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# Family and Child – a Public Health Perspective

## – Invited Editorial –

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The year of 1994 is the UN Year of the Family, and one of the issues is child health and the family. This is a very important combination, not only this year, but always and in all settings. The children are our future and the family shapes is the texture of social relations in the society, and thus forms the prerequisite for the children's health and development.

In addressing the topic of child health and the family in this context I believe that a public health profile is important, not only because I work in a school of public health and my main activities in teaching and research are devoted to children's public health, but also because I believe it is a very fruitful approach that should be used more by professionals working for the improvement of children's conditions.

So what is then a public health approach? The first issue is health. Most professionals involved in caring for children's health problems have a clinical background and thereby a formal training that has concentrated on tracing, caring and alleviating diseases, disorders and deviations in children and young people. As a medical speciality that is called pediatrics and is a task that demands knowledge, skills, empathy and understanding of the individual child, his development and environment.

Children's health, however, is much broader and positive concept, addressing many more aspects of children's well-being than their medical care. Many attempts have been made to define health, and however, they differ there is a general agreement that it is a positive and multidimensional state; it is not only freedom from disease that is at stake. Most well-known and still most quoted is the definition of health given in the 1946 constitution of WHO: *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*. Although this definition has been heavily criticised, on the grounds that it is imprecise, utopian and impractical, it has undeniably made its impact on

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the debate on health. It should therefore be noted that it does stress the positive nature of health, and in its notion of well-being it expands the concept beyond physical health or fitness.

Today, many prefer a concept of health that is connected to the individual's situation and allows her to cope with the demands of life. Thereby, health is the ability to resist endurance of a physical, mental and social nature, so that they do not lead to reduced life span, function or well-being. These thoughts have been more poetically expressed by the Danish author and scientist Piet Hein[1]:

*"Health is not bought with a chemist's pills,*
*nor saved by the surgeon's knife.*
*Health is not only the absence of ills,*
*but the fight for the fullness of life".*

WHOs concept of health was to some extent clarified in 1977 when the World Health Assembly adopted the resolution known as *Health for All by the Year 2000*[2]. This stated as a central objective of member states' social policy goals a level of health to enable everyone to achieve a socially and economically productive life. Thus, health is a resource for everyday life, not the objective of living. The underlying philosophy or ideology of this goal is equity; equity within and between countries, and social justice in health. But the goal became more than ideology when it was developed into a strategy with 38 targets for Europe, accepted by all the member states. In 1991 the targets were updated and a new target on ethics was added[3]. They now represent a common European view of what could and should be done to achieve health for all. These targets place emphasis on promotion of healthier lifestyles and a healthy environment and on the reorientation of health care towards a broad concept of community based primary health care.

In the traditional education and training of health personnel, there is little to be found of topics that are important in this connection, i.e. community health, epidemiology, environmental health, health education, leadership, health economics. An educational programme with such a broad and comprehensive view must be built on a multi-disciplinary approach, based on social, humanistic, natural and of course medical sciences. And then we are in fact describing public health science, a multi-disciplinary area with special reference to the influence of social structure, environment and care system on the health of the population.

Or, as it is defined in Sir Donald Acheson's influential report on Public Health in England: *"Public health is the science and art of preventing disease, prolonging life and promoting health through organised efforts of society"*[4].

This report also introduced the concept of "the new public health" or as it was later designated "the renaissance of public health"[5]. "The old public health" was concentrating on the "sanitary idea" where health hazards were drained away, burned or buried. The limitations of that framework of thinking about public health have been increasingly exposed in the growth of ecological knowledge and awareness, a new consciousness of the finite resources of the planet and of each generation's responsibility for their stewardship, a realisation that man exists in nature not above or outside it. These are among the essential planks

in the "new public health" platform. "The new public health", thus, deals with maximising public involvement in health, and with making promotion of better health a responsibility of decision makers in all organisations in all sectors of the economy, manufacturing and services, public and private.

