The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 13 May 2014

Session 4

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HEALTH AND SPORT COMMITTEE
15th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Paul Bradshaw (ScotCen Social Research)
Professor Sir Harry Burns (University of Strathclyde)
Dr Katie Buston (University of Glasgow)
Jackson Carlaw (West Scotland) (Con) (Committee Substitute)
Brenda Dunn (University of Dundee)
Ben Farrugia (Centre for Excellence for Looked After Children in Scotland)
Professor John Frank (University of Edinburgh)
Dr Sarah Hill (University of Edinburgh)
Alyson Leslie (University of Dundee)
Professor Sir Michael Marmot (University College London)
Dr Jonathan Sher (WAVE Trust)
Alan Sinclair (Centre for Confidence and Well-being)
Professor Philip Wilson (University of Aberdeen)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health and Sport Committee

Tuesday 13 May 2014

[The Convener *opened the meeting at 09:45*]

Early Years Health Inequalities

The Convener (Duncan McNeil): Good morning and welcome to the 15th meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone in the room to switch off mobile phones and other wireless devices, as they can interfere with the sound system and can, of course, disturb the meeting. However, those attending should note that some members and officials are using tablet devices instead of hard copies of their papers. I have received apologies from Nanette Milne, and I once again welcome Jackson Carlaw as the Conservative Party's substitute.

The first item on our agenda is our inquiry on early years health inequalities, which is part of our themed work on health inequalities. I welcome once again to the committee Sir Harry Burns, professor of global public health at the University of Strathclyde. I also welcome Professor Sir Michael Marmot of the University College London institute of health equity. I offer our witnesses the opportunity to make some brief remarks.

Professor Sir Michael Marmot (University College London): Thank you. If Harry Burns is an adequate reflection of what is happening in Scotland on health inequalities, I think that Scotland leads the world on this matter. As you have him, you do not really need me; his views and mine certainly accord very well. However, I will make a few brief introductory points.

First of all, when people think about health inequalities, they commonly think about the health of the poor. The poor certainly have poor health—that is part of the story—but the real challenge for all of us is the gradient. It is a fact that people near the top have worse health than those at the top and that people in the middle have worse health than those near the top.

As we are talking about children, I should say that the same applies to every marker of good early child development. There is a gradient to children's physical development and growth and their cognitive, linguistic, social and emotional development, and to their performance in school and the socioeconomic characteristics of their parents or the area in which they live. The lower the socioeconomic level, the worse the performance. Globally, the United Kingdom—Scotland, England, Wales and Northern Ireland—does pretty badly among Organisation for Economic Co-operation and Development countries in markers of early child development and school performance. If we want to do better globally, we must address not just the poor performance of those at the bottom, but the gradient.

Last week, I was in Sweden—I could say that almost any week. The Swedes are very enthusiastic. A Swedish television interviewer said to me, "The last time I interviewed you, you told me a story about an economist at Her Majesty's Treasury." The interviewer remembered that, when I showed the economist a graph of the gradient, he said, "Oh, don't come to me with that Scandinavian nonsense—we're Anglo-Saxons here." In fact, he was Irish-Jewish, but never mind. He said, "We focus on the worst off. That's the default position of British social policy, and this Scandinavian nonsense is not for us."

When the interviewer asked me whether that was still the case, I said—and this is my second point—that we are trying to get across the message of proportionate universalism. The presence of the gradient suggests that we need universalist policies—in other words, policies for everybody—because a health service for the poor is a poor health service, and an education system for the poor is a poor education system. We want people to have the entitlement to be part of the mainstream, and we want to bring them into universalist systems in education, healthcare or society in general.

However, we might need effort that is proportionate to need—hence proportionate universalism. In the health service, for example, we do not expend the same amount of effort on everybody. I would be perfectly happy if, despite paying tax all my life, I never used the health service. I feel that that would be a great deal, because it would mean that I was well. However, if I had diabetes, dementia or peripheral vascular disease, I would want a lot of expenditure from the health service. The service is universal, and we expend proportionate to need.

So, the first issue is the gradient and the second is proportionate universalism. My third point is relevant to you as the Health and Sport Committee and concerns the question of what the health service can do, given that the key drivers of good early child development and good health lie outside the healthcare system. My institute produced a report suggesting that health and medical organisations can do five things. The first relates to education and training. The second is about treating the patient in his or her broader context, which means that you do not just hand out pills to someone but think instead about the issues that brought them before you. The third

involves the health service as employer; that relates to work-life balance, which is important with regard to early childhood. The fourth issue is all about working with others, especially those who have early childhood as their main domain. The fifth concerns advocacy because, as a doctor, I take the line that goes back to Virchow's view in the 19th century that

"physicians are the natural attorneys of the poor"

and that we in the medical profession should be the advocates for improvements that will improve conditions for the worst off.

My fourth point is about the importance of monitoring, which is absolutely vital. I know that Scotland understands that and that it is leading the pack in developing good monitoring. A report that the institute of health equity was commissioned to produce on monitoring in early childhood said that the following areas must be monitored: early child development; parenting; the parents, given that parents with mental illness, little education and so on have a reduced ability to provide good parenting; and the context in which parenting takes place.

Having looked at child poverty before and after taxes and transfers, I believe that the UK has the highest pre-tax child poverty level out of the OECD countries in Europe, where poverty is defined as less than 60 per cent of the median income. The post-tax figures are interesting. Although in Latvia and Sweden pre-tax child poverty levels are 35 and 32 per cent respectively, the post-tax figures are 25 and 12 per cent respectively. Regrettably, the United Kingdom looks more like Latvia than Sweden. Slovenia, which is not a rich country, has even lower post-tax child poverty levels than Sweden. Ours are above 20 per cent after taxes and transfers. Therefore, the decisions of the Chancellor of the Exchequer and the Department for Work and Pensions are affecting the quality of early child development. In fact, what the chancellor does probably has more effect on the quality of early childhood than what the minister with responsibility for health does.

I have made a pilgrimage to a Finnish school; I am not the first to pray at the shrine of Finnish education. Why does Finland always do best of any European country in the programme for international student assessment—or PISA—scores? It does not do quite as well as South Korea and Shanghai, but it is the best of the European countries. What is it doing? What is done in Finnish schools is interesting, but one of the key points that the headteacher of the school that I visited made to me was that what goes on in the school cannot be divorced from what goes on in wider society. She argued that Finnish schools do really well, with relatively small social gradients in education outcomes, because they reflect Finnish society. That is a way of saying that, if we want to improve early child development and address inequalities in that, we need to look to wider society—it is not simply a matter of having technical interventions.

Professor Sir Harry Burns (University of Strathclyde): I had not intended to make an opening statement, because I think that colleagues around the table know exactly where I am coming from—I have spoken about this subject before. However, I will make a couple of points.

When I was appointed director of public health in Glasgow 20 years ago, one of the first people whom I went to see was Sir Michael Marmot. Ever since then, he has been the fount of terrific scientific advice for me, and where I have got to owes a lot to the work that he has done over the years.

In the past few years, we in Scotland have moved ahead on methods of change. I now find myself going to Scandinavian and southern European countries a lot, because they are really interested in how Scotland is beginning to tackle the problem.

The realisation came from the fact that, although lots of studies have indicated that specific issues needed to be changed, the method of change has always eluded us. We still think in terms of a machine metaphor—the idea that pulling a lever here will make everything all right over there—but society ain't like that. The system is complex and we need different ways of dealing with it.

We have adopted an inclusive approach that we have borrowed from improvement science and which has worked effectively in the Scottish patient safety programme. The approach is not the finished article and I do not claim that what we are doing is perfect, but it is being co-produced across the whole system.

As Sir Michael Marmot said, we cannot identify a single issue that can be divorced from others as the cause of our inequalities problem in early years. We need to tackle the complex system that is society, which means supporting parents who do not know how to be parents and helping them to understand the way ahead. It also means addressing young people who become alienated from school.

I keep going on about the fact that young people who have difficult early lives are at a much higher risk of having mental illness and behaviour problems, but what does our school system do? It excludes them from school, which is completely the wrong thing to do. What they face is alienation throughout their lives. Young people who are excluded from school have a high risk of going to jail and of never working. Throughout life, we need to take a life-course and pan-societal view that

allows younger people to grow and remain integrated as part of society.

We have adopted an approach that seems to allow us to begin to co-produce with other agencies in society and with people in communities the solutions to some of the problems. I know from reading *Official Reports* of previous committee meetings that people are anxious to know whether the approach is working and whether things are moving in the right direction. That will take some time, but we must not chop and change. If we feel that we are on the right track, we need to stick with it.

10:00

Some years ago, I helped a colleague in Glasgow go off to America for a year on a Harkness fellowship. He examined many of the early years programmes that had been set up under President Johnson, who had a big interest in the early years. My colleague said that early years interventions such as pre-school education produced significant improvements in outcome, but that most of those improvements were not obvious until the children were in their mid-teens. By then, they were not getting drunk or getting involved in crime and they were staying on at school, finishing high school and getting jobs. At that time, the return on the investment began to rack up. I would argue that economic reasons are not the prime reasons for doing such work—it is an issue of justice and fairness and doing the right thing because it is the right thing to do—but it makes sense for everyone in society to support such an approach.

I would claim that Scotland is ahead of the game in our approach to the issue, which includes the work of the early years collaborative. We need to build on that and extend it. The Scottish Prison Service is using some of those techniques at Polmont, which, instead of being called a young offenders institution, is now regarded as an educational establishment. That must be a great leap forward.

We need to join up all the good work that is being done and make a movement out of it. In my previous job in the civil service, I was not allowed to be an advocate in the traditional sense of the word, but that is what I now intend to do—I am going to be an advocate for this kind of approach.

The Convener: Thank you. Richard Lyle will ask the first question.

Richard Lyle (Central Scotland) (SNP): Good morning, gentlemen. I welcome and agree with all your comments. Although the state should not be a big brother, we can start to help people as their children are born and educate them right through the system, because what we do for our children today affects their future tomorrow.

One of Professor Marmot's six points was about child poverty. The Child Poverty Action Group has estimated that more than 100,000 children in Scotland might be pushed into poverty as a result of United Kingdom welfare reforms.

Professor Marmot, in October last year, you said that the UK was

"failing too many of our children, women and young people on a grand scale."

You said:

"In the UK we have chosen to have relatively high child poverty rates."

You said that that was "a policy choice". In your opening remarks, you mentioned the actions of the chancellor. What are the policy choices that have driven the increase in child poverty? What do you expect to happen in the coming years?

Professor Sir Michael Marmot: I referred to the comparisons among OECD countries in order to make the point that some countries are intolerant of high levels of child poverty. There are no countries that have a child poverty level of below 10 per cent. The reason for that is statistical. If being in poverty is defined as having an income of less than 60 per cent of the median income, it is unlikely that a country will have a distribution of zero, with no child poverty. The country with the lowest level is Norway, where it is 10 per cent after taxes and transfers. That is a benchmark. We could choose to aim for that in Scotland, England and the other parts of the UK. We could choose to be more like Slovenia. What an aim—to be like one of the fractured bits of the former Yugoslavia in our social and economic policy.

I will not go into all the details, as you probably know them better than I do, but let us look at the data from the Institute for Fiscal Studies on the changes to the tax and benefits system by deciles of income. The top decile gets a drop because the 50 per cent tax rate kicked in—it is now 45 per cent—but for every decile below the top one, the lower the starting income, the greater the decline in income as a result of the operation of the tax and benefits system. That is a political choice. A choice has been made that the worst-off should suffer more as regards the percentage decline in income as a result of the operation of the tax and benefits system. The lower someone's income, the greater the drop. That is a political choice.

I have been very careful never to make party political comments in public. I analyse the data—the evidence—and I point out the political choice that has been made. If the chancellor says that he is happy with that choice—if it is the way that he

chooses to do things—that is absolutely fine. However, I feel a responsibility to say, "That will damage our children."

In the US, I showed people the figures for the US, where, after taxes and transfers, the child poverty situation is worse than in Latvia. I addressed 7,000 public health people at the American Public Health Association and said, "You live in a democracy. I couldn't care less whether the policy is Democrat or Republican—this must be the level of child poverty that you want, otherwise you would elect a Government that did something different. You are damaging the next generation, and the situation has got worse."

That is what I mean by political choices. Welfare reform is a political choice. When I heard the Prime Minister say that money was no object in the context of the floods, I wondered why he would not say that in the context of child poverty. Floods are terrible, but so is child poverty. Child poverty is like a flood—it is like a natural disaster—and the Government could take action to reduce it. Arguing from a health point of view, I think that it should.

Richard Lyle: You are neither a Democrat nor a Republican. What different policy choices would you make to reverse the change?

Professor Sir Michael Marmot: The theme that runs through the three reviews that I have conducted—the World Health Organization commission on social determinants of health, the Marmot review of health inequalities in England and now the European review of social determinants and the health divide—is that health equity should be at the heart of all policy making. The filter that I would run over all policy making is the impact on health equity.

