Chapter 17

National and Public Cultures as Determinants of Health Policy and Production

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Abstract

The Models of Child Health Appraised (MOCHA) project recognises that child health policy is determined to a great extent by national culture; thus, exploring and understanding the cultural influences on national policies are essential to fully appraise the models of primary care. Cultures are created by the population who adopt national rituals, beliefs and code systems and are unique to each country. To understand the effects of culture on public policy, and the resulting primary care services, we explored the socio-cultural background of four components of policy-making: content, actors, contexts and processes. Responses from the MOCHA Country Agents about recent key national concerns and debates about child health and policy were analysed to identify the key factors as determinants of policy. These included awareness, contextual change, freedom, history, lifestyle, religion, societal activation and tolerance. To understand the influence of these factors on policy, we identified important internal and external structural determinants, which we grouped into those identified within the structure of health care policy (internal), and those which are only indirectly correlated with the policy environment (external). An important child-focused cultural determinant of policy is the national attitude to child abuse. We focused on the role of primary care in preventing and identifying abuse of children and young people, and treating its consequences, which can last a lifetime.

Keywords: Health policy; population; culture; transferability; child health; values; child abuse

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Introduction

Child health policy is influenced and determined to a great extent by national culture. In order to fully understand and appraise models of child primary care, it is essential to explore the cultural influences upon the policies and actions that create the individual systems.

Culture is not abstract, but is created by individuals and organisations, who use material, organisational and political resources to develop their own systems of cultural codes which are made into rituals and passed on to others (Turner, 2012). The specificity and separateness of culture do not depend on the multiplicity and originality of elements but rather on the relationships between them (Dyczewski, 1993). Culture is characterised by a range of interacting influences: (1) it has individual character, as we create and are influenced by culture; (2) it has social character as it is created by interpersonal communication; (3) it simultaneously connects some people together, and separates others; and (4) it is dynamic and can evolve in some conditions and lessen in others (Dyczewski 1993, cited in Majchrowska, 2002). Culture remains in a relationship of interdependence with the social system therefore changes in one system entail changes in the other (Dyczewski, 1993).

To understand the effects of culture on public policy and on primary care services, we explored the socio-cultural background of four components of policy-making, namely, content, actors, contexts and processes (Buse, Mays, & Walt, 2005; Walt & Gilson, 1994). This work also formed an important background in the development of the Models of Child Health Appraised (MOCHA) conceptual child-centric framework (see Chapter 4). To investigate how culture influences child health policy, we interrogated the European Values Study (EVS) (2015a), alongside a MOCHA survey on child health-specific influences on policy. Finally, we look at how the primary care systems interact specifically with the very important topic of child abuse and neglect.

European Values Study

The most significant element of culture is values. They are the baseline for its existence and development (Dyczewski, 1993). The worldwide socio-cultural transformations across various aspects of life affect the system of values in terms of both declarations and actions (Bogusz, 2004). Therefore, our theoretical preposition is that the process of multi-level contextual changes over time, causes the shifts in normative systems (see Chapter 4), and influences attitudes towards child and childhood, child health and child health care and policy.

The European Values Study (EVS) is an international survey of the values held by a sample of Europeans and aids our understanding of the opinions of Europeans about such matters as family life, social issues and beliefs. In the MOCHA project, we looked at the EVS from the perspective of a value-based approach. Although it is a survey of adult attitudes, EVS contains several issues that are pertinent to children and also relevant to child health services and policy, such as family and marriage, a topic which contains questions about what

constitutes a successful marriage, attitude towards child care, marriage, children and traditional family structures. The EVS (2015b) survey is conducted every 10 years, and the next results will be available in 2019; currently, the latest data are from 2008. Nevertheless, despite their age, there is likely to be an influence on policy from these values in the past nine years.