Action on these issues in order to enhance population health is referred to as the public health function. Naturally, this includes the whole population, but here are several major reasons why children's health and well-being is of special importance in public health[6]:

1. Children make up a substantial part of the country's population, in Europe generally around 20 per cent.
2. Children represent a vulnerable group in society, and its health and well-being thus reflect the will and ability of the society to care for its citizens.
3. Children have no political power and are not represented in formal or informal pressure groups able to influence health and related policies.
4. Adult knowledge, attitudes and behaviour in health matters are learned and cemented in the formative years of childhood and youth.
5. The United Nations have proposed special protection for children through their Convention of Rights of the Child, adopted in 1989.

WHO had already in its constitution identified "the basic importance" of the "healthy development of the child" and "the (child's) ability to live harmoniously in a changing total environment". The European Health for All Strategy made the explicit claim that what was at stake in the achievement of the targets was nothing less than the future of the children of Europe. A special and very strong emphasis in this strategy is put on the concept of health promotion.

Having said these things about the importance of seeing children's health and their care in a wide multi-professional and societal perspective, it is necessary to dwell on the most immediate and close network that makes the social and emotional support system for the child, and that is the family. Through all secular changes of societies, the family has kept its role as a central institution in human life, and, as an object of study, it has been of age-long interest to a large variety of disciplines. The size, the structure, the functions, the support of families have varied, but their existence have always shaped the texture of social relations in a society.

For Europe the family formation has followed a distinct pattern for at least two centuries up to 1940: a high proportion of the population never married, the first marriage occurred at a high age (late 20ies) and childbearing lasted over a long period. After the second world-war the European pattern changed into earlier marriage and earlier childbearing and is now again back to later marriages and childbearing. Societies have changed, as have the functions of families. Historically, having been the primary group for production, reproduction, and socialization, families now face a divergence of functions[7]:

- working life (production) has moved outside the family;
- socialization of children largely happens within institutions;
- the meaning of reproduction has changed – today sexuality and reproduction can be separated because of modern contraceptive methods;

- attitudes towards the creation of relationships between men an women have changed; issues of equity, economic independence, and the quality of the relationship have become more important.

Most of these changes started long before the rapid increase in divorce rates occurred, which makes it difficult to relate the causes and effects directly. The emotional contents are now most important and often the only fragile ties that hold the family together. The fragility of these emotional ties (bondings) is clearly shown by the increasing number of family breakdowns in Europe.

According to the 1982 *UN Demographic yearbook*[8], the annual number of individuals in Europe that officially are involved in a divorce amount to over 5.5 million people, out of which at least 2 million are children under the age of 18 (Table 1). Furthermore, there has been rapid increase in the number of divorces over the last decades, which has decelerated in the last few years (Fig. 1)[9]. Globally, the highest figures are found in the USA, while countries having strong religious traditions linked to the Catholic or Orthodox church tend to have the lowest figures. One curiosity is the rapid increase and then decrease in divorce rates in the mid 1970s in Sweden, which was caused simply by a change in legislation which made it easier to have a divorce. Similar changes have been seen in other countries for the same reason. Statistically, there is at least one child involved per official divorce.

**Table 1.** Population annually affected by divorces in Europe. (Source: UN Demographic Yearbook 1982)

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|---|---|---|
| Number of divorces in Europe | 1 833 500 | |
| Number of adults affected | | 3 667 000 |
| Number of children affected | | 2 016 850 |
| Total population affected | | 5 583 850 |

Since 1982 collective data to estimate the number of children in divorce has not been published.

The data presented in the figure only represent official statistics. Family formation patterns have changed as people also increasingly form ‘unofficial’ relationships (so-called consensual unions) which in some parts of the world, as in some of the Nordic countries, have become the dominating form of intimate couple formation (Fig. 2).

