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Introduction to "Diversity of Child Health Care in Europe: A Study of the European Paediatric Association/Union of National European Paediatric Societies and Associations"

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The field of pediatrics in Europe is characterized by the diversities, variations, and heterogeneities of child health care services provided in 53 European countries with more than 200 million children below 18 years of age. Managing the health care of infants, children, and adolescents in Europe requires balancing clinical aims, research findings, and socioeconomic goals within a typical environment characterized by cultural and economic complexity and large disparity in availability, affordability, and accessibility of pediatric care. Since its foundation in 1976, the European Paediatric Association-Union of National European Paediatric Societies and Associations has worked to improve both medical care of all children and cooperation of their caretakers in Europe. Such a report has been conceived in the strong belief that broadening of the intellectual basis of the European Paediatric Association-Union of National European Paediatric Societies and Associations and creating a multidisciplinary society will be necessary to reduce fragmentation of pediatrics and tackle the legal, economic, and organizational challenges of child health care in Europe. *(J Pediatr 2016;177S:S1-10)*.

Comparing and evaluating the child health care systems of different European countries is a bit like studying travel guides when planning vacations in Europe. Both will provide information on geography, history, demography, economy, technology, and most importantly, the behavior and culture of other people and nations. Identifying and interpreting differences in the infrastructure of countries and the variations in processes affecting lifestyles may lead to inspiration and irritation at the same time. Unbalanced intercultural comparisons and reviews may create stereotypes and prejudices, which have substantially contributed to past political crises in European history. Diversity means understanding that each individual or nation is unique and recognizing this individual or national difference. These variations can manifest themselves in the dimensions of mentality, ethnicity, sex, culture, socioeconomic status, religious beliefs, political beliefs, and medical care. The medical field of pediatrics is characterized by the diversities, variations, and heterogeneities of child health care services provided in 53 European countries with more than 200 million children below 18 years of age.

The European Paediatric Association (EPA)-Union of National European Paediatric Societies and Associations (UNEPSA) embraces the strategy of building bridges between and among medical and nonmedical experts.[1] The aim of EPA is to educate without being limited by boundaries, across country borders, while respecting national idiosyncrasies. EPA strives to expand activities on planning, performing, and publishing studies on child health care services in Europe. A publication of surveys alone should not be the end result of EPA projects. Implementing theory into practice in all European countries will instead be the main ambitious aim. These EPA projects endeavor to attract all those experts in the field of child health care who would like to work with EPA to improve child health by putting children and young people into the center of all their activities. This supplement on the diversity of child health care services in Europe will deal with many aspects of the heterogeneity of child health care systems in 22 representative European countries.

Four key elements characterize the essence of child health care and the clinical and scientific interchange among pediatricians: knowledge, technology, caring, and values. Although the nature, quality, and mix of the above 4 indicators can vary widely within different circumstances, each of them is usually present in medicine and includes a variety of single subgroups.

The beginning of this introduction deals with values, the most neglected of the 4 elements. In the field of general health care, the enormous benefit of successful communication between professionals, patients, and physicians is well documented. Because there are different types of communication, medical universities have, therefore, started to integrate varying amounts of professional communication training in their curricula. Effective physician-to-child communication is a necessary prerequisite for comprehensive pediatric care.[2,3] Communication between pediatricians

EPA	European Paediatric Association
EURYPA	European Young Paediatricians Association
GP	General practitioner
SPA	Strategic Pediatric Alliance
UNEPSA	Union of National European Paediatric Societies and Associations

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and children and young people, however, differs fundamentally from communication between general practitioners (GPs) and adults, thus making a specific child communication training an indispensable requirement. Communication between care givers is an equally demanding challenge. In fact, cooperation has always been an important value and basis of science. In the 20th century, the team approach has proven to be superior to the situation of an isolated researcher of the 19th century. Other than merely the financial background, the ability of medical colleagues to cooperate determines the success of treatment. Yet, the outcome of child health care does not only depend on care givers, it also depends entirely on cooperation with children and their families.