People have asked me—as you have asked me—what I would do if I were the Chancellor of the Exchequer, and I have said that it is a great benefit to the people of Great Britain that I am not the Chancellor of the Exchequer. I am really pleased that I am not. However, I would put the likely impact on health equity at the heart of all policy making. If something would make child poverty worse, I would not do it. I would run that filter over my policy making and ensure that nothing that I did would make child poverty worse.

Professor Sir Harry Burns: I absolutely agree with Professor Marmot. However, it is about equity not just in health, but in attainment. We have had some publicity about differential attainment in schools. If we really want a future generation to deliver intellectually, to be innovative, to be creative and so on, we must give them the best start in life. We know, from our studies in Glasgow and from studies done internationally, that the physical damage that is done by poverty limits the capacity of young children to learn and behave appropriately in complex situations. There is very powerful evidence of that. The more adversity that young children experience in early life, the more likely they are to become alcoholics, drug addicts, violent and so on. That evidence comes from cast-iron longitudinal studies. Why would we not want to prevent that?

We are talking about health, but the whole of society would benefit. In Victorian times, it was often said that major public health interventions occurred only when the children of the rich were being damaged by infectious diseases, such as tuberculosis, because that gave the people at the top of the social tree a reason to be concerned. The whole of society is losing out because talent and ability in young children are not being given the opportunity to flourish. We should be concerned.

The Convener: We have received a considerable amount of written evidence about the policy-rich agenda that we have and the poor delivery of those policies. Why have we not delivered those policies?

We see from the papers and the news this week that the number of looked-after children in Scotland has increased by 49 per cent since 2001. We see that the number of children on the child protection register in Scotland has flatlined since 2008. The UK has the worst rates of excess child mortality in western Europe and Scotland is even worse.

How do we act on those policy areas using proportionate universalism? The child mortality figures that were published last week show that we are talking about children dying of poverty. I hear what you say about there needing to be a broad thrust, but how do we change those figures, which have been an issue since I raised them in 2009?

Professor Sir Michael Marmot: I gave evidence to the Westminster Parliament following my English review. We had been monitoring early child development. If we look at the degree of deprivation of the local authority, it shows the gradient. If we plot 150 local authorities graded by degrees of affluence or deprivation, we see that the proportion of children aged five who are classified as having a good level of development goes up progressively the more affluent the local authority. That would be harder to plot for mortality because, although our figures are shockingly bad, there are still not many child deaths, I am happy to say, so we cannot monitor at local levels.

Some sportsman in the audience—not a member of Parliament—said, "The proportion of variance explained in that graph would be quite low." I thought, "That is just what members of

Parliament want to hear: a discussion about multiple R squared and correlations," so I tried to translate his comment into English.

He was saying that there was spread around the line. The reason that I make a point of that is that it suggests that two strategies are needed. The first is to flatten the socioeconomic gradient. The degree of social and economic inequality is very large and child development follows that gradient in social and economic circumstances so, if we bring the social and economic circumstances of the worst-off up towards the middle, we will flatten the gradient in early child development.

However, a second strategy is needed. The fact that there is variation around the line suggests that, for a given level of deprivation, some local areas do better than others. That is important.

Early child services in Birmingham have been bad news lately, but I went to Birmingham because the local authority told me that it had six Marmot champions—one for each of the six domains of recommendations that I made in my review. I got out the figures on early child development. Birmingham is more deprived than England on average and the early child development scores in the city are worse than those in England on average. However, over three years, the local authority closed the gap between the city and the English average. It did not close the gap in deprivation in three years, but it closed the gap in early child development.

Social and economic inequalities are getting worse, although not in all countries. They are getting worse in France, the United States and the UK. Everywhere I go lately, I talk about Thomas Piketty's book "Capital in the Twenty-First Century". It will be very hard for Scotland, England, Wales and Northern Ireland to make progress and catch up in the face of increasing inequalities.

10:15

However, there is a second strategy. There are good evaluated programmes that really improve early child development, and we should be taking the best of them. That is not something that we have been doing systematically. I do not know the Scottish scene but I know that, in England, sure start children's centres have been closing because local authorities are strapped for cash. When I recently visited Newcastle, I found that people there were not despondent—they were trying to make do with the hand that they had been dealt—but they were saying that, in the face of 24 per cent cuts, the only things that they would be doing in Newcastle would be those for which they had statutory responsibility and nothing else. I heard the same story in Manchester. Again, they are pushing on doggedly, but in the face of huge cuts. If sure start centres are closing at a time of increasing social and economic inequality, it is no mystery that we are not doing as well as we might be.

Professor Sir Harry Burns: We are doing a lot through the early years collaborative, the family nurse partnerships and the positive parenting plan, which are all very much focused on young teenagers who are having children. At the heart of many of these interventions is the philosophical view that no one wants to be a bad parent—they just do not know how to be a good one. We are managing to maintain that approach at the moment and I think—I certainly hope—that in the course of the next year we will begin to see significant impacts on markers of child development.

Why have we not made a difference? I think that there are a number of reasons, the first of which is that the analysis of inequalities has moved on a lot over the past two or three years. If we define inequality in economic terms, we automatically assume that the solutions are economic. Part of the solution is no doubt economic, but the fact is that although it is necessary to tackle child poverty, that is not sufficient on its own. We have to do a whole set of cultural things differently.

Gerry Hassan's new book argues that Scotland's problem is a lack of empathy and connectedness; indeed, the Glasgow Centre for Population Health's comparative analysis of Glasgow, Liverpool and Manchester shows that although the three cities are the same in terms of inequality and average income they differ significantly in their causes of premature death, and that the set of indicators that is completely different between the three cities is that related to empathy and connectedness. For example, Glaswegians are far less likely to trust their neighbours. When 1,000 people in each city were asked whether they thought a purse or wallet they had lost would be handed in by their neighbour, people in Glasgow turned out to be far less likely to say yes than those in Liverpool or Manchester. Glaswegians are also far less likely to be members of clubs, to volunteer, to go to church or to be part of a definable community. One of my close friends in public health at the time was the director of public health for Liverpool—indeed, she lived in Manchester, so she knew the two cities well—and when I presented her with these figures, she immediately responded, "Ah—that's easy to understand. People in Liverpool feel well supported." There was a fundamental difference in the sense of community of Liverpool.

Since then, I have spent a lot of time in Liverpool as a visiting professor at one of the city's universities and there is no doubt that there is a

palpable difference in the sense of community. When I have asked people there how that came about, I have been amazed by how often they point to the leadership provided by the churches, particularly Archbishop Sheppard and Archbishop Worlock. In the centre of Liverpool, you will find statues of these two men, holding their hands out to each other. There are also footprints in the pavement alongside the two statues and when you go past them someone is always standing in those footprints with these two men, getting their photograph taken. Another description of that sense of community that I have heard is that Liverpool and Everton supporters are really good friends—they do not care who beats Manchester United. There is simply a stronger sense of community down there than there is in some parts of Scotland.

Part of the challenge is about not just pulling a set of policy levers, but creating a sense of community and of compassion for people. I listened to Amartya Sen, the Nobel prize-winning economist, giving a lecture a couple of months ago entitled "Poverty and the tolerance of the intolerable". His analysis as to why societies such as India tolerate extremes of poverty is not that there is nothing that they can do about it—there is plenty that they could do about it—nor that they do not care about it, but that the middle classes do not understand how destructive poverty is. They think, "We live with people, we know they're poor, but if they get free schools and a free health service and that kind of thing, it can't be that bad."

Amartya Sen's argument is that poverty is very destructive and that we have evidence showing that extreme poverty changes the way babies' brains develop. It is as definable as that; we now have evidence that shows that chaotic early life changes the way in which genes are expressed. The whole science of epigenetics is beginning to throw up how the seeds of chronic disease in later life are laid down by not just your experience as a child but your parents' experience as children. Big studies in Scandinavia show that adverse nutritional circumstances in grandparents at the turn of the 19th to 20th century are still being shown in the grandchildren, so the biological consequences of social adversity are defined and profound. The way to deal with that is to deal with the social adversity, and we do not deal with the social adversity just by changing the way in which taxes are distributed. That is necessary but not sufficient. We need to go much further and change the ethos in our society.

If you go to places such as Holland and Scandinavia—I have no doubt that Alan Sinclair will talk about that later—you will find that people's attitude to children is completely different. They do not exclude children from school. Before she went to university, my daughter spent a year teaching in a school in Spain, and every morning her five and six-year-old children would line up at the door to the classroom and give her a kiss and a hug before they went into class. Culturally, teachers would run a mile from that kind of thing here. We do not show children care and empathy, and it is high time that we did.

The Convener: I look forward to a future discussion on biology and genetics at the committee. What you have said seems to indicate that health is important, because we will be dealing with mitigation for a long time, rather than with the game changer.

Professor Sir Harry Burns: The health service runs hard and fast to deal with the consequences of inadequate investment in children. The last time I was here was to give evidence to the Public Audit Committee, which was looking at the Auditor General for Scotland's report on how the health service puts money into health inequalities. The health service is spending tons of money dealing with the consequences. We need to spend our money more wisely in early years.

An academic from England told me recently that a looked-after child will cost society about £2 million by the time he has reached his 20s as a result of a variety of things, such as the consequences of offending or of mental health issues. We have far too many looked-after children as a result of dysfunctionality in families in which the parents do not know how to be parents.

Rhoda Grant (Highlands and Islands) (Lab): My question follows on quite well from that, because you have mentioned all the different aspects of the issue, and parenting is the one that is really important when we are talking about social and economic issues. Professor Marmot said that parenting can be important, but if the curve on the graph goes upwards in the way that you described, does that mean that people with more money are better parents? Where does that fit in, and how do we tackle parenting for people in the second or third generation of families without good experience of parenting?

In addition to that—I am sorry to come out with a load of questions at once—successful policies such as on family nurse partnerships are targeted at a very small number of people, but are hugely expensive and are probably sucking resources out of other interventions, for example health visiting, that support the wider community. How do we get the benefits of such policies without damaging others?

Professor Sir Michael Marmot: I like to talk from evidence, so when I am making it up I signal it as such. I will be making up what I am about to say—there is no evidence to support it at all. I will then return to the evidence.

I speculate that we are biologically programmed to be good parents—the species would not have survived if parents did not look after their offspring. We get pushed off that track by circumstances, but if that did not happen, we would naturally know how to nurture children. Rhesus macaque monkeys do not need to be taught how to be good mothers; they just are. It turns out, however, that some Rhesus macaques are not good mothers—mostly because of how they have been reared. There is an experiment in which Rhesus monkeys are reared with their peers rather than by their mothers, so they do not experience good mothering and, when they grow up, turn out to be terrible mothers. However, if you take one of the terrible mothers' offspring and have her reared by a good mother, she turns out to be a super mum. Even if there is an inherited biological programme, it is possible to get them back on the right track by good circumstances.

I return to humans and where the evidence is. It is tricky terrain. A woman stood up and said, "That man Marmot is saying that I'm a bad mother because I'm poor", which was a bit confrontational. I thought that she was remarkably well informed; I do not know how poor she really was, as she had been reading my reports—but never mind. The evidence shows that you need only follow the social gradient when looking at parenting activities including reading, talking, playing and singing with children: the lower the income quintile, the smaller the input of those good things from parents. The evidence from a nice example of proportionate universalism from France also shows that in universally available pre-school services the kids from more middle-class backgrounds do not benefit so much because they get the inputs at home, while the kids who get less input at from home benefit more from the services.

Parents who are depressed and ground down by misery and poverty are less likely to be playing, singing, talking, reading and so on with their kids. You might wonder what else an unemployed parent has to do, but they do those activities much less. The famous "30 million word gap" study that everyone cites shows that families who are on welfare speak to their children less. In families in which both parents are working outside the home, the parents somehow manage to address more words to their children than is the case in families who are not working. Being unemployed is not great for child development and it is not great for the well-being of those who are unemployed.

However, services can make a difference; a service could help parents to be good parents, as Harry Burns said, or it could make up for what is lacking. I return to Harry Burns's point; the evidence that we compiled for the European review shows country by country that the greater the proportion of children who spend at least one year in pre-school education, the better the country's children perform on PISA scores at ages 15 and 16. In other words, good pre-school education is not just good for early child development but for educational performance a dozen years later.

We can help parents to be better parents, and we can fill the gap with professional services when that is not possible.

10:30

Professor Sir Harry Burns: I would bet that if we were to look at the family tree of every person in this room and go back one, two or three generations, we would find families living in poor circumstances. In every case, something will have happened that allowed someone in our families to make the leap forward. In my case it was my father. My grandfather was a miner in Lochgelly in the 1920s, and my father left school at 15 to wash bottles in a lemonade factory. He was there for two or three days when a teacher from his school appeared, put his arm around him, and said, "You're coming back to school, son." My father ended up with degrees in physics, mechanical engineering and chemical engineering. He built secret weapons during the war, helped to build the hydrogen bomb after the war—

Professor Sir Michael Marmot: And you are proud of that? [*Laughter*.]

Professor Sir Harry Burns: No, I am not proud of that.

The point is that my father did significant things in his life, starting from washing bottles in a lemonade factory, because a teacher made the difference.

Poverty does not condemn people to failure. We all know about positive deviance; it is one of the interesting things that the research community might start to look at as we begin to get datasets that show why some children succeed when many of their fellows fail. Those will be the interesting studies during the next few years.