This figure describes two similar age cohorts (15–30 years) in 1968 and 1981. In 1968 40.3 per cent of the population had formed couples out of which only 0.3 per cent were not officially married. In 1981 the proportion living as couples was 40 per cent but only 17 per cent were in official marriages, which means that most couples were 'unofficial'. There are few reliable data about these relationships but they tend to last for a shorter period of time and produce fewer children. In 1980, 84 per cent of all newly formed couples in Sweden were consensual unions; this percentage increased to 88 per cent in 1985 and the number of children living with unmarried parents had simultaneously increased by 30 per

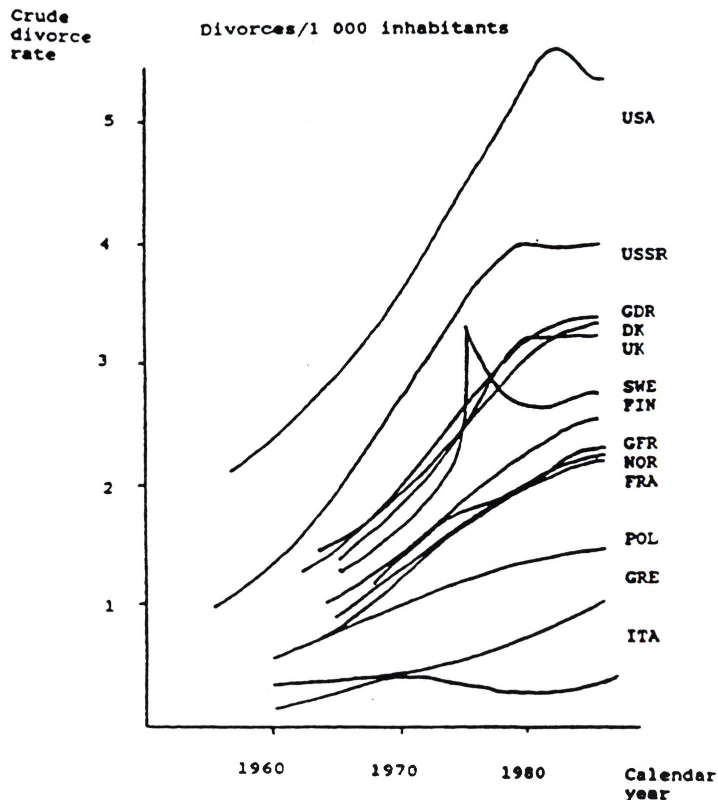


**Fig. 1.** Crude divorce rate in selected European countries and USA, 1955–1988. (Source: UN Demographic Yearbook 1955–1988)

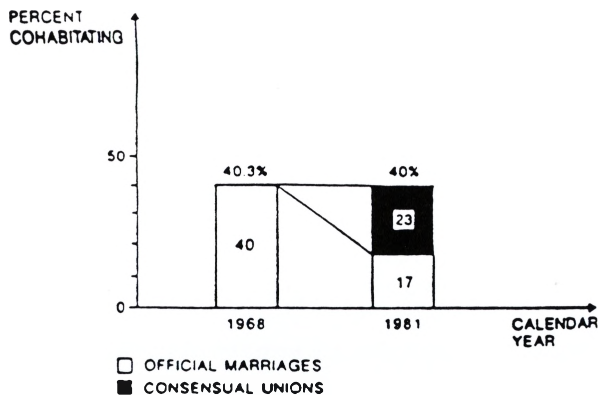


**Fig. 2.** Percentage of population in Sweden cohabiting and mode of cohabitation. Age group 15–30 years, calendar years 1968, 1981 (Source: Köhler et al 1986)[7]

cent although they comprised only 15 per cent of the total child population. The group of children that were most likely to face a family breakdown were under the age of three, had parents of low socio-economic class in consensual unions and who lived in small households in urban areas. These were also the children who were at the greatest risk of losing contact with non-custodial parents after family breakdown.

