Approach to Child-Friendly Health Care—The Council of Europe

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The Council of Europe was founded in 1949 to defend human rights, parliamentary democracy, and the rule of the law in order to promote a European identity based on shared values across different cultures. It started as 10 nations, but now covers 47 nations, which collectively have a population of 200 million children.

Although the rights of children are well established in the United Nations Convention on the Rights of the Child, Article 24 specifically mentions two elements—the right to the highest attainable standard of health ("the right to health") and the right of access to health care ("the right to health care"). The challenge has been to translate these principles into practice by developing a comprehensive and consistent model that informs and influences policy making, planning and the delivery, and improvement of services.

Child-Friendly Health Care is the third in a series of reports (which also includes Child-Friendly Social Care, Children's Participation, and Child-Friendly Justice[1-3]) that form part of the Council of Europe strategy entitled "Building a Europe for and with Children."[4] The program's main objective is to help decision-makers and stakeholders protect the rights of children through a practical approach for the provision of services.

Process

The writing process started in 2009 with a 2-day brainstorming event in Madrid involving a wide range of stakeholders, ranging from parent organizations, professional groups, health service managers, civil servants, and Council of Europe experts, to identify the problems currently affecting the delivery of services for children and families across Europe. After further meetings in Strasbourg, the report entitled "Guidelines of the Committee of Ministers of the Council of Europe on child-friendly health care and their explanatory memorandum,"[5] was endorsed by ministers and civil servants representing the 47 nations of Europe by signing the Declaration of Lisbon 2011.[6]

Throughout Europe, the epidemiology of childhood conditions is changing. Admissions to hospital for infectious disease are declining thanks to immunization programs. More children are surviving with significant degrees of disability arising from improvements in neonatal care and specialist care for conditions that would previously have been lethal. There are health-related lifestyles problems, including substance misuse and sexually transmitted diseases. Finally, new morbidities are increasing "diabesity," mental health problems, attention deficit/hyperactivity, and autistic spectrum disorders. Not all nations are equally affected, but increases in inequity of health are of concern, both within and between nations.

Service response has lagged behind this changing epidemiology. The new morbidities often require interventions, care, and support from a number of different professional groups, often from different sectors simultaneously, and this multiprofessional team must come together around the family and deliver a service in community settings rather than in a hospital. This process of transition of service delivery is occurring at different rates in different places and, as a result, there are unacceptable variations in both access and outcomes for children and families. Finally, the knowledge base for systematic improvement is limited by both lack of health services research and a limited adoption of improvement science within the culture of service delivery.

The expert reference group recognized that there are many different systems within the nations of Europe delivering a diversity of health services. Therefore, the child-friendly approach needed to be sufficiently generic, yet sufficiently specific, to enable all systems to adopt and then adapt the model in order to drive improvement within their own systems.

Key Messages

Simply stated, the goal of the child-friendly health care approach is to embed children's rights to ensure that the right things happen, to the right children, at the right time, in the right place, and using the right staff having the right support, to achieve the right outcomes, all at the right cost. The approach integrates life course pathways to improve health and service pathways to address health problems as they arise.

Investment in Children is Worthwhile

Children have a right to good health. Promoting the health and the well-being of children brings benefits to society as a whole, both because the antecedents of adult ill-health are often established in childhood (life course epidemiology) and because healthy, happy adults are more able to look after their own children, contribute to society, and provide for an increasingly aging population.

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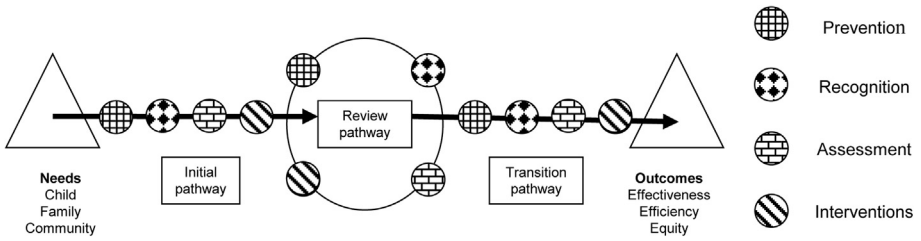

Figure. Pathway thinking of health care services: illustration of the initial, review, and transition phases, each with four repeating component parts.

A Whole Systems Approach is Required

A health system is defined by the World Health Organization as "all organisations, people, and actions whose primary intent is to promote, restore, or maintain health." Its purpose is to "improve health and health equity in ways that are responsive, financially fair, and make the best use of available resources."