We know a lot about why some children succeed; it is about inclusion. Instead of the child drifting away from the path to success, someone sticks their neck out and says, "We want to help you." We need to do far more of that; it needs to become the culture.

Is it the case that the richer someone is, the more likely they are to succeed? Some very wealthy children are spectacular failures—we see them on the front pages of the newspapers all the time. Events knock people off course; the key point is that the wealthier a person is, the more control they have over their life. Control is important. For the person who is worrying about

being sanctioned by the DWP, or about having to pay the bedroom tax, or about the drug pushers who are trying to lead their children off the straight and narrow, other people are in control of their lives; they are not, and that lack of control has consequences for their health as well as for that of their children. The more control people have over their lives, the more likely they are to succeed and to be healthy, and the richer people are, the more control they have over their lives.

I am thinking about when I used to take my children skiing. It was a real trauchle. We had to fly to wherever it was and we had skis and passports and all that. When my son was at Oxford, one of his friends would go skiing in a private jet, flying straight to the ski resort because daddy had fixed it with the passport authorities. The rich live a very different life from the poor and the middle classes; they are much more in control of their lives. That is the difference.

Rhoda Grant: I suppose that everyone who has a role in a child's life has a parenting role because they can make an intervention. You said something earlier about the Spanish school where all the children line up and give the teacher a kiss in the morning, which is absolutely alien to us, and would be alien to most people who work with children because all child protection legislation and guidance tells us not to touch children.

Professor Sir Harry Burns: That is bonkers.

Rhoda Grant: I always think that looked-after children never get any affection from anyone, and that it must impact on their mental wellbeing.

Professor Sir Harry Burns: It does. I had a conversation with a German person who works with looked-after children who was shocked by our attitude in Scotland. If someone in a children's home here walked past a child's room one night and heard the child sobbing, they would not be allowed to do anything about it. In Germany they would go in and comfort the child as a natural and normal way of doing things.

We have to rethink empathy. Children learn empathy very early on in their lives. If empathy is what is missing across Scottish society, the sooner we start to spread it in as prudent a way as possible, the better. We will not raise a society of people who care for each other if we demonstrate to children that we do not actually care for them.

Bob Doris (Glasgow) (SNP): I have found the information that has been put on the record fascinating. Sir Harry Burns made a comment about Glasgow. I represent the city, so I am sure that he expects that I will say something about it. I noted down the phrase, "community spirit versus community empowerment". In my experience, Glasgow has community spirit in shovel loads, but quite often it does not have community empowerment; they are two very different dynamics. I could give detailed local examples—for example, school closures—of public policy decisions that have meant that communities have felt completely disempowered. I will not dwell on that, but it is important for my constituents—I hope that you do not mind, convener—that I say that in my day-to-day activities as an MSP in Glasgow I see bag loads of community spirit, but I do not see a lot of community empowerment, although it is there and it is growing.

I turn to the figure of 100,000 children being pushed into poverty because of austerity and welfare cuts. I do not want to dwell on the UK politics; I want to look beyond that. People know my views on it, so it is not particularly helpful for the committee for me to elaborate on it any further.

Let me tell you a specific story, which I tell a lot—it is a brief one, convener. It is about a single parent, who was working in a part-time job and was desperate to work, but was pushed into unemployment because of UK tax credit reforms. There you have a single parent who was in a working household but who is now on welfare. I am not sure whether that person would count as one of the 100,000 people who are being pushed into poverty.

The gradient of poverty, which Professor Marmot and Sir Harry Burns talked about, cuts right across all income groups. Do the 100,000 people who are falling down the prosperity scale and becoming more impoverished have to be targeted specifically, or will they be caught by universal services when we seek to support them? In other words, when someone who was not poor is pushed into poverty, should they be caught by the same universal services as their new peer group—people who have been in intergenerational poverty—or is there a need for targeting? Is there a danger of consigning such families to similar intergenerational poverty and poor health outcomes? I hope that that is not too abstract; I am just trying to work out how we can identify who those families are, where they are and how we can make useful interventions to benefit their lives. Otherwise, 100,000 just becomes a number, and we are talking about individuals and families across Scotland.

Professor Sir Michael Marmot: I want to pick up a theme that has been touched on. The implication of what Thomas Piketty has said, and the reason why he has become a rock star overnight—it is a bit unusual for a book that has been published by Harvard University Press to be a bestseller—is that the gap between the 1 per cent and the middle is expanding at a frightening rate. It is not just the worst-off versus the middle but the best-off versus the middle. In the US, for men in full-time employment, the bottom 80 per

cent have seen virtually no improvement over the past 25 years. Between 2010 and 2012, of every dollar of economic improvement that happened in the US, 95 cents went to the top 1 per cent. Given that I have been pushing the idea of the gradient for 35 years, the idea that we should stop thinking only about the people at the bottom is music to my ears.

As I said at the beginning of the meeting, it is important that people are missing out; we are all—all of us below the top 1 per cent—in danger of missing out, to a degree. I was talking to a prominent doctor in the US who said, "I'm really worried about social unrest. People in the middle are really angry and are getting very upset because the system is not delivering for them."

On Bob Doris's specific question about whether we should take a targeted approach or a universal approach, we should not be targeting the bottom 99 per cent or the bottom half. If the middle group is in danger of falling below the poverty line, that reinforces the need for proportionate universalism; it means that we need universal services.

If we look at UK figures now, we see that a majority—it is small, but it is a majority—of people in poverty are in households in which at least one person works. In those households, three quarters of the adults are working. The problem with poverty is not that people are shirking; it is that they are not paid enough—they are low paid.

Our taxpayers' money is subsidising employers to take on low-paid staff. We are, in effect, saying that it is okay not to pay them much and that we, the taxpayers, will make up the difference. We give them housing benefits and tax credits, and we try to give them enough so that they can just about buy enough food or heat their houses. As we know from our report on fuel poverty, they are having to choose between heating and eating. Those people are in work. Most people think of the poor not as people in work but as people who are not working. However, the majority of people who are now below the income threshold for poverty are in work.

We have to be much broader and—dare I say it?—radical in rethinking how we want to organise our affairs as a society. What sort of society are we running when people who are working—the mythical "hard-working families" whom we hear about all the time—do not earn enough to have healthy lives? We—Sir Harry Burns and I—worry about the children in those families, and about the circumstances in which they are being raised. My response to Bob Doris's question is that we need not just proportionate universalism but a much broader approach to how we, as a society, use our considerable wealth.

Professor Sir Harry Burns: I absolutely agree with all that, and would add to it the need to care for the individual. We have a network of services and an approach that we would describe as having evolved out of a caring society, but individuals find themselves in individual difficulties, so we need to be able to mount some type of connected approach that allows us to address that, whether through the voluntary sector or through statutory agencies. My bias is always towards the voluntary sector, because statutory agencies have rules on child protection and that sort of thing, whereas volunteers are there because they want to be there and because they care, not because they are paid to be there.

People who have specific difficulties—drug or alcohol problems, domestic violence, mental health issues or whatever—need specific help. I am not about to propose some new set of services that could address that, but we need to be more compassionate.

I once suggested to the permanent secretary that a good way of moving forward might be to allow every civil servant to volunteer for one day a week. Maybe one day a week would be pushing it a bit far, but if we all took part in volunteering, it would show us just how bad the lives of some people are. That recognition would create movement and would allow us to move society in Scotland in a much more caring direction.

That is what it will take; you in Parliament are not going to be able to fix the problem. You can go a long way by enacting legislation and policies that will support that, but at the end of the day it is about people looking after each other. We do not do that nearly enough in this society, and we have data to show that.

Bob Doris: I have lots more questions to ask, but I see that my fellow committee members want in, too. I hope that I will have time to pursue some more issues later.

10:45

Gil Paterson (Clydebank and Milngavie) (SNP): I am getting a wee bit confused about what seems to be a contradiction in your evidence, so maybe you can help to clear it up. Sir Harry says that the prospect of intervention can solve the problem, but the gradient that Professor Marmot talked about suggests that the actions of the chancellor can prevent the requirement for intervention in the first place. From what you say, Professor Marmot, I gather that, by the chancellor's tax methods, he can cause the problem to start in the first place.

Professor Sir Harry Burns: I do not think that that is what we are saying.

Professor Sir Michael Marmot: No—I did not say that. I am sorry if I was not clear. I said that there are two strategies, one of which is to reduce social and economic inequalities. I said that, for a given level of deprivation, some communities are doing better than others. I cited the example of Birmingham, which has closed the gap in early child development between it and England as a whole without reducing the level of poverty or deprivation. I did not say that the issue is just for the chancellor. The evidence shows clearly that good-quality parenting and, where that is not happening, support by providing good-quality services, can make a difference.

So it is not an either/or—we cannot just leave it all to the chancellor and think that everything will be fine. Children need good-quality parenting or support from others in that parenting role—they need that hands-on approach. Think about what reading to children does—apart from send the parent to sleep, with the child saying, "Come on, Daddy, wake up!"; it gives children cognitive and literary stimulation, cuddling, warmth and care—everything. The chancellor cannot deliver that—not even our present chancellor could deliver that.

Professor Sir Harry Burns: He is very cuddly.

Professor Sir Michael Marmot: Whatever the chancellor does, it will not take away the need for children to be cuddled and read to, loved, played with and all those wonderful things. All that I am saying is that that is harder for people who are in dreadful poverty.

That relates to another point that I want to make. An interesting recent book called "Scarcity", by a Harvard economist and a Princeton psychologist, asks why the poor seem to make self-defeating decisions. Why do they not take their medicines or attend for screening? In India, why when people get a bit of money do they spend it on their daughter's wedding or whatever rather than buy fertiliser that would improve their crop yield? It seems that the poor make self-defeating choices, and that is why they are poor. The authors of the book say that that thinking has the causal direction absolutely upside down, because it is being in poverty that reduces the executive function of the brain and makes it harder to make longer-term decisions.

Harry Burns said that everybody in this room will have some family experience of poverty. If the adults in a family are worried about feeding their children, they will be less concerned with making the long-term strategic decisions. The issue is how they get through the day or the week, not what the next 10 years will look like.

However, there is a wrinkle in that thinking—it is more than a wrinkle; it is a different approach, which would be to say not that the authors of "Scarcity" are wrong in saying that the circumstances of poverty reduce executive function, but that the effect begins in early childhood, which relates to what Sir Harry said about early deprivation sculpting the brain. The effects of poverty on different parts of the prefrontal cortex, the temporal lobe and other parts of the brain can influence children's empathy and executive function—they influence their ability to make strategic decisions as they get older. By no means am I saying that the issue is just about poverty and what the chancellor does; but it is about the quality of input that children receive, and that quality of input is affected by children's circumstances.

People can rise above their poverty. In Tower Hamlets in east London, the director of education said, "We tell ourselves every day that poverty is not destiny. We think that we can deliver good services despite poverty." I said, "Show me." I was sent the data, and the authorities have closed the gap in school performance between Tower Hamlets and the English average by putting that approach into practice through good services. The director of education is unable to reduce poverty, but she can motivate her staff to give good services, and they are doing that.

I am sorry if I misled you. The two of us are on the same page here.

Gil Paterson: What if the chancellor's decision had been different earlier on in a child's life, perhaps before the child was born? Do you have data on whether it would be cheaper to take different decisions at an earlier stage? Is it more expensive to do all the interventions that Sir Harry outlined? They were substantial.

Professor Sir Michael Marmot: I very rarely quote Chicago economists—I develop a tic when I start to think about them. However, James Heckman, the Nobel prize-winning Chicago economist, says that early childhood is a rare example of an area of public policy where equity and efficiency come together. I do not believe economists' models unless I agree with the conclusions. His clear conclusion—he has a graph—is that the earlier in life that a dollar is spent, the greater the economic benefit. I do not know whether James Heckman took it back to pre-birth or even to pre-conception—it would certainly be possible to take it back to the in utero stage—but he says that the earlier in life that a dollar is spent, the greater the economic benefit.

I agree with Sir Harry that we are not in this for economic benefit; we are in this to improve the health and wellbeing of our populations. However, it turns out that there is good economic benefit, too.

Gil Paterson: Unfortunately, politics is full of politicians, who make decisions based on cost rather than on improving people's health. That is for sure. That is what is happening at this time.

Professor Sir Harry Burns: The very children who experience chaotic early lives will turn out to be the adults with chronic disease and long unhealthy spells in later life. It is a no-brainer. Many years ago, I wrote a paper on programme budgeting and marginal analysis. We changed a service in Glasgow and, by working with clinicians, produced a better service, with additional consultants, physiotherapists and so on, and we saved about £1 million in the process. By viewing the whole programme as a single budgetary entity, we were able to move money around and save money at the same time.

It is high time that we began to see the life course in those terms. The costs of chronic disease, keeping people in prison and educational failure are huge. Demonstrating that would allow us to identify the sum of money that, theoretically, could be moved into the early years. We could then identify what at the margins is moveable and begin to turn that around. Finance directors hate that, because it stops them doing what finance directors do, which is to move money from one box to another and keep everyone happy. That imposes a discipline that prevents people from being able to vire money in all sorts of directions. However, that is how we will transform the economics, and it can be done.