Thus, from available statistics in practically all Europe, it is easy to show that the family structure and especially the divorce rate, has changed radically during the last decades. Much more difficult, however, is to pin-point exactly the consequences of these changes for the individuals involved, children and adults. However, according to sociologists, anthropologists, historians, psychologists, and, lately, health scientists, the significance of the family lies in the creation of a *social and emotional support system for the individual*. There is, by now, abundant evidence of the connection between a tight personal network and the health of individuals. Especially evident is the association between the lack of family relations and increased morbidity and mortality, e.g. the consistent findings of lower death and disease rates for married people compared to single, widowed or divorced. As regards children, there is a general agreement that they need, for their growth and development, *love*, *security* and *recognition*. There are also many reports on what happens to the child if these basic needs are not satisfied, or if they are broken, e.g. by divorce: there are short-term effects as fear, anger, psychosomatic disorders, depression and guilt, and long-term effects as criminal behaviour, problem with sexual adaptation, low self-esteem and psycho pathological reactions.

For many reasons, however, we must be cautious when interpreting these results: There is a general lack of good population based studies, especially long-term follow-ups. Most studies are made in the USA, and, therefore, not automatically transferable to the cultural scenes of Europe. The phenomenon of divorce is becoming more frequent which will also change the impact for future generations. And, perhaps most important, family breakdown is only one outcome of totally changed human living conditions. Therefore, it should be observed that effects, attributed to divorces, could very well depend on other factors, inside and outside the family; on what the epidemiologists use to call confounding factors.

Nonetheless, there seems to be enough evidence to suggest that close social relationship is vital for the well-being of individuals in all societies, and that the family, so far and still, is the main provider of this support, both in material and emotional regard, and both in order to maintain health and to cure disease.

So then it is perhaps not surprising that the UN has decided to proclaim this year as the Year of the Family, with the intent to focus on the problems and possibilities of the family around the world. The motto is *"In the family the foundations are laid for a democratic society"*, and among the objectives the rights are the support of the families and their roles are underlined. This is very much in line with other UN initiatives, perhaps most obvious with the *Convention on the Rights of the Child*.

Contrary to many people's belief, initiatives like these do play an important role to direct interest and resources towards essential topics. In this case it also

stimulates a collaboration between professionals of various kinds and laymen, i.e. the families themselves.

For us in public health or child health initiatives like these make us see still clearer the importance of working together with our patients, clients, populations or whatever we call them.

During the last decade, a leading theme in public health as well as in HFA has been Health Promotion. It basically means the process of enabling people to increase control over, and to improve, their health. This process involves the population as a whole, not only the so-called risk populations, with their particular biological and behavioural characteristics or persistent exposure to unacceptable hazards to health, and is directed towards determinants and causes of health. Action to promote population health requires the close co-operation of many sectors in society, reflecting the diversity of conditions and factors which influence health. Not only legislation but also communication and education. Not only organization of services but also community development and spontaneous local activities against health hazards.

Basic to this new look at health, centred around protection, prevention and especially promotion, is the concept of "empowerment", the realization that health cannot be reached without the active involvement and actual responsibility of the people themselves. There is no such a thing as a total professional taking over of a responsibility, the patients or the clients should always be involved.

In these sentences it is not difficult to recognize the line of thinking that has gone into the whole public sector during the last decade or so, most obvious perhaps, with the health and social services: the professionals can advise but decisions on their lives should be taken by the individual.

There is a good illustration of the historical development of the official view on the role of professionals contra target groups to be seen in the overall objectives of the Child Health Services in Sweden, developing from a purely bureaucratic, professional statement from above, over a supportive and activating approach, coming close to a partnership in the last statement, which is however, not yet official (Fig. 3)[10].

