There are two over-riding points about the Committee’s goal to create, and then act upon, a preventative spending agenda within the health arena.

First, the Scottish Parliament and Scottish Government’s announcement several years ago that ‘preventative spending’ would be their priority, was quickly followed by a remarkable amount of redefining existing policies, programmes and allocations as ‘preventative’ across both the public and Third sectors in Scotland.

There may have been an element of cynicism and opportunism in simply relabeling the status quo as preventative spending. However, it reflected the reality that many such actions were intended to, and sometimes did, prevent additional harm and its associated costs. For example, placing an already seriously abused or neglected child into residential care does prevent the adults previously in that child’s life from inflicting more maltreatment. While often good and necessary, preventing further harm is less effective and dramatically more costly (in human, societal and financial terms) than primary prevention, i.e. keeping the harm from happening in the first place. So, the Committee has the chance to clarify its definition here.

Second, not all preventative spending is equally valuable and equally worthy of governmental support. Edinburgh University’s Professor of Public Health (Dr John Frank) and colleagues published a book exploring this topic in 2016: http://www.ed.ac.uk/usher/news-events/news-2016/new-book-disease-prevention-a-critical-toolkit

My point is not that there must be irrefutable scientific evidence favouring taking actions intended as primary prevention – or very little of the action needed right now would actually occur. Rather, the recommendation is that when promising new approaches, strategies and programmes are funded, then rigorous monitoring and independent assessments of their actual impacts (positive and negative) must be built into the design and implementation package. After a reasonable period of time, the ‘So, what?’ question must be answered accurately and persuasively, i.e. how effectively and how efficiently do new actions prevent the potential harms/dangers/adverse consequences being addressed.

Which areas of preventative spending/ the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

Preconception health, education and care across the life course

Scotland continues to display an unfortunate professional, political and societal 'blind-spot' about the root causes and starting points of child health and health inequalities. Just as child development does not begin at birth, so too, early intervention and primary prevention do not begin with pregnancy.

Preconception health, education and care is a powerful, multifaceted, democratic strategy for: * Reducing inequalities and preventing gaps from opening, instead of waiting to close them; * Promoting social justice across generations; * Making the integration of public services and public action real; * Preventing harm from happening at all, e.g. adverse childhood experiences (ACEs); * Easing the demands upon health professionals and the NHS; and, * Grasping the opportunity (not the nettle!) to listen to, and then support, girls and women, boys and men across Scotland in ways leading to healthier families, wiser use of public resources and a better society.
While primary prevention and preconception issues are my main focus these days, I am certainly not alone in understanding their importance. For example, last year's annual report by England's CMO (Professor Dame Sally Davies) allocated an entire chapter to preconception health. Similarly, the CDC has been supporting a national initiative across the US devoted entirely to preconception and interconception health.

Inadequate, or altogether absent, preparation for parenthood (whether with the first, or a subsequent, baby) is both a cause and a consequence of intergenerational poverty and perpetuates a crucial obstacle to good child health and wellbeing. Acting on the overwhelming international evidence presented in my recent e-publications -- and the detailed recommendations in my independent reports to NHS GG&C -- offers the Committee and the Scottish Parliament a powerful new opportunity to break our nation’s cycle of ill health, inequality and injustice. [The links are listed at the end of this submission]

One very good untapped example of primary prevention can be found in the One Key Question programme from the US. Adapting and piloting this programme in Scotland would provide a chance for help people of childbearing age make better informed, empowering choices about whether they want to become a parent in the foreseeable future. If not, then they receive advice and assistance with avoiding pregnancy. If so, then they get access to help in answering for themselves such basic questions as ‘when’, ‘with whom’, and ‘how best to prepare’ for pregnancy. See: http://www.onekeyquestion.org/

More than a quarter million babies will be born during this term of the Scottish Parliament. Most have not yet been conceived. The human, societal and financial costs of continuing to overlook preconception health, education and care are overwhelming, while the potential savings are enormous. Preventative spending on these half million prospective parents is a brilliant investment that reflects an accurate understanding of what is means to start at the very beginning in making Scotland ‘the best place in the world to grow up’.

Everyone who will ever become a parent wants: a safe pregnancy, a thriving baby and a rewarding parenthood. Too often, these universal goals are not met in Scotland. We can, and must, do better through spending on primary prevention during the preconception period.

Fetal Alcohol Spectrum Disorders
Alcohol exposure in utero is a risk that can, and too often does, diminish the lifelong health and wellbeing of those affected. Smoking in pregnancy, as well as obesity, deserve the prominent attention they routinely receive. Yet, we live in a nation with a widely acknowledged 'unhealthy relationship with alcohol'; plus, roughly half of all pregnancies in Scotland continue to be unplanned/unintended/mistimed (as well as often alcohol-fueled).

Consequently, FASD is neither a minor nor a rare condition in Scotland. Based upon the most conservative international epidemiological studies, more than 500 Scottish babies each and every year are born with fetal alcohol harm. Thus, FASD adversely affects roughly 10,000 young Scots right now.

