Health Inequalities - Early Years

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

The most reliable way to produce a physically and mentally healthy, independent adult is to ensure that when he or she is a baby his or her neurological and biological development takes place normally. The effects of this are magical but it does not take much to achieve it. What it requires is providing secure, stimulating and nurturing relationships with one, or if possible, with both parents. It also requires preventing the baby from experiencing trauma and stress (commonly resulting from alcohol, drugs and violence).

No doubt you will receive all sorts of evidence to support the above thesis. The evidence does exist and I use medical and time-series evidence in talks and written work. But I have come to realise that evidence in this area is at best of secondary importance.

In the countries that fare best in child well being (The Netherlands, Denmark, Finland, Sweden) the reason that they have such strong preventative approaches to health and young babies and their parents, is because they consider it to be the right thing to do. And it has been ingrained in public health for a hundred years or more.

For some reason the Scottish health system looks at young children in the way we look at a leaking roof. It is a technical problem and it needs an intervention to be fixed - as is implicitly illustrated in question 1.

All parents struggle in bringing up children and some parents struggle more than others. At the centrepiece of what works well is the relationship between the parent or parents and the baby.

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

We have no shortage of policy. Our issue is Implementation Deficit Syndrome.

In recent years there has been more talk about early years. But if you are a health board chief executive or chairman, you get your collar felt if you fall down on budgets, capital spend, waiting lists, hospital induced infections and now care for the elderly. Early years and parenting does not feature as a priority.

GPs are busy dealing with whoever comes through their doors.
Health Visitors are the profession that has the most contact with babies and parents. It varies across the country but the trend seems to be one of an ageing profession with those that retire not being replaced. The pressure is on those remaining to cover more babies and mothers.

Politicians do not find this easy. The public do agitate about waiting lists and the like. Young babies do not form a vocal lobby or vote.

Yet the paradox is, if you want a physically and mentally healthy adult, you need to support the baby and the parent from conception to about age two or three.

I have a growing fear that by framing early years as a health inequality issue we are marginalising the middle class and the problems they have with their children (anxiety, depression, self harm, eating disorders, abuse of drugs and alcohol and suicide) and the role of the middle class in expressing and agitating for change.

I fear that the concentration of government policy (across governments) on child-care intensifies the policy idea that early years is about parents going back to work. It takes us further away from the key notions about attachment, relationships, care and love. Local authority day care usually starts at 3 years of age. The big issues and opportunities are in the period before day care starts.

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

A useful way of answering this question is by contrasting practice in The Netherlands which is very good and undergoing a major drive for further improvement, with Scotland where performance is “middling”.

In The Netherlands there are Family Centres in every neighbourhood that aim to support parents and babies and answer all questions about growing and raising a child – without tipping over into picking up needless issues.

Mother and Baby Wellbeing Clinics is the centrepiece of Family Centres providing a relationship and support from birth to school age.

One home visit is made shortly after birth. The parent(s) and child then visit the clinic in weeks 4 and 8, then in months 3, 4, 6, 7, 9, 11, 14 and 18, then at 2 years, 3 years, 3 years and 9 months and then at 5 years or 6 years as the child learns to read and write.

In contrast, in Scotland, Health Visitors sign off the overwhelming majority of their parents and children at 8 weeks. The next single port of call is around two years later.
Clinics are staffed by doctors who attend to health, social and emotional development, motor skills, language and general health and by nurses who concentrate on baby care, parenting, feeding, toileting and sleeping. Back-up for health and development is provided by walk-in surgeries and a telephone helpline.

Several features are worth stressing. The support starts early and is truly comprehensive across the country for all babies and their parents. It has continuity of care built in – it is about relationships formed with doctors, nurses and development staff. It is comprehensive and welcomed by parents across all socio-economic groups.

The health system in Scotland looks at technical health. In The Netherlands, this service looks at the child in the round: their development, language, emotional life and how the parent(s) cope or do not. From this regular and personal contact, relationships grow and where necessary specialist services like speech therapy or a family counsellor are identified.

**Question 4**

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

Before addressing barriers it is worth bringing to mind the obvious: health services start by having the most contact with parents and babies, they are trusted and are universal.

The first barrier is one of framing and history. Our health services are dedicated to helping ill people get better or manage their conditions. Only a smaller sliver of attention and resources goes into prevention. When health services intervene it is to provide a technical fix. As we see from The Netherlands and other countries, their focus is on the whole mother and father relationship with the child and is concerned as much about the child’s development as with the child’s physical health.

The second barrier is low priority and status accorded to early years and parenting support. Senior health board management, as illustrated earlier do not have early years and parenting as a big-ticket item. It is not what real men do. Health Visitors as an endangered species, comes as a consequence of this low priority. A number of local authorities have also found children services a comparatively easy place to look when reducing budgets.

The third barrier is the crisis of care. Estimates vary, but it seems safe to conclude that 40-50% of lifetime health spend goes on the last few months of life. Given the age profile of the population the clamour is on to meet the health and care needs of older people. Our health services are stretched to meet this demand, a demand that comes with a trump card. The more important question of intergenerational success and failure is in this context the loser.
Question 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) Below you will find three graphs of spend/consumption for people aged 0 to 90 years of age for 1960, 1991 and 2007. The data is from America and I have been unable to find a similar exercise conducted on Scottish or UK data. But given that major qualification, I feel that it does give us some insight to the creeping and thus almost imperceptible increase in inequality between generations as well as within generations.

The biased growth of the welfare state

US consumption by age (ratio to labor income ages 30-49)


b) In The Netherlands a group of local authorities got behind a report that identified that the ‘youth chain’ was not working: no one owned the problem; the needs of children and parents needed to be seen as pivotal; local cooperation between different services was too loose; and help was insufficient. A list of barriers, I am sure, which will have been identified in different submissions. In short, support needed to be timely and tailored.

Central government shared the concerns and was prepared to act. In 2005, Professor Schrijvers of the medical faculty in Utrecht lead the three wise people called in to advise the government in the face of rising levels of dyslexia, Attention Deficit Disorder and Hyperactivity Disorder (ADHD), autism and stresses in children. For teenagers and young adults, the government was concerned about violence at home and on the streets, suicide and depression. Schrijvers’ argument is that parents are psycho-pathologising their children’s behaviour and that the root cause is that, “parents do not know how to handle their children”.
It was out of this work by local and central government that the national government adopted the plan to set up Family Centres in every neighbourhood, in all 418 municipalities. These would complement and supplement the Mother and Baby Wellbeing clinics by providing a means for spotting and anticipating problems; giving guidance and counselling; and creating a means for coordinating local care.

The Netherlands already has the highest rating for child wellbeing in the OECD and among the countries of the EU. I strongly commend their approach to the Committee.

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