is for better, relationship-based support, rather than simply increasing the size of the early years workforce.

6. **Preconception health/care is crucial to preventing health inequalities because: a) birth outcomes are the first indicator of health inequalities; and, b) the health of the mother at conception remains the best predictor of birth outcomes.** Expecting a baby can provide a wonderful motivation to become healthier, but pregnancy is not the best time to begin dealing with the conditions, behaviours and concerns that can negatively affect birth outcomes – and sow the seeds of lasting health inequalities. If at the time when pregnancy is confirmed, the expectant mother: is obese; has major mental health problems (e.g. stress or depression); has been binge drinking, smoking or taking a variety of either illegal drugs or inappropriate medications; not had adequate folic acid or good nutrition; and/or has underlying serious problems (from domestic violence or homelessness to undiagnosed medical conditions (e.g. diabetes), then there are greatly increased risks of poor birth outcomes – and of health inequalities being present from a baby’s first breath. Valiant efforts to compensate for such difficulties during pregnancy are underway and need to increase, but none of them are as good as being healthy and well prepared at conception.

Responding to the Health Committee’s five specific questions

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

Health inequalities reflect, and contribute to, larger social, economic, gender, educational and geographic inequalities across Scotland. A fairer society – starting with a stronger safety net, and a higher ‘floor’ (below which no individual or family is allowed to remain) – is the national goal toward which we all should be working. Early years interventions – especially those operating effectively from pre-birth to pre-school – have the potential to make an enormous difference in diminishing health inequalities. One of the characteristics of more equal societies (e.g. in the Netherlands and the Nordic countries) is that they have made, and sustained, robust investments in primary prevention and early intervention during at least the first 1,001 days of life. Not coincidentally, these are also the societies rated highest on international child wellbeing measures.
2. **What are your views on current early years policy in Scotland in terms of addressing health inequalities?**

If Scotland’s early years policies are judged by: their good intentions; high aspirations; intended direction of travel; cross-party support; coherent analysis; persuasive rhetoric; the responsiveness to the needs of children born with immediately obvious birth defects; and, shining examples of good practice, then they are excellent.

By contrast, if they are judged by: the consistency of their implementation; their relative priority within public budgets (especially within the NHS); the balance between primary prevention and reactive interventions; the proportion of children affected by significant/multiple adverse childhood experiences and toxic stress; the robustness of parental preparation and support; the identification and response to developmental problems arising in the two years between the end of universal health visiting and the new 27-30 month health checks; the effective promotion of breastfeeding and positive/secure attachment; the investment in upgrading the early years workforce; and, the affordability, accessibility and average quality of childcare during the first three years of life, then Scotland’s early years policies do not compare favourably with the rest of Europe.

Health inequalities from pre-birth to pre-school remain far too great, despite a genuine desire to reduce them among Scottish policymakers and practitioners. The most accurate answer may be to state that early years policy in Scotland has a strong foundation upon which to build, is off to a good start and has great potential not only to improve overall child health and wellbeing, but also to diminish longstanding health inequalities.

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

WAVE Trust’s general answers have already been provided – especially the need for the health service to emphasise primary prevention (not just ‘interventions’ as the question asks). The following are the specific steps for addressing health inequalities:

a) Act strongly in favour of the five recommendations in *Putting the Baby IN the Bath Water* (as the new Children and Young People Act only takes some initial steps toward them);

b) Create a preconception health/care commission, then convene a preconception health summit to launch this field (including holistic family planning) as a national priority;

c) Provide the resources, time and powers needed for the Early Years Collaborative to achieve its ‘stretch aims’ and fulfill its potential;

d) Remove the barrier within the Additional Support for Learning Act that limits assessments of, and robust support for, all children under school age having additional support needs (and their parents/carers) – most of which are health-related;

e) Robustly promote good infant (and parental) mental health, the best possible infant nutrition (especially breastfeeding) and positive/secure attachment, especially within families that are already dealing with inequalities and vulnerable to being left behind;
f) Assess and assist patients/clients/users in adult services (e.g. mental health and substance abuse) as parents/carers, not just as individuals;
g) Increase the focus and resources devoted to preventing, identifying and responding effectively to fetal alcohol harm
h) Raise awareness, and significantly enhance the diagnosis and treatment, of co-morbidities and multiple morbidities in young children (instead of stopping assessment at the first one identified);
i) Devote greater priority and resources to preventing, stopping and reversing the harm done through child abuse, child neglect, toxic stress, disorganized attachment and living with domestic violence; &
j) Combine relationship-based support, social marketing and co-production with parents/carers to conduct effective public health campaigns resulting in better child outcomes and less inequality.

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

There are three key barriers to overcoming health inequalities during the early years.
The first is the misperception that the early years are already receiving a disproportionately high level of public resources; whereas, in reality, the government spends less on the first 1,001 days of life than on any other age cohort across the entire life span. An abundance of wonderful proclamations about the importance and virtues of the early years is no substitute for actually investing in them.
The second is the myth that good parents “comes naturally” to most people; and therefore, parenting education is only needed by a hopelessly deficient minority (usually defined socioeconomically). This creates a disincentive to focus on properly preparing the next generation of parents/carers.
The third is a lack of confidence about, and commitment to, transformational change in the early years by most of the relevant groups. This can seen in the sense of fatalism that the majority of pregnancies will continue to be unintended (instead of an empowered, informed choice) to thinking that ‘more of the same’ people and practices is the only way forward.

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?

A wealth of the relevant research evidence can be found in WAVE Trust’s 2013 publication, Conception to age 2: the age of opportunity. Hard copies were sent to the Health Committee.

Other major publications and sources of information WAVE recommends are listed below. These eleven recent documents are not only important in their own right, but also include references to the major research, meta-analyses and other evidence that the Health Committee might find helpful.
a) WHO European Review of Social Determinants and the Health Divide, 2013
b) What can NHS Scotland do to prevent and reduce health inequalities? GPs at the Deep End, 2013
c) Fair society, healthy lives: strategic review of health inequalities in

d) Doing better for children, OECD, 2009

e) The earliest intervention: Improving birth outcomes and lowering costs through preconception health and health, Children in Scotland, 2010


g) The international charter on prevention of fetal alcohol spectrum disorder, The Lancet Global Health, 2014

h) Leveraging the biology of adversity to address the roots of disparity in health and development. J Shonkoff, 2014 (Harvard University Center for the Developing Child)

i) WHO European Report on Preventing Child Maltreatment, 2013


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* Copies have already been provided to all MSPs on the Health and Sport Committee

Dr Jonathan Sher
Scotland Director
WAVE Trust
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