We have started looking at exactly how we can do it, and that was the first thing that I did in my new job, because I understand that it is what will allow politicians to say, "Yes, we can do this." As I keep saying, all politicians want to do the right thing; they just differ slightly in how they want to do it. I have no doubt that you guys want to do the right thing. Our job is to try to show you how you can do that in ways that meet political expediency.

Gil Paterson: Okay. Thank you.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Scotland has a long history of trying to improve things for people. The lad o' pairts is an expression that we recognise and, when I was at university, we had meal Monday, which allowed the poorer people to go back and get their oatmeal supplies for the next few months. We have a long history at that level and we have increased further and higher education; it involves 50 per cent, whereas it was only 10 per cent when I was at university. When Labour came in, the next stage was to introduce nursery education and there was sure start—there is some evidence that it has been helpful—and community schools. Those things are down at the next level.

The group that I believe we have not explored adequately is the minus one to six months group. I am old enough to remember Bowlby, but we are now 60 years on from that, and we are 80 years on from Lorenz's original gosling studies. If people do not have initial attachment, they have had it, no matter what we do to provide free nursery education, pick up people with speech problems at school or study people in schools to see where we can improve things. What should we be doing? There is the family nurse partnership and that work is great, but it is only happening in Edinburgh. There is substantial deprivation and there are massive attachment problems, but that work is only provided to 120 families.

What are we doing about the minus one to six months group, and can we do it without addressing attachment?

Professor Sir Harry Burns: You are absolutely right. We attribute the whole business of the plasticity of the brain to different patterns of attachment in very early life. Different centres of the brain grow more rapidly depending on the attachment experience.

The early years collaborative has set a focus on minus nine months to five years—although that is being extended to eight years. Starting at minus nine months is about beginning to get young women who have no experience of attachment to understand what it means, and beginning to support them.

As you said, in the east of Scotland, there is FNP provision. For those of you who do not understand what that is, I note that every teenage girl who becomes pregnant is offered a family nurse, regardless of whether they live in Barnton or Wester Hailes. The fact is that most teenage pregnancies occur in deprived areas, but there is no discrimination. That nurse then stays with the girl during pregnancy and the first couple of years of the child's life.

When I went to see the work in action, I saw a 16-year-old girl, and the attachment behaviour that she showed with her baby was utterly impressive. The father came in and he, too, had learned to attach. The girl then got into a taxi and went back to school: she was sitting five highers, she had planned a career and she knew what she wanted to do. When I asked the nurse, "What would she be doing if you weren't here?", she said, "Well, typically, she'd be out with her friends down the shopping centre buying a bottle of vodka." The family nurse partnership is utterly transformative of the lives of both the children who are the parents and their children's lives, and we need to do far more of such work, which is about building empathy. Glasgow is using triple P, which is a different style of approach, but it seems to be as evidence based.

11:00

The point is that we want local authorities and community planning partnerships to develop their own style of enhancing attachment behaviour. There has been too much direction, and the business of co-producing is really important. The key thing is that we want them to collect the data so that they will see what is working and what is not working and will stop doing what is not working.

I could not agree with Richard Simpson more. Attachment is an absolutely central foundation of future success, and it builds the kind of biology that we have talked about. It will lead to reduced risk of ill health later in life and reduced risk of mental ill health in early adulthood. Richard Simpson is right.

We want to do more of that work, and we will continue to do more of it, but in order to afford its expansion, we will have to find ways of looking at the programme budget in its entirety.

Professor Sir Michael Marmot: Richard Simpson began by saying that we have been concerned about the matter for a very long time. However, things have got better—there is no question about that. He will know that from his own experience, apart from the data. Indeed, things have got dramatically better. We should think about what it was like to be born in Scotland 100, 50 or 30 years ago. Babies do not die in the way that they used to.

Again, I know the English data better than I know the Scottish data. In the Rowntree study in York in 1900, the best-off group—the servant-keeping class—had an infant mortality rate of 90 per 1,000 live births. The figure for the worst-off in England now is around six, although we can find that among single mothers or the unemployed, for example, the figure perhaps gets up to nine. Therefore, 100 years ago, the best-off had an infant mortality rate of 90 per 1,000 live births, whereas the worst-off now have a rate of perhaps nine per 1,000. The figures are an order of magnitude different. I presume that the quality of early child development has improved, too, although we do not have good figures on that over time.

The inequalities are the major issue that confronts us. The major challenge is the fact that not everybody is benefiting to the same extent. Some of what we have understood over those years has been put into practice and things have got dramatically better, but we are now challenged by inequalities and the fact that, particularly in Glasgow—I have mentioned this around the world—the life expectancy of the worst-off does not look very respectable compared with life expectancy in any country in the world. That is really shocking.

This is not really relevant to the committee, but Bowlby's son is my neighbour. When I went for a walk, I bumped into him and said something about attachment. Afterwards, I had to explain to my wife where I had been for the past hour, because he gave me a lecture about attachment and his father's theories.

Dr Simpson: We have already mentioned another group: the 16,000 looked-after children in Scotland. I was adopted and I was extremely lucky—I had a rapid adoption after birth. When I worked in adoption and fostering, in the first case that I had I was appalled to see when I looked at the papers that the baby had already been put in foster placements 17 times.

To link to my question on attachment, my generation's philosophy has been that we must always try to get the child back to its natural parents, but if a child has been placed 17 times, what chance does it have of getting any sort of reasonable attachment or any sort of reasonable brain development that will allow it to benefit from free nursery education and good care? What can we do about that?

Professor Sir Harry Burns: The committee will have an opportunity later, I think, to discuss with colleagues who have a specific interest in the area exactly how we deal with that. The study in Glasgow of the New Orleans approach to adoption and fostering is interesting. I do not presume to have anything to say about it, other than that it seems to involve quite a strongly evidence-based pattern for deciding whether a child should go back to its natural parents or be looked after in an adoptive home.

You are right about bouncing a child around. One of the key determinants of stress and poor outcomes among macaque monkeys is inconsistency in parenting—patterns of rearing that change from one day to the next. Consistency is really important and we need to work to achieve that.

We come back to the point about our attitudes to children. Do we care enough about them? If a child falls and hurts itself in the playground, not to be able to give it a hug and comfort it seems inhuman.

Dr Simpson: Hear, hear.

Professor Sir Harry Burns: When I said that to the Association of Directors of Social Work a few years ago, there were gasps of horror in the room—there was a view that this man was a raving lunatic who wanted to hug children.

We now know that epigenetic effects of happiness in children switch certain genes on and

off. That is not why we should give hugs, however; we should do it because it is our natural instinct to nurture people who are in difficulty and people who are weaker than us. All of us in society benefit from demonstrating that.

We are not Anglo-Saxon. The more time I spend in the Nordic countries, the more I think that we have much more in common with them. Their attitudes to children and each other are where I want to be.

Jackson Carlaw (West Scotland) (Con): I have found the opening presentations and contributions from Sir Michael Marmot and Sir Harry Burns enormously lucid and interesting. I have noted and—sometimes as a surprise to me—agreed with a lot of the comments, although I have disagreed with some. Having listened, I shall certainly reflect on a lot.

The themes that have been explored are so broad and huge that it is almost impossible to condense anything into a meaningful question. I have had a long-term attachment to the idea of universal health visiting. I noted what Sir Michael Marmot said about proportionate universalism and focusing on where that is most needed.

I will draw out two or three small questions. I agree with what Sir Harry Burns said about silos in financing, about the inability of some to see where future savings might be assumed now, which would allow funding to be redirected, and about the individuality that is needed. I noted what Sir Michael Marmot said about different outcomes at certain levels of inequality in different places. How do you reconcile the need for individual approaches in different authorities and health boards with the different outcomes that we sometimes see? Are we, for want of a better word, ruthless enough about directing what works rather than always allowing what does not work to become embedded and entrenched?

Sir Michael Marmot said that he is asked what he would do if he were chancellor and that he says that he would not be chancellor. We have perhaps skirted a utopian ceiling in some of our conversation. However, given that you have been in Scandinavian countries, which have a greater focus on early years, what would you tell us, as politicians who must work within an envelope, that health services in those countries do not spend as much time on and we perhaps spend too much time on, which could be a source of funds to redirect?

Professor Sir Michael Marmot: Thank you for those interesting questions. I will start with Scandinavia. Human nature is alive in the Nordic countries. People there are not different from us; they are not a different species. I have been to the Swedish Parliament, where I could pick out who was on the left and who was on the right—that was all recognisable. That Parliament has the same sort of debates as we do, which is interesting.

What has inspired me more recently is the fact that, where the national Government has been reluctant to act, local government has acted and has taken it on. One Swede said to me that I have become a brand name in Sweden. There have been three reports now. Last year, I was in Malmö when a report on a socially sustainable Malmö was produced by the city. People there took my report for the WHO commission on social determinants of health and asked how its recommendations could be applied in one city. I said, “Sweden, you don’t need this,” but they took me to areas of Malmö where there is greater than 60 per cent male unemployment, and I saw that they do need it. They have big inequalities in the city. What they did was get not only the health service but the mayor involved. In fact, the mayor commissioned the review. They involved local politicians, the education service and the health service, and all those main sectors owned it.

Something similar happened in Linköping and Norrköping, in Östergötland, which is just south of Stockholm. I was there last week for a progress report on their big review. They got the politicians involved from the beginning as members of the review. There was concern that the politicians might be too pragmatic and keep asking for more feasible proposals. However, that was not the case, and everybody got involved to the same extent. The advantage of having the politicians involved with the third sector, the civil society people, the academics and people from local government is that there is more chance that what they come up with will be implemented, because the politicians own it. The Social Democrats came up to me and told me what they were hoping for, and so did the right-of-centre people. I was trying to get out of their political debate—it is the same in Sweden as it is anywhere else; they do not like each other much. I am just pleased that the centre-left and the centre-right are engaged at the same time. That seemed to be an important message. They are saying that, starting right from birth and going through the course of someone’s life, those inequalities have to be addressed, and that that has to happen not only through the healthcare system.

If the national Government is not doing that, local and regional government can do it. Of course, I think that it is important that national Government does it, too. I do not want to get into Scottish politics, but I think that it is important that it be done at the city level, the Scottish level and the UK level. We know that, in England, three quarters of local authorities have Marmot implementation plans. Whatever is or is not

happening at the national level, work is being done at the local government level.

I have talked to the Local Government Association which, until recently, was always led by a Conservative. It is my great ally in England. That is an important message.

Professor Sir Harry Burns: I think that the localism approach is important. Earlier, Bob Doris mentioned community empowerment. That is central to this issue.

I am not going to go into great detail but, working with local authorities across Scotland, I can see great differences in capacity and willingness to act. You come across the "not invented here" syndrome—people saying, "If someone is doing something over there, we have to do something different over here." That is fine. The critical thing is that you should monitor what you are doing and, if it does not work, you should be man enough to admit that you have done something wrong and stop doing it.

That is at the heart of the early years collaborative. Every five months or so, 800 people from across all 32 community planning partnerships get together to talk about what they have done and to share the results. We are beginning to see key changes emerge that we need to build on. All those things are necessary but not sufficient—we need to join it all up.

11:15

It is perfectly possible for really good local authorities—the one that you and I are familiar with is good at this kind of thing—to move a long way in this direction, but we also need the overarching economic structures that will allow us to tackle the lives of people who struggle. I am sure that Martin Johnstone would not mind my saying it, but to sit with the poverty truth commission and hear the stories of middle-class people just like us who cannot afford to eat for two or three days a week—they literally eat nothing for two or three days a week because they cannot afford it—is chastening. It makes one realise that we need an overarching approach from the Government that ensures the equitable distribution of goods, power and so on in society. We also need the localism that will allow us to support people who are in difficulty and do not know how to look after their children. We need all those things, and at the heart of it we need a culture in which we start to look after each other.

A few months ago, the violence reduction unit invited over to Glasgow a clergyman from South Los Angeles who had transformed the gang culture in South Los Angeles. Basically, he found jobs for the gang members by creating social enterprises through Homebody Industries. He said something that struck a chord with me:

> "What we need is a compassion that stands in awe at the burdens the poor have to carry, rather than stands in judgment at the way they carry it."

Wow! How would we be in similar circumstances, if we had to live the lives that those people live? What help and support would we need? That is a good starting point for transformation in our society.

Colin Keir (Edinburgh Western) (SNP): In the six months that I have been a member of the Health and Sport Committee, I have found the debate fascinating. The subject has grabbed me from your first words. I have been thinking about proportionate universalism and how, as soon as levels of taxation are set, the people who are just above those levels tend to get hit harder. The idea that it should be proportionate hits through, and perhaps we can bring that into wider society. It has got me thinking, and I will go away with these things in my mind.