The abundant evidence led Professor Sir Harry Burns to state repeatedly that FASD is the "leading preventable cause of learning disabilities". His successor as Scotland's CMO, Dr Catherine Calderwood, convinced all UK CMOs to agree on 'no alcohol' advice during pregnancy as a means to help prevent FASD. Only a year ago, the BMA (led by Professor Sir Al Aynsley-Green) published a major report on the detrimental and enduring impacts of fetal alcohol harm: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-
The simple truth is that lifelong, irreversible brain damage can be caused by alcohol exposure in utero – from any kind of alcohol during every trimester of pregnancy. This has enormous implications for individuals, parents, pre-schools and schools, as well as the larger society and the public purse. It deserves to be firmly on the Committee’s agenda, too.

In Canada, these are known as ‘million dollar babies’ because of the extra costs of dealing with the many damaging consequences of FASD – a price exceeded only by the human costs to the individuals and families impacted by this preventable harm.

Five basics are clear from the evidence. First, FASD is a risk, i.e. neither a predictable outcome nor an inevitable one, when alcohol is consumed during any pregnancy. Second, FASD primarily is manifest through how affected people think, act and learn, not how they look. Third, while FASD can exist on its own, or be mistaken for other neurological conditions, it often is only one of multiple learning disabilities (co-morbidities) within the same individual. Fourth, naming, blaming, shaming and punishing mothers (or the children themselves) is both cruel and ineffective. No one drinks alcohol because they want to harm their baby. Fifth, FASD-affected pupils do not act inappropriately in classrooms -- or fail to meet educational standards -- because they are willfully disobedient, uncaring or ‘bad’, but rather because of the varying degrees of invisible damage to their brains and central nervous systems (including diminished impulse control). That includes impulses leading to substance misuse, petty criminality, inappropriate/early sexual behaviour and other problems.

Giving priority to the prevention, identification/diagnosis and management of FASD is another terrific opportunity for the Committee to demonstrate the power of preventative spending for families, communities and overburdened health, education and justice services in Scotland.

Actually doing what it says ‘on the tin’

There is a longstanding gap between rhetoric and reality. Scotland is excellent at expressing undeniably worthwhile goals, aspirations and intentions. But, we tend to be less terrific at implementing them, especially in an equitable, large-scale manner.

Two recent examples of this phenomenon speak directly to the preventative spending agenda of the Health and Sport Committee.

First, more than one year ago, the then Minister for Public Health announced that Scotland was no longer going to wait for Westminster in order to proceed with adding folic acid to the flour supply. There is abundant scientific evidence about the value of folic acid in the months before conception (and the first month of pregnancy) as an effective, inexpensive, equitable way to reduce the number of miscarriages, stillbirths and such birth defects as Spina Bifida caused by neural tube defects. For an explanation, please read the recent column I co-authored for Holyrood with NHS GG&C’s Public Health Director (and obstetrician), Dr Linda de Caestecker: https://www.holyrood.com/articles/comment/folic-acid-bread-barn-gates-and-neural-tubes It was a welcome announcement, but this desirable action has still not be taken.

The second involves two sections of the Children and Young People Act 2014, both of which now have official statutory guidance issued for their implementation. There is a very strong and consistent emphasis on primary prevention in the statutory requirements for Part 3 of this Act on Children's Services Planning: http://www.gov.scot/Resource/0051/00512307.pdf.

For the first time, there is an explicit and robust statutory requirement for public bodies
throughout Scotland to give priority to 'take action that prevents needs from arising' for children -- and then to take action to meet their needs 'at the earliest appropriate time' -- including pre-birth (Section 57). These provisions were not in the original Bill, but they now are on the 'must do' list (despite budget cuts), not just the 'nice to do' list for public bodies.

Second, there was a major change from the original Bill's section on 'counselling services for parents of looked after children' to a much earlier, preventative focus on the 'parents of children who are at risk of becoming looked after'. This very helpful, positive change is evidenced in the recent SG Guidance on Part 12 of this Act: [http://www.gov.scot/Resource/0051/00511327.pdf](http://www.gov.scot/Resource/0051/00511327.pdf). Again, the dots are being connected between what happens pre-birth and the subsequent wellbeing of children.

However, the reality is that the Scotland’s health sector is going to need to play a strong, leadership role in making these statutory obligations have practical meaning. Effective implementation cannot be accomplished solely (or even primarily) by educators and social workers. It would be very helpful for the Health and Sport Committee to include this implementation challenge within its preventative spending agenda.

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My main independent, national reports commissioned by NHS Greater Glasgow & Clyde (Public Health):

Select brief columns/blogs related to these reports:
For politicians and policymakers (re: Holyrood baby): [https://www.holyrood.com/articles/comment/life-chances-are-often-shaped-even-we-are-born](https://www.holyrood.com/articles/comment/life-chances-are-often-shaped-even-we-are-born)
For parenting groups: [http://www.parentingacrossscotland.org/info-for-practitioners/articles/preparing-for-the-next-pregnancy/](http://www.parentingacrossscotland.org/info-for-practitioners/articles/preparing-for-the-next-pregnancy/)
For youth workers and youth groups: [https://youthlinkscotlandblog.wordpress.com/2016/06/23/falling-pregnant-versus-preparing-for-parenthood/](https://youthlinkscotlandblog.wordpress.com/2016/06/23/falling-pregnant-versus-preparing-for-parenthood/)
For the general public (Where Do Parents Come From?): [http://www.productmagazine.co.uk/ideas/ten-things-4/](http://www.productmagazine.co.uk/ideas/ten-things-4/)

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