RCPCH response to the Scottish Parliament Health and Sport Committee Consultation on Health Inequalities – Early Years.

March 2014

Introduction

The Royal College of Paediatricians and Child Health (RCPCH) is pleased to contribute a response to the consultation exercise and welcomes a new phase of work on health inequalities in early years in Scotland.

From conception through to the early years, the majority of our blueprint is being set; therefore it is a key opportunity to give the next generation the best start in life. Early years, including both infancy (birth through to age 1 year) and toddlerhood (1 to 3 years), involve children undertaking a number of important developmental tasks relating to their physical development (e.g. establishing healthy patterns of eating and activity), social and emotional development (e.g. establishing a capacity for self-regulation via their attachment relationship to the primary caregiver) and language and cognitive development (e.g. early acquisition of both expressive and receptive language skills, and wider learning)[1].

Fair Society, Healthy Lives suggested that in order to reduce future social and health inequalities we need to give every child the best start in life, and this reflects the view that the origins of much adult disease lie in the 'developmental and biological disruptions occurring during the early years of life' and more specifically what has recently been referred to as 'the biological embedding of adversities during sensitive developmental periods. The early years are important in terms of building children's physical resilience. Optimal nutritional intake (e.g. in terms of iron and vitamin D) alongside the development of healthy eating and activity patterns have been identified as key to building resilience and protecting against later chronic diseases[2].

Developmental Origins of Health and Disease (DOHaD) highlights the importance of early years; demonstrating that interventions in early life have lifelong effects on health and wellbeing. A strong and flourishing society is one built on the foundation of healthy child development.

How effective are early years interventions in addressing health inequalities?

During pregnancy and the early years, particularly the first 5 years, the foetus, then infant and young child is undergoing rapid development. This therefore is a time full of windows of opportunity, many of which close for ever once they have passed. Hence pregnancy and the earliest years can be the **only** time for some effective interventions to take place. Also, interventions so early in life can influence a multitude of outcomes.

Over the last twenty years with an ever-increasing evidence base, breastfeeding has been recognised as a major contributor to public health which can play a key role in reducing health inequalities. Breastfeeding, protects children from a range of later problems including reducing the risk of ear (otitis media) and lung infections, asthma, obesity and diabetes, sudden infant death syndrome (SIDS), dermatitis, gastrointestinal disorders (coeliac and inflammatory bowel disease) and leukaemia, and may also have an impact on neurodevelopmental outcomes including intelligence [3, 4, 5].

Smoking is a recognised reproductive risk-factor, increasing the risk of adverse pregnancy outcomes such as low birth weight (LBW), babies being born prematurely and miscarriage [6]. Smoking prevalence is higher in areas of greater social deprivation and therefore investing in smoking cessation programmes in low socio-economic areas can potentially reduce health inequalities.

Shonkoff and Garner (2011) stress the importance of early years interventions in reducing health inequities with regard to brain development; highlighting that exposure to toxic stress in early childhood can not only alter brain architecture but can have potentially permanent effects on a range of important functions such as regulating stress physiology, learning new skills and developing the capacity to make healthy adaptions to future adversity [7, 8].

In summary, unless the nutritional, chemical, emotional and developmental environment is optimised in utero and the early years, an individual's potential in terms of health, development and well-being is compromised. To prevent that compromise, interventions should aim to optimise the environment, or at least to build resilience to any damaging impacts.

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

Optimising the environment for the child is impossible without tackling the stresses on the parent(s)/carer(s). Early years services are well placed to identify those stresses and advocate for them to be addressed, but early years policy in itself can't address them, and needs to be joined up with policy on support for families regarding housing and the built environment, employment, mental health and substance abuse, debt, relationships etc. Whilst services directed at the adult may lose track of their patient/client due to non-engagement, those services directed at the child have continuing responsibilities under the UN Convention on the Rights of the Child (UNCRC), and the Children Act (Scotland), and therefore have to continue supporting the parent/carer in finding/engaging with appropriate services, until their own needs have been addressed sufficiently to allow them to meet the needs of their child.

Whilst recognising that resources are constrained, it is important that resource allocation models adequately take into account the additional cost of delivering core services in a manner sufficiently flexible to be accessible and appropriate to all, including the most

needy. Assessment of a family affected by multiple stresses, including socioeconomic deprivation, disability or ill health affecting several family members, and/or not fluent in English, is time-consuming. Building trusting relationships demands that time investment, and a family's multiple stressors make it likely that a service will need to provide additional support, eg home visits, interpreters, additional or longer appointments, assistance with transport, etc. This is true of primary and secondary health services, and also of education and childcare provisions, and of social services and third sector support. Current national formulas for allocating resources according to socioeconomic deprivation are inadequate. This is very clear on the ground in terms of core services for these groups.
Formulae derived for adult services may not hold true for early years services.
Patients/clients differ by not being independent; hence universally requiring a more holistic assessment including parent/carer, and discharging a patient for failure to attend is rarely acceptable under child protection/UNCRC provisions.