As we are running a little shy on time, let us go back to what was said, by Sir Harry Burns in particular, about empathy. We always shout about the fact that Scots are probably one of the most social-minded groups in the world, but I found what you said about the differences between people in Manchester, Liverpool and Glasgow fascinating. A lot of it appears to come down to attitudes and to what we think we are, and it goes back to the point about not being able to hug a child or a sports coach not being able to touch a child to show them where to put their arm in badminton or something like that. A fear appears to have been brought through—we have heard about the child protection issues. Have we gone too far with that, and will we have to rethink our attitudes on tactile methods of communication such as hugs in our entire society? I am not necessarily just thinking of the young child crying; I am thinking of people not being able to do things because of fear. Is that going to drag down the ideas that you have been talking about?

Professor Sir Harry Burns: In the talks that I give, I talk about the notion of the molecular biology of a hug, and there is often a wee queue of people who want to give me a hug after the talk. Sometimes that is okay, and sometimes I am just not so sure.

It is a difficult question. The child protection issue is serious. We cannot duck it; it is out there and we have reacted to the situation in a way that dehumanises us. It is a small issue, but it is very serious. Damaging a child in any way is, to my mind, a serious crime against humanity, but we are damaging children by not showing them that empathy and we need to rediscover a balance.

I am very conscious of this because my daughter has just had our first grandchild, so I am obsessed with watching how she interacts with her and how the attachment process is going on. We need to realise that that is an important part of human development. It is not exclusively the province of the parents; it is the province of other people who show affection for the child. We need to rediscover that balance. I leave it to experts in child protection to comment on where that balance lies, but I want to raise the flag and say that we have gone way too far to one side and, when a child is crying and looking for comfort, it is our responsibility to give them that comfort. The rules and regulations get in the way of us acting like human beings.

Colin Keir: I suppose that my next question would be about how we do that.

Professor Sir Harry Burns: We need to talk to child protection experts about it and not accept the blanket bans. There has to be a better way of doing things.

The Convener: The message that I can take away today is that the examples of Tower Hamlets and Birmingham show that good services can close the gap and make a difference. The other message that we are hearing continually is that health interventions are important but they cannot deal with everything on their own. That reflects all the evidence that we have heard throughout this scoping exercise.

Health is the only portfolio that has a clear priority for tackling health inequalities and it sets out a whole list of targets. Are they still relevant? If they are, should similar targets and the principle of equity be reflected in other portfolios? Would that help?

Professor Sir Michael Marmot: That is a very important question, and it is a question that has given me more sleepless nights than anything else since I started to chair the WHO commission on the social determinants of health. Ministers of education ask, "Why should I care about health? That is your job, minister of health, not mine." The minister of finance asks, "Why should I care about health? That is your job, minister of health, not mine." The ministers of health say that if we take seriously what I am saying about the social determinants of health, they will be out of a job.

I have had ministers of education, environment, and finance saying that health is not their job, and ministers of health saying that they do not want to listen to what I am saying because they will be out of a job if education, environment and finance take the issue of health seriously. I have been struggling with all that for the past decade, and I can show good examples of where we have managed to break down those barriers and make ministers of education realise that what they do in their day jobs has a positive impact on health.

To come back to the Nordic countries, I heard the Minister of Foreign Affairs in Norway say, "I am a health minister, because what I do in my day job impacts on health." In fact, I had a phone call later from an official in the Ministry of Health and Care Services in Norway saying, "You've been going round the world quoting our foreign affairs minister as saying, 'I am a health minister,' and he now is our health minister and he wants to meet you."

The Convener: That will teach him.

Professor Sir Michael Marmot: He came to that portfolio with a rich understanding that he had to work with his colleagues and, when I went to Norway to meet the Minister of Health and Care Services, we had a seminar at a table like the one that we are sitting at now, with 13 different Government departments represented. They even had the Ministry of Defence discussing health. When the ministers left, the senior officials stayed in the room to keep discussing their cross-Government strategy. Health inequalities should be a corporate issue for the whole of the Government. There should not be a health inequalities goal for the ministry of education; there should be a health inequalities goal for the Government. It should be for the whole of the Government.

I recently went to a similar meeting in Lima, Peru, where the Prime Minister chaired a meeting and they had 11 other ministers round the table. It was a corporate issue for the whole of the Government, so if the whole of the Government says, "We have under-five mortality figures that shame us," it is a reflection not on the Minister of Health but on the Government. If they say, "We've got early child development inequalities that shame us," or, "We've got programme for international student assessment scores that shame us," those are issues for the whole of the Government because they will impact on health.

That is my way of saying that we have got to get health, and health equity, into the thinking of the whole of the Government, so that it is in what every Government department does.

Professor Sir Harry Burns: My response to that is that, when you use the word "health", lots of people think about illness. The health service treats illness and prevents illness. What I have been talking about is wellbeing, because inequalities in wellbeing include inequalities in educational attainment, in offending behaviour and in employment success. Inequalities in wellbeing are clearly a matter for the whole of the Government and for the whole of society, so I would encourage you to think about positive health, as opposed to disease. Inequalities in

disease incidence are important, but inequalities in the whole panoply of outcomes are also important.

We are ahead of the game in Scotland. Historically, Scotland had two medical officers of health before England had one. We have a long history in Scotland of concern for public health. The first study I can find of health inequalities anywhere in the world was carried out by the city treasurer of Glasgow in the mid-19th century, when he looked at infant mortality and measured affluence and deprivation. We also have a huge tradition of academic research into inequalities in health, and you will hear more about that later on, so we know more about it than most places in the world. We have a good start in Scotland, and we really need to push on and fix it.

The chief medical officer in England is the chief medical officer of the UK Government, and the UK Government is the member of the World Health Organization, so when the World Health Organization wants a chief medical officer, it is supposed to go to the chief medical officer in Westminster, but in fact it often comes to me, because it sees Scotland as being a leading place for thinking about the issue. Countries in the Balkan region and Scandinavia want to know what we are doing. We need to build on that as we move forward, and we have a huge opportunity to do so. The fact that the Health and Sport Committee and the Public Audit Committee have taken such an interest in the matter is a terrifically positive sign.

The Convener: You are in a privileged position in that you have worked with all shades of Government over the period of devolution.

Professor Sir Harry Burns: Yes, and every health minister with whom I have worked wanted to do the right thing.

11:30

The Convener: Yes, absolutely. Have other Governments throughout the world taken that wider corporate responsibility? Did you witness that over the period of devolution? It is not evident, is it?

Professor Sir Harry Burns: It is patchy. Most places that invite me to go and talk about such matters are already interested and have already made the decision. However, I have recently been to some countries significantly affected by austerity—I will not name names—and, when I talk like this, they look at me as if I am daft. I went to speak to a group of doctors in one country recently, and they thought that I was bonkers talking about wellness and wellbeing rather than treatment of disease.

We are ahead of the game. Our size makes it accessible. The fact that we can get 800 people into a room and that reaches into every community planning partnership is a significant advantage.

The Convener: We had evidence on community planning partnerships last week. There are some gaps—we are running out of time—because half of the local authorities have not embarked on the journey.

Professor Sir Harry Burns: There is a variation.

The Convener: There are issues that we are not applying and we might have an opportunity to discuss some of those with the next witnesses. However, I am trying to focus on Scottish Governments—not just the present one but Governments over the period of devolution.

Given all the world-leading knowledge, the studies that have been carried out and the fact that you are a personality and advocate for all that, what more do we need to do to ensure that, at Scottish Government level, there is corporate responsibility for health and wellbeing as it impacts on children? There are a number of cabinet secretaries and ministers—not one single person but four or five—who have shared responsibility for the matter. Over the period of devolution, I have been involved with some of the issues and raised some of them. Children continually fall through the gaps because the corporate responsibility—the one line—seems to be lacking and equity, as Sir Michael Marmot described it, is not embedded into every policy and every Government decision.

Professor Sir Harry Burns: My experience as chief medical officer was that ministers were accessible and civil servants across Government considered it their responsibility to come together. Silos were not in evidence within the civil service.

Everyone continues to come together. I am still involved in work on inequalities among young people for the Scottish Government. What could improve is coming together with local authorities and voluntary agencies. We need to work seamlessly, not only across the way but at different levels. That is where the gaps are.

Some local authorities have the not-invented-here syndrome and some local authorities are less willing than others to take on new ideas. The voluntary sector is doing fantastic work. Can we spread that, join it all up and learn from the successes? Lots of small projects are doing good things. If we can measure what they are doing and spread it, we will begin to plug the gaps. We will seal the gaps. The Government cannot do it on its own. It can facilitate it, but the other levels of action in society need to be involved.

The Convener: I am sorry to press you, but is the seamlessness that we require from local government evident at a Scottish Government level when one portfolio makes a decision that impacts negatively on the outcomes for certain groups and children?

Professor Sir Harry Burns: My experience was that the Government tried to ensure that there were no unintended adverse consequences of that kind. If some such adverse consequences emerge, a better dialogue must be important.

The Convener: I am talking not just about the present Government but about Governments in the period since devolution.

Professor Sir Harry Burns: The striking thing, in my experience with ministers in different Governments in the years since 1997, has been their great willingness to do what they need to do to fix the problem. Initially, they said, "Tell us what to do," but there is no one thing. It is a question of thinking much more about complex systems and how the interactions within those systems make things happen, and that is much more difficult.

Much more dynamic change needs to happen across the whole of society, but a collaborative approach is evolving. We are the first country in the world to try to achieve such a level of change with that type of method, and to my mind we will soon see some positive impacts.

The Convener: Thank you very much for your precious time and for all the evidence that you have given us this morning. It will certainly make the committee's discussions much more interesting.

11:36

Meeting suspended.

11:42

On resuming—

The Convener: We will now have a round-table session as part of our inquiry into early years health inequalities.

I apologise that the first evidence session ran on a wee bit, which means that committee members and panel members are already under time pressure. I will go quickly to Aileen McLeod, who will kick off by asking the first question.

Aileen McLeod (South Scotland) (SNP): Earlier, we heard from Professor Sir Harry Burns and Professor Sir Michael Marmot, and I certainly agree with a lot of their points. Sir Harry Burns mentioned that Scotland is ahead of the game in trying to address health inequalities. My concern is about the extent to which progress is affected by austerity and welfare reform.

I was struck by Professor Marmot's comment about the Chancellor of the Exchequer's political choices affecting the quality of early childhood development. For example, the Scottish Government has estimated that welfare benefits will be cut by £6 billion by 2015-16, with more than £1 billion of the cuts relating directly to children in Scotland. A number of those have a direct impact on young families, such as the removal of the baby element of child tax credits, the abolition of the health in pregnancy grant, the abolition of the child trust fund and cuts to the sure start maternity grant. Obviously, the number of the working poor is rising.

How does all that affect the life chances of our children and, in the longer term, their health? How can we, for example, better align our welfare system with our early years priorities so that, in the longer term, we can make improvements in relation to inequalities not just in our health but in our wellbeing?

11:45

The Convener: I mention to committee members that we are short of time, but we will give that time to the panellists. Professor Wilson, do you want to come in at this point?

Professor Philip Wilson (University of Aberdeen): Thank you very much, convener. First, I must apologise because I have to leave at 12 o'clock.

I am involved in a programme of work that assesses the social, emotional and language developments of children at various ages in Glasgow. I make a plug for the need to acknowledge the importance of early childhood behaviour and social and emotional development. In particular, I make a case for measuring social and emotional development in children because that is the only way to assess the impact of our services in the early years.

The issue is important. In addition to what you have heard from the previous panel, there is a lot of other evidence that supports the importance of early language, social and behavioural regulation development and long-term health. For example, in the 1958 birth cohort, children aged seven were rated by their teachers, using a very simple, old-fashioned scale, for good and bad behaviour. The children who were rated in the top quarter for good behaviour were half as likely to be dead at age 46 as those rated with bad behaviour. Lots of other longitudinal studies demonstrate the relationship between early behavioural, emotional, social regulation and language development and later health.

You will have seen in the written evidence to the committee the differences between different economic areas of Glasgow. We used a tool called the strength and difficulties questionnaire to measure emotional problems, conduct problems, hyperactivity and attention problems, and peer relationship problems. The questionnaire was very simple—it takes five minutes to complete. We found that the more deprived areas had on average a score that was half as high again as the score for more affluent areas.

If you look at my written submission, you will see a map that we produced. Questionnaires were completed by nursery staff for every child in Glasgow, and around 10,000 pre-school year children are represented in the map. You will see that the scores in Springburn were twice as high as the scores in Hillhead.

That is not the whole story. The strength and difficulties questionnaire shows strong social patterning of scores. However, the scores are not simply a consequence of finance. For example, although Govan is economically as badly off as many areas in the east end of Glasgow, it is doing much better than we might expect. It may be that it has better services and a better sense of community cohesion; it may be that a person in Govan is more likely to have their granny living round the corner.

Factors exist beyond the financial, and we have started to unpick some of them. In an area-based analysis we have found that, for example, the crime level is the strongest predictor of conduct problems in boys. The crime level in local areas seems to have a very strong relationship with conduct problems in boys but, interestingly enough, there is not the same relationship for girls. By analysing data from lots of children geographically we can start to think about what the impact of interventions might be.

The other advantage of measuring social, emotional and language development is that you can look at trajectories—if you can collect the data more than once for the same child, you can look at what factors are indicating whether they are getting better or worse. Our recent analyses of children in primary school show that the big social differentials that exist in the pre-school year get much bigger by primary 3. Children in the affluent areas, who probably start school with an advantage, get better, and children in the more deprived areas, who probably have less of an advantage, get worse.