In most European countries, the family and children are extensively valued with between 95% and 100% of Europeans declaring that family is either very or quite important in their lives (EVS, 2011e) and 80% of the respondents in most countries (73% in Denmark) stating that children are very or rather important for a successful marriage (EVS, 2011a).

Generally, Europeans do not consider having a child as their societal duty. The majority of those surveyed in Bulgaria (71%) believe this to be the case; but elsewhere, the agreement with this statement varies from above 40% in Malta, Cyprus and Portugal and Czech Republic to 10% or less in the UK, Finland, the Netherlands and Sweden (EVS, 2011b)

The belief that a woman needs a child to be fulfilled increases in rates, the further south in Europe that the survey is conducted. The difference is noticeable in countries such as Great Britain, Ireland, Norway, Sweden and Finland where the indicators do not exceed 20%, compared to continental Europe, where most of the countries, except the Netherlands and Belgium, report quite positive attitudes towards this statement. (EVS, 2011c)

The percentage of people that agree or agree strongly with the statement that 'a job is alright but what most women really want is a home and children' is lower in northern Europe and the Scandinavian region and higher in the southern and eastern regions, ranging from 83% of Romanians to 11% of Danes (EVS, 2011d).

The EVS demonstrates that not only are children an important feature in people's lives and values, but that children are no longer an inevitability, but for most people a considered choice and as such, they are placed at a high value in many families. As the EVS states:

> Children requir[e] and deserv[e] high investments and intense emotional involvement from their parents. Where the father used to be the centre of the family, home has slowly transformed into a child-centred haven. (EVS, 2015a)

This is, in part, some explanation as to why issues involving children's health and well-being can be very potent influences on public attitudes and consequently child health policy.

Public Opinion and Drivers

The MOCHA project investigated the extent to which societal views on the content and quality of children's health care, influence how policy-makers respond.

To achieve this, we used a hybrid approach, which linked the constructionist data-driven inductive perspective (Charmaz, 2006), with the elements of deductive coding which was based on the classification of contextual determinants by Leichter (1979). In our study, the constructionist constant comparative method was supported by elements of deductive thematic analysis.

The MOCHA Country Agents (CAs) (Chapter 1) were asked to identify the three strongest public and professional discussions related to child health services in their countries in the past five years (2011–2016). As these are strongly embedded within national context and influenced by various external factors, we used the results to analyse the contextual determinants of subsequent child health policies in Europe.

Semi-structured questionnaires were developed in accordance with the following criteria designed by the researchers: identification of the object and area of public concern, characteristics of the broader context of the case and identification of the level of discussion, the characteristic of the vehicles of public expression and the outcomes of the case.

The research stages have been described in full in Blair, Rigby, and Alexander (2017), Zdunek, Schröder-Bäck, Blair, and Rigby (2017), but in summary, they were as follows:

- Data was collected from the MOCHA CAs (see Chapter 1).
- The data were reviewed by a MOCHA researcher and then incorporated into a qualitative analysis software programme (NVivo 11).
- The data were then coded, by analysing the phrases used to transform the text into codes.
- The data were then categorised in terms of their significance, common themes were extracted, and patterns were identified. This allowed us to define the properties of the extracted themes and analysis of the data.

The analytical phase of the work was based on the adapted classification of contextual determinants, as proposed by Leichter (1979), of four categories: cultural, structural, situational and international factors. We adapted them to our survey as socio-cultural, structural (external and internal), situational and international factors. Seventy-one cases resulted from the MOCHA exercise, the analysis of which revealed the contextual determinants. We grouped the inductively identified codes into categories, which were subsequently assigned into four groups, reflecting Leichter's determinants. A number of sub-elements which influence child health policy were further identified.

Socio-cultural Factors

Socio-cultural factors constitute everyday choices, behaviours and attitudes that affect the way the things are done. We identified several elements which affected child health policy in European countries. The CAs gave detailed examples of national issues, which are described in full in Zdunek et al. (2017). Although there was a huge range of national debates, many started by a single

incident or awareness of a perceived injustice; it was possible to classify the socio-cultural factors that influenced subsequent policy developments into eight categories.

