

## Health Inequalities – Early Years

### Royal College of Paediatricians and Child Health

#### 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].

**Dr Peter Fowlie**

**Royal College of Paediatricians and Child Health for Scotland**

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**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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# DEEP END SUMMARY 23

## The contribution of general practice to improving the health of vulnerable children and families

***This report summarises the views of General Practitioners at the Deep End in addressing the needs of vulnerable children and families, as part of efforts to invest in the early years, improve health and prevent inequalities. It draws on previous Deep End reports, the research literature, the Deep End Response to the Health and Sport Committee's consultation on health inequalities and the early years and proposals for integrated care for the population served by Govan Health Centre.***

- Inequality and poverty in early childhood have long term consequences that affect the entire life course.
- Interventions in early childhood provide the foundations of good health and reduce the scale of disease and premature death in later life.
- GPs at the Deep End recognise the magnitude of the challenges in addressing inequalities in early years and have outlined the intrinsic strengths of general practice in contributing to this challenge.
- General practices' contacts with the wider family, in good times and bad, allied to continuity, flexibility, cumulative knowledge and trust, provides an important resource and basis for sustained preventive efforts, linking with other services and community resources.
- Current policies such as GIRFEC (Getting It Right For Every Child) make virtually no reference to this important role of general practice teams.
- The key professional relationship between health visitors and GPs is undermined by the disproportionate numbers of vulnerable children on health visitor caseloads in very deprived areas, and the gaps that arise as a result of difficulties in health visitor recruitment.
- General practices can lead in developing strong local systems, based on multiple relationships between services, to contain and prevent problems without recourse to emergency services.
- This requires a fundamental policy shift that recognises the "Inverse Care Law" which continues to limit what practitioners in the front line are able to offer, in terms of a proportionate response to the needs of vulnerable families.
- The high political priority given to policies supporting the health of families with young children should be evaluated in terms of their impact on health inequalities in the early years and beyond.
- The Govan Integrated Care Project is a pragmatic approach to develop and evaluate a robust intervention to support vulnerable children and families at an early stage

"General Practitioners at the Deep End" work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.

### Deep End contacts

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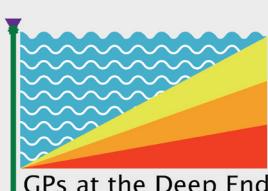
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Full report available at <http://www.gla.ac.uk/deepend>



This vignette, from *Deep End Report 20: What can NHS Scotland do to prevent and reduce health inequalities?* highlights the importance of the wider family as the context in which vulnerable children and families may need to be supported.

### **Preventing and reducing inequalities in health are complementary activities in general practice**

David is 14 months old. His 18 year old mum Sarah has had anxiety problems since her older brother hanged himself four years ago. She started college but left when she fell pregnant shortly afterwards. Sarah does not get on well with her mother, whom she accuses of drinking and “always shouting” since her brother died. Her mum says she is “mental” and “a teenage brat”. Sarah relies heavily on her own gran Margaret. Aged 50 she has moderately severe COPD (emphysema) and continues to smoke. Margaret has had several chest infections recently and is struggling to cope with Sarah’s often strange behaviour and with a lively toddler for whom she is the main care giver.

For David the next two years, as he learns to walk, talk and interact, will have a huge effect on the rest of his life. Early years interventions such as parenting classes may be important, but on their own will fail to change his life opportunities. He will need supportive neighbours, a good nursery and adequate family income, but also optimal COPD nurse reviews, responsive alcohol and mental health services, good communication with social work, persistent contraceptive advice and smoking cessation support, to name a few. At the hub of these lies the primary care team, offering unconditional care and the possibility of trusted relationships over the span of David’s life.