I have almost finished my point about collecting data. I make a plea to the committee not to forget the importance of general practice in managing early problems in child health. Along with health visitors, GPs are the only professionals who are in contact with all children and they are potentially a very useful resource for identifying vulnerability in early childhood.

The Convener: Does anyone else wish to respond?

Dr Sarah Hill (University of Edinburgh): To respond to the original question, I reiterate the point that Sir Michael Marmot made about the need for a dual approach in addressing inequalities in the early years. Cuts to benefits will be problematic in terms of increasing the underlying social gradient.

There are policies that the Scottish Government can pursue to ameliorate decisions that are made in Westminster, such as its commitment to implement a living wage, including in its capacity as an employer. The second element of Sir Michael's strategy is important, which is an area in which the Scottish Government has much more capacity to take a lead. In particular, I emphasise the role of early childhood education as an ameliorating influence for children who come from disadvantaged backgrounds.

It is important to think of the opportunities that exist to improve the early childhood experience of children who grow up in Scotland. The Government has taken steps to improve access to early childcare. That is an extremely positive move, which I suspect will be beneficial in economic terms, but if we want it to lead to improvements in educational and health outcomes, stronger investment is needed in the educational aspects of early childhood care. It is not just childcare that is important. The provision of well-supported early childhood education by qualified staff offers a huge opportunity to ameliorate some of the more negative impacts of cuts in benefits.

Alan Sinclair (Centre for Confidence and Well-being): Although I am representing the Centre for Confidence and Well-being, I set up a body called Heatwise Glasgow, which became the Wise Group, that dealt with the long-term unemployed. I was involved with it for many years, and I can relate a lot of that experience to the question that has been asked.

Of the couple of thousand long-term unemployed people whom we took on each year, we got 50 to 60 per cent of them into jobs, but there was a significant slice of them—they were usually young men, but they included young women—whom we could not help. When we analysed and dug into that, we frequently found that they had virtually no social skills when they came to us. They had home-made tattoos and they wore sports clothes. They could hardly talk to us and hold our eye, and yet we were supposed to find them jobs. If truth be told, there was no chance of them getting a job.

We also discovered that most members of that group were already parents two or three times over, so there was a major intergenerational issue going on. The tools that we were meant to use to change that were welfare benefit and getting them a job, but we had to look at a different category, because we could not retrofit them with the soft skills that they needed. That leads me on to what we are trying to do on welfare policy and on health policy to ensure that people develop the necessary empathy and language and behavioural skills, which needs to happen before they go to school rather than when they reach 21 years of age.

Brenda Dunn (University of Dundee): I want to go back to the point that Sarah Hill made about educating young children as well as providing care for them and looking after their wellbeing.

If we are going to do that, it is important that we consider how we educate the practitioners who are looking after those children. It is not just a case of giving children extra hours in a nursery situation, out-of-school care or a play group; it is about considering who is going to look after those children.

We want that to be done by people who are really well qualified, but what concerns me is that, quite often, it is the most inexperienced and the youngest practitioners, who do not have the qualifications, who look after the babies in the baby room.

We really need to consider things such as Education Scotland's report, "Making the difference: the impact of staff qualifications on children's learning in early years", which shows that educated practitioners—lead practitioners with perhaps a BA in childhood practice or teachers with an early years qualification—can make a difference. The Her Majesty's Inspectorate of Education reports have shown that to a large extent.

The Convener: I want to engage some people on that theme, which came up in the written evidence in different ways. In the very early stages—zero to six months—there is a presumption that general practitioners and nurses will be involved. None of the written evidence says how important nursery workers or care workers are, and yet they spend an awful lot of time with children and young people. Can we have a bit of discussion about the workforce capacity and the quality of what is there on the ground? What is there and what is important?

Dr Jonathan Sher (WAVE Trust): I will leave it to others who are more expert about workforce issues than I am, but—

The Convener: I want to develop that issue. If you do not have a workforce issue—

Dr Sher: The point that I have to make involves the workforce, but not just the workforce.

One of the very basic messages that I hope that the committee will pick up and act on is that so much of reducing health inequalities, or other inequalities, is about the nature and quality of the relationships. First and foremost is the relationship between the baby and the parent or carer, but also important are the relationships between the parents and between the parents, GPs, health visitors and nursery staff. It is not enough just to make this a numbers game. The research is absolutely clear that increasing the number of workers has meaning only if healthy, trusting, two-way relationships of respect and care have been built up all the way across the spectrum.

We should absolutely increase the number of health visitors and reduce their case loads, but that will work only if they are able to develop nurturing, two-way relationships with parents. Having more health visitors going around saying, "This is what you need to do," or "Oh my gosh, what a terrible job you are doing!" will not be very effective. Having those relationships across the board is absolutely crucial, but we do not tend to focus on that.

The Convener: The written evidence shows us that there are fewer health visitors.

Professor Wilson: In my written evidence, I raised the issue that GPs are now doing much less preventive child health work than they used to, which is largely a result of the 2004 contract. There is no incentive for GPs to get involved in preventive child health work or child health surveillance.

In addition, there have been a number of well-intentioned but ultimately ineffective policy decisions around health visiting. Health visitors have ceased to be the experts in normal child development. Child development fell out of the syllabus for health visiting about 10 years ago. There is an ageing workforce, and there have been a whole series of developments that have demoralised the workforce. That is a big issue, because health visitors are the major support for parents in the pre-nursery years.

There has also been a strong managerial push towards so-called "skill mix" in health-visiting teams, which means that health visitors themselves—the professionals who are educated in this area—do not deliver most of the service; most of the service is delivered by much less well trained colleagues. There has been a mentality in which continuity of care is not given the importance that perhaps it should be. People do not know who their health visitor is anymore, which is a big issue for a lot of families that should be fixed, if possible.

12:00

Ben Farrugia (Centre for Excellence for Looked After Children in Scotland): I echo Jonathan Sher's words about the quality of relationships, but my day job is working with local authorities and, in some cases, NHS boards to look at some of the interventions that they can provide to looked-after children. Our experience tells us that there is a capacity gap.

A lot of the solutions that we look to are constricted by the envelope being so small. When I think about care leavers in particular and the world that they are projected into, I can see that what we expect in terms of them holding on to relationships with workers—whether social workers, throughcare workers, foster carers or residential care workers—is very difficult in the context that we currently have in Scotland. A foster carer will take on new children, so it may be difficult for a care leaver to maintain a relationship with them. As was said in the prior session, maintaining a relationship with a residential care worker can be actively frowned upon.

There is a capacity problem whether it is in schools, with support staff and guidance teachers for children who may need them in that context, or whether it is with health visitors and elsewhere. It would be helpful for the committee to hold that in mind when it is considering what the solutions to the problem are.

Paul Bradshaw (ScotCen Social Research): I am from ScotCen Social Research, and I am also project director for the growing up in Scotland study. I want to come back with some information for panellists and committee members on the point about pre-school educators and practitioners. We have a forthcoming piece of research that uses growing up in Scotland data on children's social, emotional and behavioural outcomes and their cognitive ability.

We have followed the children from birth, and those in the older group are approaching 10 years old. We know which pre-school centre they attended and we linked that information and extracted details from those pre-schools about quality inspections. We are exploring the relationship between quality aspects at the pre-school centre that the children attended and changes in their behavioural and emotional outcomes and their cognitive ability, and are finding a relationship between those things. I cannot say any more at the moment, but the report will be published next month. That relationship is not unusual. Other research in the UK has found a relationship between the pre-school environment—particularly its quality—and children's outcomes.

The point, in the sense of proportionate universalism, is that upwards of 95 per cent of children in Scotland who are eligible for a pre-school place take it, and most of them go for the time that is allocated to them. There is a real opportunity to make a difference on a very broad scale.

Alyson Leslie (University of Dundee): I work at the University of Dundee in the fatality investigation and review studies team. The issues that have been raised about workforce are crucial, whether we are talking about the workforce for young children—as Brenda Dunn did—the workforce for looked-after children or the teaching workforce.

I want to pull in some of the thinking from the earlier session. In the wake of Bowlby's work, the concern was that if the attachment bond was broken it could never be repaired. We have since learned that even children who have had the most traumatic, challenging and dreadful experiences can recover and become both productive, fulfilled members of society with fulfilled relationships, and productive and caring parents.

What makes the difference is the child having one person who nurtures them, responds to them, believes in them and values them. So often when you talk to people who have had that journey, it comes down to a teacher or a dinner lady.

I cannot tell you how many times over the years people have told me about dinner ladies, janitors and care assistants in schools who, as they do their work of tidying up and so on, talk to a child and make them feel important. We do not invest enough in or recognise those people.

We need to ensure that the people who work in schools and early care centres in the areas of Scotland that contain the greatest clusters of children suffering from the early emotional trauma that can affect their life chances and their health so significantly are the most qualified, compassionate and nurturing. That is where the difference is going to be made.

The Convener: If no one else wants to come in on that theme, we are done.

Brenda Dunn: Sorry—

The Convener: No, no—not at all.

Brenda Dunn: It is something that I feel very passionate about. Many years ago, when I was a primary teacher in a school in a very deprived area of Dundee, there was a scheme called educational priority areas, for which no longitudinal study or any such thing was ever done. We worked in partnership with parents and had smaller classes. I had the same class right through primary 6 and 7, and I know that we made a difference to those children. We worked with them individually and we

empowered them. That approach came from a deficit model that I do not really agree with, but we gave the children goals and the targets, and they then set up their own.

The children came to visit me years later when they were in secondary school. It was the first of my classes from that school from which children had gone on to further education, and some of them even went on to higher education. I was so proud of them. We made a difference: not just me as a teacher, but other people in the school who were working with individual children and classes.

Why do we just abandon such things and not do the research over the years to find out—it takes a long time to find out—whether they make a difference? There were elements in that approach that really worked.

It is a bit like the HighScope approach; we should be learning things from the past that we can take forward and use to make a difference. The children with whom I worked were in primary 6 and primary 7, and they went on to secondary school full of confidence and with a can-do attitude. The approach was about giving them the power and motivating them so that they ran with things.

The Convener: Does anyone want to pick up the point about continuity and the importance of long-term relationships in education? If not, I will let Bob Doris take us in another direction.

Bob Doris: I will stay on that direction. Brenda Dunn spoke passionately about primary 6 and 7, but pre-school provision is also important.

Pre-school provision can involve blocks of two and a half or three hours of early learning and childcare two or three days a week, depending on how it is structured. Irrespective of how we get there, there is a growing consensus that we need radical and significant advancement in early learning and childcare from the age of one onwards. That is presupposed to be the best approach to take.

I will put aside issues of economic benefit and gender equality—although I do not diminish those aspects—and focus on attachment and relationships. If a young child at age one, two or three is developing a relationship with someone in a childcare establishment, not for two and a half hours two or three times a week but right through the week, will that have a much greater nurturing effect on their development? They are not just interacting with other kids but getting the continuity of an adult role model throughout the working week. Is there research on the piecemeal approach to childcare versus a consolidated early years childcare approach that enables children to form bonds at the age of two or three with early learning professionals? Some information on that would be helpful. If there is none, that is okay.

Brenda Dunn: There could be more research in that area. I currently work with childcare and lead practitioners who are very aware of attachment theory, and there are specific staff who are responsible for specific groups of children. What concerns me is that when a child moves from the baby room to the next room, that bond may be broken, as they have to relate to new people and different practitioners. Bob Doris makes a very good point, which we should consider.

The primary 6 and 7 class that I had for two years led to an attachment; the children and I had a bond. For very young children, we should realise that it is not just about moving them from one room to another; perhaps we should be thinking about attachment. That is a really good point that is worth considering. I will take it to the university BA course.

The Convener: Does Jonathan Sher want to come back in?

Dr Sher: If you insist.

The Convener: I am not insisting, but you were looking in my direction and I felt under pressure. Professor Frank has not contributed, so I will bring him in.

Professor John Frank (University of Edinburgh): Everyone here has agreed that investing in better, earlier, high-quality, pre-school education combined with care is essential for Scotland. However, my concern is that you will not know whether you are doing a good job because you are not measuring any of the outcomes. Scotland has no standardised measure of child development and no data collected by everybody that can be analysed. The early years collaborative asks every local authority to improve early child development but does not give any guidance on the yardstick to use.

I will not go through our briefing, but it describes a project that we did in East Lothian to pilot just one measure that the teacher can fill out in 20 to 30 minutes for each child in their P1 class after they get to know them at around Christmas time. We happened to use an instrument that is used every three years for every P1 student in all of Australia and now most of Canada, where it originated 15 or 20 years ago. I have no intellectual property rights in the pilot; it is run by a non-profit organisation. It is not even in my area of interest but I am doing it because I think that it is what Scotland needs.

We have showed that the instrument works beautifully. At an annualised 7p per taxpayer in the local shire, if you like, it is very cheap. However, nobody wants to talk about it because of the

gridlock between local authorities and the Scottish Government about who will pay for anything new and how much direction the Scottish Government can give local authorities about anything.