(1) Awareness: This includes individuals or institutions raising awareness of a problem, or awareness of its impact; it also involves information and misinformation.
(2) Contextual change: This can manifest as shifts in the proximal and/or distal child environment. It might be a phenomenon at the macro or micro level.
(3) Freedom: Discussion about the rights of the child and the family to medical treatment or provision.
(4) History: Tradition is usually strongly embedded in a country's culture; thus, history was extracted as a separate category from the data of the case studies. The impact of the past policies and solutions, as well as inherited traditions, may help or hinder an issue.
(5) Lifestyle: Digital media and its use in schools is a component of modern lifestyle interpreted as a set of behaviours which directly or indirectly may positively or negatively affect child health status. Lifestyle is also the component which should be taken into consideration while defining child health policy priorities.
(6) Religion: Attitudes and religious beliefs affect national debates as well as individual lifestyle choices.
(7) Societal activation: The level of societal activation in the country determines what is initiated within child health policy as well as care and often is driven by public sensitivity for child-related issues. Activation can be twofold: either in terms of public involvement in the policy modifications or as a lack of involvement.
(8) Tolerance: Among the issues analysed and discussed in Europe, we observed that they reflected contemporary socio-cultural dilemmas. Migration and the changes to the traditional family pattern brought about the emergence of discourse in terms of tolerance.

What was interesting in our analysis was the similar nature of many of the discussions that emerged in the different countries that were surveyed. Many debates could also be classified under different headings to the ones that were given; it was only subtle differences that differentiated them from each other. Vaccination was a common source of debate, lifestyle factors and fears about changes in lifestyle that lead to sedentary behaviour, childhood obesity and the influence of the digital revolution, including artificial intelligence are seen in many countries. Religion influences debates about changes in society, for example in Malta, changes in the influence of religion have been discussed as a possible contributor to the rise in single-parent families and subsequent child poverty. The full list of characteristics is described in Blair et al. (2017).

Structural Determinants

Among the many determinants of child health care and policy, we identified some as structural in character, meaning that it is proximal and distal elements of the child health care system itself that influence the way services are provided. In particular, the relationships of primary care services with other models of care are crucial (see Chapters 10 and 15). We divided the structural determinants into two groups and defined them as internal and external determinants. The internal determinants are those identified within the structure of health care and policy, whereas the external determinants relate to the elements indirectly correlated with health care and policy.

Internal Structural Determinants

Our data identified interdependent processes such as access to care and provision of care, which are often very closely related to access issues. Other internal structural determinants of policy change or for demand for change include the issues of organisational culture, workforce and organisational functionality of the system. The examples of internal structural determinants that were subject to debate and policy change, as a result of contextual and societal action, are described in full in Blair et al. (2017) and Zdunek et al. (2017).

- Access to care: This includes the provision of services that allow access, particularly in rural or remote regions of Europe; protests at the cessation or centralisation of services which means fewer local services; access to specific forms of care, such as mental health care available locally. National debates emerged between the need for quality as a justification for centralisation of services; and the need for locally accessible services.
- Provision of care: These issues closely interrelate to access issues and continue debates about centralisation of care, for example paediatric services only available in large national hospitals, and the restructuring of eligibility criteria to access services for free.
- Workforce: Issues identified here include proposed changes in medical training to work with children in primary care, the ageing of the primary care medical workforce, workforce shortages which were correlated with adverse events and outcomes for child patients and a lack of interest in the medical or nursing professions among young people.
- Organisational issues: Identified here were exposures of a lack of procedures in emergencies, poor capacity of the health system to deal with emergency situations, inefficiency in the health care system, out-dated methods of caring for children and lack of capacity for long-term care of children in need of child protection or needing complex care.

