



Diversity of Pediatric Workforce and Education in 2012 in Europe: A Need for Unifying Concepts or Accepting Enjoyable Differences?

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Objective To evaluate differences in child health care service delivery in Europe based on comparisons across health care systems active in European nations.

Study design A survey involved experts in child health care of 40 national pediatric societies belonging both to European Union and non-European Union member countries. The study investigated which type of health care provider cared for children in 3 different age groups and the pediatric training and education of this workforce.

Results In 24 of 36 countries 70%-100% of children (0-5 years) were cared for by primary care pediatricians. In 12 of 36 of countries, general practitioners (GPs) provided health care to more than 60% of young children. The median percentage of children receiving primary health care by pediatricians was 80% in age group 0-5 years, 50% in age group 6-11, and 25% in children >11 years of age. Postgraduate training in pediatrics ranged from 2 to 6 years. A special primary pediatric care track during general training was offered in 52% of the countries. One-quarter (9/40) of the countries reported a steady state of the numbers of pediatricians, and in one-quarter (11/40) the number of pediatricians was increasing; one-half (20/40) of the countries reported a decreasing number of pediatricians, mostly in those where public health was changing from pediatric to GP systems for primary care.

Conclusions An assessment on the variations in workforce and pediatric training systems is needed in all European nations, using the best possible evidence to determine the ideal skill mix between pediatricians and GPs. (*J Pediatr* 2015;167:471-6).

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From the perspective of understanding how to improve child health care systems, Europe's pediatrics community is unaware of the diversity of provision of primary care offered in 53 different countries and is lacking a comprehensive understanding how this diversity impacts health outcomes.¹ Neither the workforce resources nor the training capacities and confidence in pediatrics are fully understood.² After the fall of the Berlin wall in 1990, health care services in general changed in several East European countries from the former Soviet Union system to a Western-orientated structure. After the 2008 financial crisis, many East European countries started discussing changes in existing health care systems, essentially as part of cost containment.^{3,4}

Differences in outcome of child health care have been reported constantly for European countries¹; however, the underlying "root-cause-effect-outcome relationships" are mostly unclear for many diseases.⁵ The existing inequalities in the health status of children and adolescents within Europe are unacceptable and therefore should be of common concern to all pediatric societies and, above all, to politicians.^{1,6} Unfortunately, the health of children and health care systems for children are seldom discussed by others who are not physicians. In addition, learning across borders about the inequity of child health care services has been hampered by the gap existing between public health research and clinical research as well as by the lack of data.⁷ Children and young people often are considered one of the healthiest groups in the population, especially compared with the elderly population, and thereby not viewed as a priority for the health system of country. However, many diseases and conditions of adults and elderly people originate in early life and adoption of the maternal and child health life course model would suggest that investment in services for children would reap benefits in adulthood.⁸

The Strategic Pediatric Alliance (SPA)⁹ is a consortium of pediatric associations, societies, and confederations lead by the European Academy of Paediatrics, European Confederation of Primary Care Paediatricians, and the European

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EPA	European Paediatric Association
EU	European Union
GP	General practitioner
PPC	Primary pediatric care
SPA	Strategic Pediatric Alliance

Paediatric Association (EPA), whose intent is to strengthen the individual efforts of pediatric European professional health care organizations to collectively work more effectively to influence the opinions of governmental administrators, politicians, and relevant European Union (EU) institutions on aspects related to the well-being and services for children. Recent surveys conducted by the SPA have been aimed at identifying the existing pediatric health care systems in 46 European countries, which comprise a population of more than 200 million children. On the basis of analyses of these surveys, SPA aims to improve future services by understanding variations and translating research into practice with a focus on “learning across borders and making a difference.”

The intention of this article is to reveal the spectrum of country profiles on child health and national health care systems and policies concerning age-dependent primary child health care as well as to present information regarding pediatric education and pediatric workforce in Europe as of 2012. The data presented are intended to examine different national approaches to the organization and delivery of child health services and also to provide the basis for comparative analyses.

Methods

In 2012, a 2-part questionnaire was mailed to the Presidents or leading experts in primary child health care of each of the 42 national pediatric societies belonging both to EU ($n = 27$) and to European non-EU-member countries ($n = 15$). A letter accompanied the questionnaire to explain not only the purpose of the project but also the definitions of specific terms used to assure consistent understanding of what was being asked. Part One of the questionnaire contained questions related to what type of health care provider (pediatrician, general practitioner [GP]/family practitioner, or other) cared for children in the 3 different age groups considered (birth to 5.99 years, 6-11 years, and older than 12 years), and 10 specific questions regarding pediatric education and pediatric workforce (Appendix; available at www.jpeds.com). Part Two included questions on emerging medical and social conditions related for instance to care of children with chronic medical/health conditions, “new” types of families, and new “minority” immigrant populations. This article will focus on data from Part One.

Results

Responses to the questionnaire were received from 40 of 42 countries (95% response rate); no data were available from Denmark and Montenegro. Results reported are for these 40 countries unless otherwise specified. Fifty-three percent of countries defined childhood until 18 years of age, 1 country up to 11, 3 up to 14, 4 up to 15, 6 up to 16, and 1 up to 17 years of age. Two countries reported the upper age limit for children in pediatric services to be 19 and 1 country 26 years.

Delivery of Primary Child Health Care

The proportion of children receiving first access care in 2012 by pediatricians varied according to countries and according to the age of patients (Figure 1). In children aged birth to 5.99 years, two-thirds of the countries (24/36) reported that 70%-100% of children were cared by primary care pediatricians. One-third (12/36) of countries reported to offer health care to 60%-100% of young children via a GP.

The median percentage of children receiving primary health care by pediatricians declined from 80% in age group 0-5 years to 50% in age group 6-11 years and to 25% in young people 12 years and older. The proportion of children switching from primary care pediatricians to GPs increased with age in one-half of those countries providing a primary pediatric care (PPC) system for infants and preschool children, and in the other one-half of countries the older children kept being followed by pediatricians. Analyzing the proportion of children seen by pediatricians according to the age groups reveals an increasing number of countries reporting an age dependent switch from pediatric to GP care (Figure 2, A and B).

Twelve countries reported to have national discussions of changing from a pediatrician based primary child health care to a GP/family physician based system (Figure 2, C). Different reasons were reported, including economical in 9 countries, political in 6, professional power in 4, historical aspects in 2, and geographical in 1.

Pediatric Education and Workforce

The number of years in pediatric training to become an accredited pediatrician after graduating from medical school ranged from 2 to 6 years (Table; available at www.jpeds.com). The majority of countries had a 4- or 5-year training period. Those countries with a 2- or 3-year training period had specialized pediatric faculties that were attended by students from the beginning of their medical studies, which meant that they had undergone more extensive undergraduate training in pediatrics. Trainees in those countries with a 6-year training period had to spend up to a year in a medical-related specialty other than pediatrics. No data are available to answer the question of how many years the trained pediatricians had to spend before or after specialization as a generalist, eg, in remote areas of their country. Thus, the mean age for starting work as a qualified pediatrician could not be analyzed in the different countries.

The recommendation of the Union Européenne des Médecins Spécialistes to have a 3-year common trunk was accepted by 20 of 38 countries; however, it was not possible to give the percentage of national training programs putting the common trunk into practice for individual countries. The median percentage of practical and theoretical training was 70% and 30%, respectively. In-training examinations were reported by 27 of 36 reporting countries. Eleven of 37 countries did not perform a board examination after the full training period. A special PPC track was defined as general pediatric care, first access care, preventive care, health

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