I just want to ask members whether it is now somehow improper to suggest that a standardised measuring stick should be used throughout Scotland for child development, at least at school entry, so that we know how to allocate resources where they are needed, instead of just giving every local authority a budget for pre-school that is proportionate to the population, which is how we do it just now. There is no measure of need. I understand that comparisons are odious and that the measure will reveal massive differences between communities but, right now, you are not managing by outcomes.

I will leave you with one thought. A very famous person in health services policy once said that what gets measured gets acted on. Right now, nothing is being measured. I do not mind which instrument is used to measure, but I am quite stunned by our inability to even have the conversation in the present climate of intergovernmental relations in Scotland.

The Convener: Are there any takers on measuring need, meeting need or funding?

Ben Farrugia: Those are certainly on my list of things to speak about today, and I agree with everything that Professor Wilson and Professor Frank have said.

I do not know whether the committee is aware of some of the initiatives that the Scottish Government has been pursuing through the joint improvement team and some of its relationships with local authorities around population-wide surveys and how that work can complement some of the great work that is being done through the growing up in Scotland study. Having been close to the development of some of those projects, I do not think that we should lose sight of the fact that some people in our society can be quite resistant to some of those things. We should also be aware that there can be parental pushback, probably as a result of a failure in how we communicate the benefits of measuring. Because of that challenge, we sometimes go about measuring in a way that could be perceived to be a little bit mischievous and devious. That is not the case and it is not our intention, but we need to be clearer about our intentions and promote the benefits in terms of planning for outcomes.

The Convener: We will hear next from Alan Sinclair, Dr Buston and Dr Sarah Hill.

12:15

Alan Sinclair: I am trying to remember the original question, which was about day care. I am increasingly concerned that we think that day care is the answer to early years issues, because that obfuscates the issues. Day care normally starts at age three, but the big issues in a child's life arise from conception to two or three years of age. The more we talk about day care, the more we get ourselves into a cul-de-sac.

Significantly more important is the issue that John Frank raised, which is that we do not even know how we are doing in Scotland—the issue gathers zero attention. We have not measured how we are doing, and unless we do so I fear that we will continue to have rather pious, woolly and well-intentioned discussions as a substitute for scientifically managed progress—in other words, the opposite of progress. We do not know whether we are going this way or that way at the moment, but we have a lot of sound and fury.

Dr Sher: I am speaking today on behalf of the WAVE Trust. In the written submission, I commend a document that was written before I arrived at WAVE—so there is no pride of authorship—called "Conception to age 2—the age of opportunity". Some committee members have had a chance to look at it. It contains a great deal of the latest evidence from around the world on what works and what does not work, whether it is to do with improving the workforce or enhancing attachment. To follow up on Alan Sinclair's point, the crucial point is about the age of opportunity being conception to age two, yet the conversation here continues to be about early years starting at pre-school. The focus needs to shift to pre-birth to pre-school if we are going to make a great difference.

That was illustrated in news stories last week, when all the attention was on closing the gap in educational attainment. Closing the gap is a great thing to do—we absolutely should do what we can in that regard. Even better, we should be preventing the gap from ever opening. However, we wait around until there is a gap and then think about how we can close it. Instead, we should be asking how we can prevent the gap from appearing in the first place. In order for that to happen, we need to pay careful attention to pre-birth to pre-school. From our perspective, that also means pre-conception health. I do not want to drag this out—I have put that in our submission.

Yes, there is plasticity. Obviously, it is never too late to help a child; it is also never too early. It is crucial for us to remember and begin to act on the declaration from the Scottish Parliament and the Scottish Government that we value preventative spending. We can say that we value preventative spending, but a hard analysis of where the money

and attention are going thus far would show that it is not going on primary prevention. In a sense, I should not have to tell you what you have already publicly proclaimed. Preventative spending could and should be the priority, but that means really doing it. You can make up for things that went wrong in the first place but there is no such thing as a second chance to make a good first impression. When it comes to the impression that we make on children's brains, their emotions, their learning and their lives, we have one chance to get that foundation right. If we get it right, a child's trajectory is good. If we do not, we will keep spending extraordinary amounts of time, effort and money on trying to catch up and redress what we failed to do in the first place.

Dr Katie Buston (University of Glasgow): I am from the University of Glasgow's institute of health and wellbeing. Although it is wonderful to hear all this talk about prevention, I think that we need to look downstream at more specific and curative approaches to wider societal issues. It was a pleasure to hear Professor Marmot and Sir Harry Burns speak. I certainly think that day care is important, although I am not an expert on that matter.

However, I feel that I cannot leave here without putting in a word for attachment-based parenting interventions. They tie in with the issue of reach; as a researcher, I believe that we need to look more at the people whom we are reaching with the interventions that are being implemented, and to understand better those interventions' effect on the most disadvantaged people. Hardly any research has looked at that group, because it is a challenging topic and because interventions cannot always reach those people.

The prison work that I have done in the past has just popped in to my head; Harry Burns mentioned the young fathers in Polmont. Given that those guys are a captive audience, why are we not doing parenting interventions with them and monitoring that approach to see whether it works? That is a huge thing that can be done for relatively little spend; it is useful to point that out in the context of the wider issues that we are talking about in this wonderful discussion.

Dr Hill: On Professor Frank's point about the need to measure and monitor what is going on in early childhood development, and Ben Farrugia's point about resistance within communities, although it is important that we recognise the role of good parenting in attachment, it is difficult to tackle from a policy perspective. I am fully supportive of any interventions that can be offered, but they are only ever likely to reach a very small proportion of the population.

Professor Marmot made the very good point that, because of the other pressures that they are subjected to, parents in less-advantaged circumstances struggle to use what they know to be components of good parenting. We have to be realistic about the extent to which policy can address that matter—although we should do whatever we can. Moreover, if we focus only on people whom we regard as poor parents, there is a risk that we will reinforce a sense of blame among people in less-advantaged communities. That becomes associated with resistance to efforts to measure and monitor such matters, because such work is seen as reinforcing the idea that disadvantaged communities are responsible for their own difficulties.

One of the real strengths of the monitoring instrument that Professor Frank highlighted is that it is not about placing blame on specific schools. Its point is to measure not the performance of the schools but the capacity of the children when they reach primary 1 and P2. The instrument is used primarily as a marker of need; we are simply asking which communities have the greatest need for investment in early years education. That is a really positive way in which the instrument can be used.

On the workforce—which the convener asked us to discuss—the advantage of looking at earlier childhood and pre-school education is that it gives policy makers a real opportunity to implement what Sir Michael Marmot referred to as "proportionate universalism". As Bob Doris pointed out, almost all children are eligible for early childcare. At present, however, the emphasis is on childcare, so I ask for a shift towards seeing it more as an opportunity for earlier child education. Alongside that, we should invest in the people who provide care in those contexts and give them adequate support to ensure that they are fully qualified in childhood development; that they can help children, particularly children from disadvantaged backgrounds, to overcome the disadvantages that are associated with growing up in an environment in which they might not have strong parenting; and that they can provide the most nurturing and caring environment possible, in which there is continuity of care. It would be a shame were the Government to miss such a policy opportunity.

Ben Farrugia: Perhaps I can add my own little looked-after element to that. As the proposals in the Children and Young People (Scotland) Act 2014 were being developed, there was some debate about the impact on children who were being looked after at home or by kinship carers of provision elsewhere of what would essentially be a full-time carer, and the building of an attachment relationship with them rather than with their primary caregiver. I think that that is partly an answer to Bob Doris's question.

To build on Dr Sarah Hill's point, in the list of things that we wish the early years workforce could do is work with parents to enable them to provide the nurturing qualities that are needed, and which parents can build on, rather than providing a different space in which to build those qualities.

The Convener: Professor Frank made a point about what the impact will be if resources are determined by population levels and not by need. How do we get proportionate universalism?

Dr Sher: I hope that my colleague Alan Sinclair will say something about the Netherlands' experience, which speaks to the issue. Sir Michael Marmot and Sir Harry Burns mentioned Sweden. One difference in Sweden is that the universal service for parents of babies and very young children has near-universal reach. People there do not spend a lot of time on talking about hard-to-reach parents, because the concept does not resonate. The service is welcome, valued and attractive. There are opportunities—it is the normal schedule; it is just how life is—for parents and babies to show up 12 times between birth and the age of two, when what is true for them—good, bad or indifferent—is assessed. When a concern is found, there is a more or less seamless transition to getting the support and help that are needed to deal with the concern as early as it is raised. That is done over and over again. No big gap arises when children are three years old, or when they go into primary school, because that is prevented from happening. Sweden provides a clear example of what works in the real world in making prevention a normal feature of what the Government supports and what parents sign up for and participate in freely, happily and gratefully.

Alan Sinclair: I have held back from speaking partly because so much policy tourism has been going on in visits to different countries. I am trying to find a way of describing in 30 words why I became a fan of the Netherlands. It relates to a few things.

When I talk in Britain about supporting parents, people frequently convert that into meaning that we are intervening and stepping over the line. I have spent mornings in the most deprived part of Holland; people there go to all their regular appointments. They do that from the child's birth to school age—they have 12 to 14 appointments—and they do it because the appointments help them, and they know the nurse and the doctor.

I also do management work in Holland. This is not about the early years, but this time last year a successful businessperson told me that nurses had been helping his family with an issue with their twins. The service is universal; it is there for everyone, it is non-stigmatised and is part of what everybody does.

My worry about health inequalities and early years is that we are getting to a position in which we think that help with children is for the feckless rather than for the population of people who are suffering. I live in a leafy part of Glasgow, but if I went down my street and described the catalogue of problems of middle-class children, it would be terrifying. Those people are struggling. Those children have struggled; some of them are now dead and others are self-harming. We have a serious issue across our society, and we are in danger of putting it in a corner and framing it as being about childcare and the feckless when it is actually about how we operate as a society.

12:30

I disagree with Sarah Hill: there are very clear ways of addressing that. The family centres that exist in Holland and deal with mother-and-baby wellbeing have been going for 100 years or more. They are well-established and cherished, and they have made a very big difference. On most international indicators, Holland is doing best on child wellbeing by a long way.

Ben Farrugia: Do families have to access the centres or are they an optional extra? I am trying to get at some of the cultural elements.

Alan Sinclair: That almost does not apply: people come because they want to and because they see the centres as a help. If a parent fails to make a few appointments, someone will knock at the door to find out why. There is a long stop, but it is a long way before people get to that because there is such an overwhelming acceptance that the centres are a help.

Dr Simpson: Professor Frank's point about monitoring is important, because we need to see where we have got to with the early years approach. It is not new; as I said to the previous panel, we have family centres, sure start, Home-Start UK and nursery education for children aged three and four. Some of those things have been running for 10 or 12 years, but we do not know whether they have really worked. There has been some research, but not a lot.

Can anyone here tell us what we should stop measuring so that we can measure what is appropriate? We seem to measure just about everything that moves in terms of process, inputs, throughputs and outputs, but we are not measuring outcomes. If people can tell us what to measure, we could perhaps have a very simple measure at age five. We could say, "In this local authority, with that programme, this seems to be working, but the other programme is not, so we can stop doing that one."

The Convener: Are there any takers?

Professor Frank: I know that Richard Simpson knows the answer to that question, because he is a researcher and a physician. I will just say that quite a lot of useless hand-wringing occurs in Scotland. The annual report on health inequalities is technically superb and is by far the best in the world—there is technically nothing wrong with it, and I say that as an epidemiologist. However, all but one of the 11 health outcomes that have been analysed again and again, for six years in a row, occur far too late in life to be influenced by any policy within the first five years of life. They are based on deaths and hospitalisations that occur predominantly among people who are past the age of 50 or 60. I am not saying that those people should not have the best possible preventative and clinical care; I am saying that such information will not direct you towards the upstream drivers that determine health. You are carrying out tombstone epidemiology.

The one measure that the report looks at for early life concerns the number of low-birth-weight babies, the main driver of which—prematurity—was very carefully reviewed last year by a world-class team. The team published its findings in *The Lancet*, and pointed out that we know so little about preventing prematurity that we could reduce it by only 5 per cent of its current levels even if we were to implement everything that we know.

Let us not measure stuff that we cannot change, and let us not wring our hands about stuff that is too far gone. Let us focus on things that we could change. Perth in Australia managed to change the early development instrument scores—the instrument that we piloted in East Lothian—in less than five years. It massively shifted a deprived community's EDI scores by putting in place reading and activity programmes and parent-child programmes within walking distance of people's homes. It is not rocket science.

The Convener: Do Alyson Leslie's tombstone figures on child mortality not lead us to a debate? Indeed, Scotland stands out in that it has a high number of deaths of school-age children. Cannot we use those figures to direct our approach?

Alyson Leslie: Interestingly enough, in respect of mortality data the situation is the other way round; the deaths in which we can make a difference are those among older children. The majority of children who die in Scotland are under six months, and half of all children who die in Scotland are aged a year or under. A lot of those deaths are related to congenital conditions causing death at birth and so on, which are things that we do not yet know enough about and cannot do a lot about. The deaths that we can do things about, in relation to which we are in a shameful position compared with the rest of Europe, are trauma deaths including road traffic accidents, suicides, deaths from reckless behaviour, and deaths in which alcohol or drugs are involved. Those are the ones that we can do something about—the modifiable ones.