External Structural Determinants

Child health policy is not created in isolation. When discussing determinants, it is essential to take into account factors which directly and indirectly affect the way health policy is formulated or provided. These external factors may

influence the hierarchy of priorities and the position of child health among other values. External structural determinants are interpreted as factors on a macro-level which influence the way problems are solved and issues are negotiated in child health care. Our data reveal a strong influence of politics, policy, the economy and finance. Many of these determinants are closely connected, for example, the level of political awareness is expressed by the initiatives undertaken at the policy level. This is expressed, among others, by the implementation of legal solutions.

- Politics: Many child health policies were formed or discussed as a result of pre-election promises – about, for example, changes to medical training or to combat public health issues such as childhood obesity. Other politically-sensitive topics included the treatment of migrant and asylum-seeking populations, particularly that of unaccompanied child migrants. A lack of political awareness or action about issues such as the rights of disabled children to equal access to health and other services was also subject to national debate.
- Policy: National debates around issues such as exposure of children to passive smoking, childhood obesity and the rights of disabled children were reflected in policy decisions, such as amendments to national law or changes in public health policy. In some cases, policy decisions prompted protests, such as those supporting disabled children who, it was felt, were disadvantaged due to recent policy changes, or the further marginalisation of families already at risk of poverty or social exclusion as a consequence of policy decisions that limit services or access to services.
- Economy: A major influence on public action and child health policy decisions was the economic downturn in Europe and subsequent austerity measures that were adopted by a number of countries. These were seen to increase hardship for populations already experiencing social problems or poverty. Public service cuts were seen to directly increase child poverty, child mental health issues, education and family security. Homelessness was seen as a particular concern. Cuts to services were also seen to affect the quality and workforce of health services, which in turn affected access and child health outcomes.

International Determinants

Membership of regional and global organisations facilitates information exchange and also obligates a country to respect shared values and adapt to commonly agreed rules. Globally published evidence may not always be available nationally and illuminates the existence of a problem. International comparison drives discussions that aim to solve the problem. The MOCHA project identified three categories of international determinants from our data. These are as follows:

- Global evidence: Global reports and comparison studies were cited by many countries as an important source of information that provoked or supported

national discussions about an issue. Many cited sources of such evidence in Europe were the Health Behaviour in School-Aged Children (HBSC) Study (2018), the World Health Organization (WHO) (2018) and the Organisation for Economic Co-operation and Development (OECD) (2018). Other less authoritative global evidence was also used, as can be seen in the countries where there was considerable debate about vaccine safety, despite using questionable research as sources.

- Cross-nationality: The surge in global and national reports is correlated with the cross-nationality of many child health policy and care issues. The issues of obesity, vaccination, child abuse or care for migrant children are not contained within the border of one country but connected to global changes of lifestyle, increased awareness of personal health due to ease of communication and increased awareness of children's rights. This has been linked to issues such as the institutionalisation of child care and shifts in European normative systems. Often, such cross-national comparison has resulted in exchange of views, ideas and learning from experiences of other countries. Examples of such cross-national debates are the proposed changes in medical education in the Czech Republic, international evidence to support changes in laws on tobacco smoking in Latvia and the outcry at discrimination against disabled children in Croatia, which contravened children's rights as set out by the United Nations.
- Global processes and movements: Global influences affect many national discussions. One of the most influential was the global economic crisis, which influenced the functioning of child health care and policy in most European countries. Spain, Portugal, Greece, Malta and Ireland, in particular, struggled with child poverty and homelessness. The global humanitarian crisis and the plight of unaccompanied asylum-seekers were items of discussion in the UK and Finland. The combination of migrant status in countries affected by the economic crisis was particularly potent, because these families were already vulnerable to poverty and hardship. Globalisation also contributed to diagnosis and treatment decisions in primary care and health services in general, in particular, medication. Specific examples of these global movements becoming issues debated within a country and leading to policy change include that of the effect of increasing digital media on children's mental health in Germany, and the use of medication in high numbers of children with ADHD in Iceland, leading to claims of over-medicalising normal behaviour.