Prevention Must Be Integrated and Valued

Prevention has many forms—primary prevention includes protection from hazards that have the potential to cause harm and promotion of assets, which contribute to well-being. Secondary prevention identifies conditions; early and tertiary prevention reduces the morbidities associated with the condition. Quaternary prevention reduces the potential for harm from within the health system itself.

Services Should Be Planned, Delivered, and Improved Based on Pathways

The intention of pathway thinking is to ensure that all the parts are in place and working well together to achieve the desired outcomes. Three types of pathways were identified–an initial pathway covering the development of the condition, a review pathway covering living with the condition, and finally a transition pathway back to normality if the condition is cured, onto adult services, or potentially into palliative care if the condition is fatal (Figure). Each pathway consists of component parts covering prevention, recognition, assessment, and interventions.

There Must Be Alignment and Synergy between All the Stakeholders to Achieve the Desired Outcomes

In today's complex world, each component part of the pathway may be delivered by a different professional group, or team, or agency. It is essential that they all work collaboratively and collectively to ensure the best outcomes.

User Participation Is Essential

User involvement is endorsed at three levels—decision-making for individuals, participation in service improvement, and engagement with policy and priority-setting.

The Health System Must Be Able to Respond to Changing Conditions, Innovate, and Improve and Learn from Experience

The use of improvement science for measurement, innovation, and learning must become an integral part of service delivery. The intention is to identify and improve the weakest link in the pathway and thereby incrementally improve outcomes.

The child-friendly health care approach is, therefore, a model relevant to the planning, delivery, and improvement of all services. It is universally applicable from a policy level to individual children and their families. The model integrates strategies to improve health and well-being with plans to tackle problems when they occur.

The implications of this approach are that: (1) policymakers, commissioners of services, providers, families, and regulators should adopt the same approach to create alignment and synergy for the greater good; (2) outcomes are only as good as the weakest link in the pathway; therefore, measures reflecting sentinel points in the pathway are required, as well as measures of safety, experience, and outcomes in order to guide where improvement efforts should start; and (3) there must be a shift from targets to a system based on feedback, reflection, and learning through improvement.

Benefits include: (1) reduced waste – "right care – first time" (ie, improved efficiency); (2) improved outcomes "all parts in place and working well" (ie, improved effectiveness); and (3) life-course approaches tackling determinants (ie, reducing inequities and creating sustainability).

Current Status

Moving from this conceptual approach, based on evidence and consensus, into practical service delivery requires collaboration rather than competition between providers, and multiple steps involving disinvestment in less effective and reinvestment in more effective practice working

simultaneously at a number of different levels. These actions may be "bottom-up" or "top-down," but the important point must be that all initiatives are in line with one another and always prioritize prevention.

Since publication, further child-friendly initiatives would include an Austrian initiative to increase child participation in decision-making,[7] and the British Association for Community Child Health adaption entitled "The Family-Friendly Framework"[8] in the UK and the Austrian work using pathway approaches to improving cross-border health care.[9]

Recently, the European Academy of Paediatrics, the European Confederation of Primary Care Paediatricians, and the European Paediatric Association agreed to embark on further strategies to encourage implementation of child-friendly health care. ■

We recognize the contribution of the members of the Council of Europe Expert Working Group on child-friendly health care.

References

1. https://wcd.coe.int/ViewDoc.jsp?id=1872121. Accessed April 17, 2015.
2. http://www.coe.int/t/dg3/children/participation/Newdefault_en.asp. Accessed April 17, 2015.
3. http://www.coe.int/t/dghl/standardsetting/childjustice/Guidelines%20on%20child-friendly%20justice%20and%20their%20explanatory%20memorandum%20_4_.pdf. Accessed April 17, 2015.
4. http://www.coe.int/t/dg3/children/. Accessed April 17, 2015.
5. http://nmd.bg/wp-content/uploads/2014/01/5_2_Guidelines_on_child_friendly_health_care__English_version_.pdf. Accessed April 17, 2015.
6. http://www.coe.int/t/dg3/health/Final%20Declaration%20Lisbon%2030%209%2011%20E.pdf. Accessed April 17, 2015.
7. Damm L, Leiss U, Habeler U, Ehrich J. Improving care through better communication: understanding the benefits. J Ped 2015;166:1098-9.
8. http://www.bacch.org.uk/policy/BACCH%20Family%20Friendly%20Framework%20final.pdf. Accessed April 17, 2015.
9. Salzer-Muhar U, Arnold Pollak A, Aufricht C, Ehrich J, Lenton S. European challenges: cross border care for children. J Pediatr 2013;161:574-6.