If we take the example of teenage suicide, which currently gets a lot of publicity, the problem is that we do not know enough. We do not know enough about the relationship between the pre-existing, predisposing factors in a child's life and circumstances, and the precipitating factors—bullying or something else. We have not looked carefully enough at what is working, and that we are not doing here, in countries where the rate of teenage suicide is significantly lower. That is underresearched; it is one of the areas that we need to think about next so that we understand the problem better before we start to put solutions in place.

The Convener: We know that a disproportionate number of those children will have been in care and will have been identified on child protection registers. We know the number of children on child protection registers who have suffered violent abuse and so on, but how does that trigger a reaction in terms of provision of services? Are the services in place to help those children? Children 1st has said that in mental health services in Scotland there are only 10 child counsellors, but every year 1,000 children go on the child protection register. Even when we have the information, are we acting appropriately to make a difference in their lives?

Ben Farrugia: What I am hearing implicit in what the convener has said is the issue of thresholds, which are a reality for a lot of communities. How bad do things have to get before the intervention is provided? I say to Alan Sinclair that I use the word "intervention" consciously, because that is often what it is. That issue is a concern. Mental health is a good example; things have been pushed into being looked at through a CAMHS—child and adolescent mental health services, which are highly specialised—lens. There is a sense that people have to reach the threshold for that, when mental health services should be about wellbeing. There should be a much lower base.

Dr Sher: Alyson Leslie is right that there is a lot that we do not know, but we also know a good deal. One issue that has not been explicitly mentioned, but which connects some of the topics is child maltreatment, which means abuse, neglect and growing up with domestic violence or in toxic and violent environments. It makes a difference in very long-term health, as has been shown by a raft of retrospective studies that are generally classified as ACE—adverse childhood experience—studies. Those studies are about people—mostly from the middle class and

upwards—looking back at the adverse effects in childhood of maltreatment or other adversity that they encountered. The essence of what the studies show is that, the more adverse childhood experience a person has in their very earliest years, the higher are their chances of cancer, heart disease and early death. What happens in the very earliest time—the first 1,001 days of life—has a lifelong effect. If the experience is negative, it has life-shortening, life-debilitating and illness-producing effects. We know something about what causes such outcomes.

It is rarely mentioned—perhaps because it is not understood—that children who are affected by maltreatment, abuse, neglect or domestic violence are mostly affected from birth to one year. The typical image of child abuse involves a seven-year-old being smacked around, but that is not where it starts; it starts in those first 1,001 days of life. If we want to reduce teen suicides and mental health problems, and if we want to reduce longer-term physical health problems and costs, the time to do that is during those first 1,001 days. It is important even to go back to the pre-conception stage.

I will mention one good thing and one not so good thing that we do in Scotland. The not so good thing is that, for all that we talk about parenting and are willing to blame parents when things go awry, we do not, as a society, take seriously the task of preparing and supporting the next generation of parents. It is the habit: we wait until things go wrong and then react, instead of getting it right from the beginning and preparing the next generation in a healthy way.

The good thing is that discussion of attachment is indicative of something that has worked well. When I came to Scotland nine years ago, the only time attachment was ever talked about was when it went horribly wrong and gave rise to a psychiatric problem that needed intense special treatment. Now, only nine years later, attachment is being talked about, and is increasingly being dealt with, as something that involves everybody, as Alan Sinclair said. It is not just a marginal issue for certain people. Attachment—the basic bond between baby and parent—does not respect socioeconomic boundaries.

Getting it right for any socioeconomic group is crucial; that has finally been learned. We are now acting on that understanding, rather than waiting for a psychiatric disorder to develop among a few children. That is commendable, as is this whole inquiry on the early years.

The Convener: Thank you.

Dr Buston: I will mention a study that we are doing in my department. It is a three-armed RCT, or randomised controlled trial, called thrive. The three arms are: enhanced triple P for baby; mellow bumps; and care as usual. The trial will not be reported on fully until 2017, which I know is not great for you guys. One of the outcomes will be to do with child maltreatment.

I take Sarah Hill's point about parenting interventions and stigma. It is a hugely political thing, although it should not be. Most parents want to be good parents and, if there is help available and someone has been recruited during pregnancy, it is important to monitor what is happening and adapt things so that the women who really feel that they want and need help can access it. We will measure that thoroughly and properly. It is an important trial.

Brenda Dunn: I wonder why we have not considered what has been done in the Scandinavian countries. Many parents and carers might wish to stay at home with the baby for the first two years, but they must return to work because of the poverty side of things and the need to earn a living. This would be a universal measure: if people had the choice to stay at home if they wanted to, they would perhaps still have half pay, for instance, which would give them the luxury and enjoyment of staying at home and bonding with their child. I am all for workforce development, but many parents would enjoy staying at home and being with their child. That links in with the points that have been made about attachment.

Alan Sinclair: I will put that point together with the childcare issue. If someone in Finland chooses to stay at home—which they can do, thanks to the Finnish Rural Party arguing the case—they can get paid the equivalent of what it would cost the state to put the child into a nursery. The child stays at home and the parent gets the money for that. Here, we think that it is a good thing to put children in a nursery, but is it not a good thing that people look after their own children? That just shows that there is some very strange thinking going on.

12:45

The Convener: Who goes to parenting classes?

Alan Sinclair: The only equivalent that we have are classes for driving cars and operating television controls. We do not do it for people.

The Convener: It is not a one-to-one thing.

Dr Sher: That is the point; we do not do it.

Richard Lyle: I have found this a very good discussion that has covered many points. My mother-in-law was Dutch and we went to Holland many times. I found it to be well in front of us on

many issues. I also found that the benefit levels were much higher than they are here.

I would say that day care up to three years old is provided first of all by parents, then local playgroups and then grandparents. My daughter recently had another baby, and my grandson was two last Friday. I put him to sleep by singing to him. He loves reading books, doing jigsaw puzzles and so on. I can see how he has developed even in the past couple of months. Sometimes, I feel that we think that kids should be brought along too quickly.

I want to talk about an issue that was raised in our discussion with the first panel but was not developed. We have a minimum wage and a living wage. When I was self-employed, I believed that, if I earned £10 an hour, I was making a decent amount of money. The minimum wage and the living wage are both under £300 a week. Yesterday, I dealt with a case involving a person who, because of certain issues, found that their housing benefit had fallen while their income went up and down like a yo-yo, which meant that they had fallen into housing arrears. We got the issue sorted out.

You see employers on the television saying, “Oh no, we can’t pay this wage.” However, if we raised wages to a decent level, people could afford to have someone stay at home. Many years ago, my wife stopped working so she could look after our kids. I have two great kids with two great jobs. I was able to do that because I was able to work and was never unemployed—I was lucky that way, although I was made redundant twice.

If we increased people’s wages so that they had a decent income, would that lift people out of poverty, or is that a simplistic approach?

Professor Frank: I think that Professor Marmot said this, but I will say it again. You have to do that, but it is not enough. There is a great new report from Harvard University, which you can get through the website of Graham Allen MP. It explains in plain language how a childhood in poverty changes the way that your brain functions, particularly with regard to your stress response, which can be turned on in such a way that you cannot turn it off. Childhood poverty starts prematurely a process of chronic disease development.

You have no choice. If you want a humane Scotland—the kind of Scotland that it seems that everyone in this room wants—you have to get rid of child poverty, or at least get it down to the levels that we heard Professor Marmot describe. However, you will still have to deal with elements of the culture, particularly those elements that influence the way in which some parents behave. You will also have to deal with the fact that not all communities are equally able to support parents and give them opportunities to do accessible things with their kids. You have to do that. We have to do that—I am not going anywhere; I am staying here.

We have to get rid of child poverty—we also have to get rid of pensioner poverty, which is a dreadful situation, although that is not what we are here to talk about—but we should not assume that doing so will fix the problem. The situation is similar to the situation regarding universal healthcare, which Canada also enjoys, although it has not done so for as long as the UK has. You have to have universal healthcare if you want a humane society, but it will not level the playing field of life entirely.

Alyson Leslie: I come back to the point that was raised earlier about the rules and regulations on child protection and the way that they affect how we react to children. My point picks up what Professor Frank said about the need, alongside initiatives to address financial inequalities in society, to consider how we ensure that children have positive experiences outside the home if they are not getting them in the home.

How awful it must be for a three-year-old to learn at their nursery or day care centre that, if they fall over, no one will comfort them but they will be sat down and someone will be sent for to come and put the bandage on their knee, give them a hug or change them because of all the rules and regulations on what is called child protection. I spend the vast majority of my professional life reviewing and investigating the cases in which things go terribly wrong and children die as a result of maltreatment. Because of the things that I have seen over the years, no one is more hawkish about child protection than I am but, to be frank, our society has gone completely bonkers in the culture and ethos that have grown up around child protection. It is ridiculous that people cannot hug or reach out to a child, particularly when the child is in distress.

We need to work with people who do the valuable job of caring for children—whether as extended family, in care settings or in day care nurseries—to change the message. One of the simplest things that we can do is to stop talking about child protection. Think of the analogy of data protection. As soon as we started talking about data protection, we lost the sense of what the legislation was about. It was actually about enabling us to share data in a way that was respectful of people’s privacy. The more that we talk about child protection, the more we create the sense that we have to take children and put them someplace safe, away from everyone. We should actually be about child nurturing. One of the

simple things that we can do is to change the language.

The Convener: We are coming to the close of this evidence-taking session. Committee members have pressures elsewhere and we have lots of good written evidence from all the witnesses. Does any of the committee members have a pressing question?

Rhoda Grant: Sorry, I tried to get in earlier. My question follows on from what Alyson Leslie said and concerns submissions that we have had about looked-after children.

We have talked generally about children's life chances but, when we take looked-after children alone, suddenly we see that their life chances are hugely different and very negative. What can we do differently about looked-after children that will change their life chances? It seems that the moment that that badge goes on them, their life chances are disastrously impacted.

Ben Farrugia: I wish that I had a nice, simple answer to that question but, of course, there is not one. The parliamentary inquiry into decision making on looked-after children that took place in 2013 opened up the wide complexity of the simple question, "What can we do?"

I echo some of what Jonathan Sher, Alan Sinclair and my fellow witnesses said. It is, of course, about the children and young people, but there is often a younger sibling on the way and we need to get systems in place to ensure that the life of that child, who will be born and grow up, will be improved.

We absolutely need better services. I am a big advocate of better services for looked-after children. We need targeted services and a wider sense of access to universal services to help to support them. To take health alone, I am conscious that some looked-after children have access to an LAC nurse and some do not. That is not even a matter of placement type but a matter of where they are in Scotland, which is perhaps a concern. Looked-after children themselves report that having an LAC nurse is a fantastic service; it is somebody whom they can trust. We have talked about attachment relationships; an LAC nurse provides an important attachment relationship as well as being someone who can support looked-after children with their health.

We can make such interventions, which would be good, but the question is whether we do enough with the families that we know will be having more children.

Dr Sher: I will give a specific response on looked-after children. We know that care leavers are disproportionately represented among early parents—many more care leavers have children very early relative to the figure for the population as a whole. We know that care leavers are also disproportionately represented among parents who will have children who will themselves become looked after. There is a non-genetic intergenerational problem.

One thing that we do not do, but which we could do, is to work more intensively with looked-after children or care leavers as prospective parents on the preconceptions and health issues that need to be dealt with so that they can make an informed and empowered choice about whether they want to become parents at all and, if so, when. The when should be contingent on what is true of them in their lives, so that they are ready to become good parents. Like everybody else, they want to have healthy, thriving and happy babies and they want to have a happy parenting relationship with those babies, but we do not do anything to prepare them for that. We keep dealing with care leavers as individuals rather than understanding that, in addition to their being individuals, they are parents and prospective parents. That is something that we could do now that would make an intergenerational difference.

Alan Sinclair: The New Orleans pilot in Glasgow, which was mentioned briefly earlier, is astoundingly interesting, because it simultaneously works with the birth family and the fostering family and with the child in both settings. There is simultaneous planning of whether the child will move to the foster family to be adopted or go back to the birth family, where intensive help and support is given for a period to see whether that can be a safe home. At the moment, we are constrained by the nature of law and healthcare. The decision making that goes on in those systems is not the kind of decision making that goes on in a child's life about attachment. The pilot, which is based on good work that has been done in the States, is trying to put that approach in place in Glasgow. I think that it is astounding.

The Convener: We have come to the end of the session. If people want to leave us with a thought—a "must do" or whatever—I will give you that opportunity now. This is a live process, so what we have heard and discussed today can be followed up by email. We are happy to receive additional information. Does anyone want to leave us with a final thought? I do not want to encourage you, but I see that Jonathan Sher is looking over at me.

Dr Sher: I have put my hands together, convener—you do not see me raising them.

The Convener: In that case, on behalf of the committee, I thank all our witnesses very much for coming along and giving us their time. We look forward to engaging with you in future on the

difficult and challenging issues that we have discussed.

Meeting closed at 12:58.

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