"Sportive" competition of experts ranks among the top motivators in modern medical research. All pediatric scientists want to be the best of the best. There is, however, a considerable risk in deleterious competition: it inevitably is counterproductive. Miscommunication of research results, mismanagement, noncompliance, different concepts of the nature of the illness, different health beliefs, values, and preferences of physicians and patient families limit the potential benefits of both technology and caring.

Globalization, the new slogan of the mid 1990s, meant global markets for businesses. Global medical care, however, means provision of information and standardized health care for all. Fifty years ago, activities in international health care were the domain of the World Health Organization, governments, and nongovernmental organizations. This has changed.[4] Today, new players, including EPA-UNEPSA and other societies, influence international health care guidelines. At the end of the 20th century, global cooperation in pediatric care was poised to open a new chapter in pediatrics. This initiative was based mainly on personal friendships of pediatricians worldwide, who frequently met at international meetings. In the intercultural field, pediatricians were vulnerable to distortions stemming from 2 directions. First, they were cocooned within the implicit perceptions of their own culture. Second, they were frequently taught theories, assumptions, and hypotheses that created barriers between them and other cultures that were being studied when attempting to acquire cross-border knowledge.

Evidence suggests that global access to medical information has a positive impact on the quality of child health care. International meetings, in particular, have the potential of promoting understanding and addressing differences in policy and practice between different nations. Why should prevention have a higher priority in one nation compared with another? Why should one immunization schedule be different from another when using the same vaccines? An EPA-UNEPSA survey also reveals that a number of European pediatricians had insufficient access to scientific journals or electronic data banks of medical literature. In 2013, many Eastern European pediatricians did still not have the financial resources to attend international congresses nor did they speak and understand English well enough to communicate with foreign experts via e-mail.

Effective learning depends on active participation rather than passive engagement. There is an increasing evidence base on the efficacy, efficiency, and overall impact of different teaching and learning methods in health care. Cochrane data showed that educational meetings alone had little effect but when combined with other interventions can improve professional practice and health care outcomes for patients.[5] Using this evidence will help structure postgraduate training and meetings to increase their effectiveness and value.[6]

In 2013 there was, in fact, no European-wide standard definition of training and accreditation of pediatricians.[7] National guidelines for training in pediatrics showed great and sometimes unnecessary and avoidable variations. A basic 3-year common trunk training in general pediatrics followed by 2-3 years of higher specialty training was not offered in all European countries.[5] Higher specialty training in pediatric subspecialties should be based in well-established and highly-specialized centers of competence for the treatment of acute and chronic diseases with a high-throughput of patients, the full range of diagnostic facilities, and collocation of interdependent specialties and facilities. These centers should be a part of academic departments of pediatrics, in which research is an integral activity and that link to the clinical networks providing care.[8]

What is the future of pediatrics and child health care? The European academic pediatric community has reached a better level of communication and cooperation since 1990, however, the common goals to be achieved in child health care still need to be defined and harmonized. What have leading European pediatricians achieved, and what do they desire to achieve in the future? It is our opinion that pediatricians should not aim at creating a professional monopoly, but they should instead set standards in child health care and actively cooperate with other professional groups and organizations representing patients. In primary care, pediatricians should initiate and possibly lead multidisciplinary teams of child health care. In tertiary care, pediatric subspecialists should focus on the diagnosis and treatment of children with rare and severe diseases and actively collaborate with general hospital teams so that care can be provided close to home when it is safe to do so. This collaboration should allow comorbidities that do not require specialist care and support for parents and siblings to be delivered locally for the convenience of families. This also includes centers for rehabilitative care for children who have undergone complex interventions. It should be clear which measures need to be taken to guarantee comprehensive family-friendly health care, to treat a child's comorbidities, and to support and strengthen non-affected family members. To avoid fragmentation of pediatric care and to integrate these centers into the classic organizational structure of primary, secondary, and tertiary pediatric care is of utmost importance. A successful approach should be the centralized organization, coordination, and decision making by special care centers, and decentralized provision of treatment whenever possible. This consensus should be based on good clinical leadership and

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