Core datasets, monitoring and research need to be strengthened, or policies aren't translated into improvements at the coal face. Examples include:

- Healthy Start Programme (HSP). A recent audit of 150 children aged 5 or under attending A&E in Glasgow concluded that "the majority did not receive vitamins and the majority of carers are unaware of the Scottish Government recommendations. Cost does not appear to be a barrier. A minority of children entitled to the HSP are receiving vitamins due in large part to a lack of awareness of the programme.
- Uptake of nursery and childcare places. Another recent study, this time of preschool vision screening in Greater Glasgow and Clyde, identified an unexpectedly large proportion of parents/carers – and particularly those in the most deprived socioeconomic groups - not having taken up nursery provision. Clinicians are aware of some very needy children not having nursery places.

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

Paediatricians take on a special dual-role of agent as the doctor is both the agent for the patient and for the parent or carer who has prime responsibility for the child. The doctor is thus an advocate for the child and in child protection issues is fully aware that 'interests of the child are paramount'. Paediatricians should be well-equipped not only to recognise problems that indicate child poverty and health inequalities, but also to intervene and treat these problems as early as possible to prevent long-term consequences to health.

It is clear, then, that paediatricians have three general roles in reducing health inequalities: in improving their own awareness of the issue, in working to create public awareness and knowledgeable patients in regards to health inequalities, and in promoting changes within both the health profession and the government; many actions are overarching and fall within more than one of these categories. All of these actions will contribute to decreasing the number of premature deaths as well as providing economic benefits in terms of saved health care costs.

Most importantly, tackling these inequalities will help to give children the best possible start in life and the ability to maximise their capabilities.

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

Governments and organisation fail to recognise the long term benefits to society when they fail to invest in early years. Services face significant funding problems as stakeholders require a return on their investment; however cost-effective interventions which have a lasting impact on children's health and wellbeing only provide significant evidence over a long duration.

Public policy has previously favoured tackling social problems much too late, where interventions are more expensive and of limited success. Early year services aim to deal with issues before they can escalate and intensify. The accentuation principle suggests that if a child has one or two adverse episodes, the risk of having more of them is increased.

Currently, we see different parts of the public sector protecting individual funds which serve only short term priorities. Tackling the root causes of health inequalities requires a cross-government long term investment to be effective and sustainable.

Are there any specific initiatives or research evidence from Scotland, UK or internationally that you would wish to highlight to the Health and Sport Committee?

- The Responsive Interdisciplinary Child-Community Health Education and Research (RICHER) social paediatrics model, developed in Vancouver is an inter-sectoral and interdisciplinary community outreach primary health care model. Partnering with community based organizations, they seek to identify gaps in the continuum of health services delivery for 'at risk' children and their families. RICHER aims to enhance traditional clinical practice approaches by partnering with community organizations to increase access to health care for children and families, specifically families with multiple forms of disadvantage [9, 10].

- Australian Early Development Index (AEDI) is a population measure of children's development, providing evidence to inform the work of policymakers in shaping and environment that fosters children's optimal development[11]

- Vitamin D deficiency was a major child public health problem in Birmingham, Moy (2012) concludes a significant reduction in case incidents was seen following universal Vitamin D supplementation to all children under 5 years of age, including pregnant and breastfeeding women[12]. In addition to this, a report published in 2011 also demonstrated an increasing trend of profound Vitamin D deficiency in children in Glasgow, concluding that there may be a case for vitamin D

supplementation of all children in Scotland, however eradicating profound Vitamin D deficiency must be of first priority [13].

- The Understanding Glasgow - Children's Indicators provides information and resources on a range of important issues concerning Glasgow's health and wellbeing; including breastfeeding, childhood obesity, infant mortality, mental health and smoking during pregnancy. Trends are monitored, allowing comparisons both within the city and with other cities[14].

About the RCPCH

The College is a UK organisation which comprises over 15,000 members who live in the UK, Ireland and abroad and plays a major role in postgraduate medical education, as well as professional standards.

The College's responsibilities include:

- setting syllabuses for postgraduate training in paediatrics
- overseeing postgraduate training in paediatrics
- running postgraduate examinations in paediatrics
- organising courses and conferences on paediatrics
- issuing guidance on paediatrics
- conducting research on paediatrics

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