The ideologies of Health for All, children's health and the importance of close social relationship merge in *social pediatrics*, or as we may call it *Child Public Health*, the tasks of which are to place the health of children and their families in their full social, economic and political context. In our times of superspecialisation and fragmentation of medical sciences and medical professions, so obvious in clinical pediatrics, Child Public Health is the counterbalance, with its intersectoral and multi-disciplinary approach to the fullness of health. Child Public Health thus implies a very broad concept, taking professionals away from the narrow experience of the specialised institutions into the community, making them aware of social context in which children live in order to better understand their health problems, and also the need to promote individual and social development towards democracy[11].

Thus, it is evident that the issues of concern for Child Public Health distinguish it clearly from the biomedical interests that dominate clinical pediatrics. Child Public Health is an open multi-professional field whose concerns relate

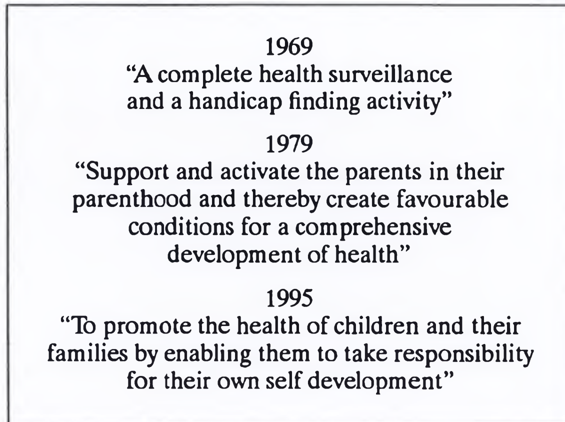


**Fig. 3.** Objectives of Child Health Services in Sweden.

to child *health*. Clinical pediatrics as a closed medical speciality has a no less necessary but equally very different orientation to child *morbidity*. Most pediatricians still identify themselves more easily with clinical pediatrics which is a well established and respected discipline in medicine rather than with the emergent and still fluid territory of child health. It is important for those working in Child Public Health, especially physicians, to accept that they will always be seen by fellow physicians as on the periphery of medicine. Public health workers must therefore see themselves quite clearly and unequivocally as in the centre of child health and to vigorously pursue their tasks in that spirit.

It is not an easy task but it is the one with most probable chances of succeeding in giving a full and comprehensive support to children and families when they most need it.

In this task we need the support of the families themselves, and we need the extra strength given to us by activities like the UN Year of the Family.

## References

1. Hein, P. (1988). *Prologue at the celebration of WHOs 40th anniversary*. WHO, Copenhagen
2. *World Health Organization. Target for health for all*. WHO, Copenhagen, 1985
3. *Targets for Health for All. The health policy for Europe*. WHO, Copenhagen, 1991
4. *Public health in England. The report of the Committee of Inquiry into the Future Development of Public Health Function*. HMSO, London, 1988.
5. Köhler, L. (1991). Public health renaissance and the role of Schools of Public Health. *European J. Public Health* **1**, 2–9
6. Köhler, L. and Jakobsson, G. (1991). *Children's Health in Sweden. An overview for the 1991 Public Health Report*. Swedish National Board of Health and Welfare, Stockholm
7. Köhler, L., Lindström, B., Barnard, K., and Itani, H. (1986). Health implications of family breakdown. *NHV-Report* 3. Nordic School of Public Health, Göteborg
8. *UN Demographic Yearbook* 1955–1988. UN, New York, 1990.

9. Lindström, B. and Köhler, L. (1994). Children and families in distress: the case of family breakdown. In: Lindström, B. and Spencer, N. (eds.) *Social Pediatrics*. Oxford University Press, Oxford
10. Köhler, L. (1993). Systems of health care for women, children and youth in Sweden. In: Wallace, H. M. (ed.) *Maternal and child health practices*. Third Party Publishing Company, Oakland
11. Köhler, L. (1994). Health for all children – a socio-pediatric issue. *Acta Paediatr Scand* Suppl. **394**, 3–6