Situational Aspects

The particular situations which contributed to the intensification of the debate were correlated with the socio-cultural, systemic and international factors mentioned above. The scope of those is reflected by behavioural episodes, procedural and institutional episodes and the global situation. Examples of such phenomena have been classified into three categories:

(1) Behavioural episodes: Situations identified as key national discussions ranged from the exposure of historical child sexual abuse by schools or other institutions in a country and health system actions as a result of current child abuse claims, to discussions about the safety of vaccinations, vaccination hesitancy and the ability of the health service to effectively refute poor research evidence. Related to these situations is a lack of trust in governmental decisions and evidence.
(2) Procedural and institutional events: These included changes in the law such as the recognition of same-sex marriages in certain countries which gave rise to discussions about emergency contraception and the content of sex education curricula. Other such events included the introduction or cessation of compulsory vaccination before certain benefits or rights to state education could be accessed (see also Chapter 16); governmental dysfunctionality or potential corruption that compromises safety for the population, economic decisions that increase child poverty and decisions that were publicly understood to have an effect on children's health – such as the cessation of physical activity in schools and a rise in childhood obesity levels.
(3) Global situation: The main global issues that influenced Europe in recent years were the wave of migrants entering Europe and the economic crisis. Other global issues that were of concern among European nations were the growth in childhood obesity and the pro/anti vaccination movements.

Full descriptions of these events have been reported previously in Zdunek et al. (2017).

Attitudes to Abuse from the Perspective of Contextual Determinants

MOCHA did not specifically address the issue of child abuse as part of its remit, but in the process of research into children's use of primary care and into the services primary care provides for children in the European Union and European Economic Area, the issue of child protection, maltreatment and safety are essential topics that warrant discussion, particularly in the light of the contextual determinants identified by the MOCHA project. Primary child health care has an important role to play in the prevention and identification of child abuse at both an individual and a population levels. This involves identifying abuse, helping to prevent abuse and treating the consequences of abuse (which can continue for a lifetime). The training of the primary care workforce to recognise, and as importantly, to report and deal with cases of abuse is vital, and one which the lack of child focus in training curricula suggests that might not be optimal (see Chapter 13). Existing research seems to suggest that although primary care services are able to identify potential abuse, it is the subsequent effective collaborative working to report and act on suspicion that is lacking (Cossar, Brandon, & Jordan, 2011; Rees et al., 2010; Richardson-Foster, Stanley, Miller, & Thomson, 2012; Stanley, Miller, & Richardson Foster, 2012).

School and adolescent health services are particularly important in this respect, because most children of all socio-economic classes and almost all social groups will attend school. School nurses and teachers often work together to help identify families at risk and may be the first point of contact for children in need. School is also an important venue for protection interventions, as stated by Sethi et al. (2018). They are an ideal setting where children can be empowered and learn to avoid and report instances of abuse (including the various forms of bullying), without increasing stigma. The WHO report, however, found that less than half the countries in the WHO European region provide primary school programmes about recognition of abuse and harm and how to disclose worries to trusted adults. In MOCHA, mental health (with the exception of Greece, Malta and Poland) and behavioural problems (with the exception of Denmark, Greece, Hungary, Lithuania, Norway and Portugal) are also main priority needs of pupils. Coping with stress, anxiety and learning disorders, bullying, depression, social and emotional learning and self-esteem are all mentioned as examples of mental health topics for pupils covered by SHS. In terms of behavioural problems, the main topic is aggression and abuse.

As part of the national and public cultural context of policy, an extremely potent element in the subject of abuse is the *societal attitudes* towards it. For instance, a recent report by the WHO Regional Office for Europe has reiterated the need for a reduction in corporal punishment:

> Societal attitudes need to be shifted to discourage the use of violent discipline and reinforce the benefits of nonviolent approaches. Universal campaigns can positively shift population attitudes away from physical punishment and other risk factors for child maltreatment. (Sethi et al., 2018)

Awareness of child abuse, and the stimulation of national debates about child protection issues, including what constitutes abuse, and what actions are best for prevention and treatment has featured in the MOCHA project. In our research into contextual determinants, we found that issues involving vulnerable children or that compromise the safety of children are particularly emotive and provoke intense discussion. Certain situation-specific 'trigger' events were identified in our research that prompted changes or calls for changes in national primary care systems. For example, reports of child abuse in boarding schools in Iceland; and reports of abuse that occurred in a nursery school in the Czech Republic. These trigger events are analysed further in Zdunek et al. (2017).

Awareness is also raised by increased visibility of the issues as a result of the use and publication of results of international standardized survey tools such as the Health Behaviour of School Children (HBSC) involving 11-, 13- and 15-year-olds. It was this survey that highlighted the issue of the extent of bullying in schools (described above) for Latvian policy-makers when compared to other countries (Zdunek et al., 2017). This underlines the need for informative and

robust data, as well as highlighting some of the difficulties in collecting data about children (see Chapter 7).

A greater awareness of the risk factors for child abuse has led to the sensitisation of national and public cultures to the issue. The risk to children's health by living with certain risk factors has been identified in the MOCHA project, migrant children, children in the care system (see Chapter 5) and children with disability (see Chapter 15). In addition, public recognition of risk factors and potential adverse consequences of this has also been identified in the project. Examples of this include the advocacy work carried out by NGOs, health and social protection groups in Spain, on behalf of children who were subject to increasing levels of poverty and unemployment. The Centre for Legal Resources in Romania, suspecting child abuse, compiled a list of issues in relation to possible inappropriate medication use in residential facilities for vulnerable disabled children, and the police investigative procedures uncovered widespread sexual abuse among missing children in Northern Ireland (the UK) (Zdunek et al., 2017).

In MOCHA's investigation into the interface between primary health and social care, we found that the legal framework for protection varies immensely between countries. All countries report the presence of a child protection framework; the Fundamental Rights Agency reports that a main law for child protection is present in only 18 EU countries. A specific legal framework for protection of children with disabilities is present in 15 of 26 (58%) of countries with further variation for federal countries such as Spain or Austria (Kielthy, Warters, Brenner, & McHugh, 2017) (Chapter 15). In MOCHA's investigation into the care of children with complex needs, the system's ability to coordinate the work of several agencies to the benefit of a vulnerable child and family was described. At the service level, the degrees of collaborative and integrated work between agencies also vary with half of responding countries having a specific care coordinator. The presence of such a system certainly is known to reduce stress of families and also may lessen the emotional environment in a household that may lead to maltreatment or abuse.

Migrant children and those in the care system are especially vulnerable and MOCHA has demonstrated a wide variation in legal entitlement to primary child health care as well as discover some innovative service models which place the child as the centre of a holistic multiagency collaborative endeavour in the best case scenario where the service follows the child – an important aspect especially for highly mobile populations likely to fall through the service safety nets (Hjern & Østergaard, 2016; Chapter 5).

Summary

The importance of context in the process of child health care and policy-making is more significant than ever. The changes within the last two decades, such as proliferation of actors, reconfiguration of their power and the new context of health, has provoked the shift from health governance to governance for health.

It also sheds new light on the factors which influence the style of child health care and policy-making. The determinants characterised in this chapter, including attitudes to abuse, play a regulatory function towards child health care and policy. They affect public activity which often is the reaction to public discontent. The reactions of society to events, and subsequent policy changes results in the implementation and/or introduction of new procedures, action plans and guidelines. This has then influenced the level of awareness, intensified the scrutiny, increased the access and availability of services, provoked the introduction of structural changes or withdrawn unfavourable changes.

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