



Models of Child Health Appraised

(A Study of Primary Healthcare in 30 European countries)

MOCHA Final Conference: Presentation of Results

Day 2 - Welcome Back!



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The starting point – Background and methods



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This project has received funding from the *European Union's Horizon 2020 research and innovation programme* under grant agreement No 634201

Mitch Blair
Prof. of Paediatrics and
Child Public Health
Imperial College, London

conflict of interest statement



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I never wanted Brexit!



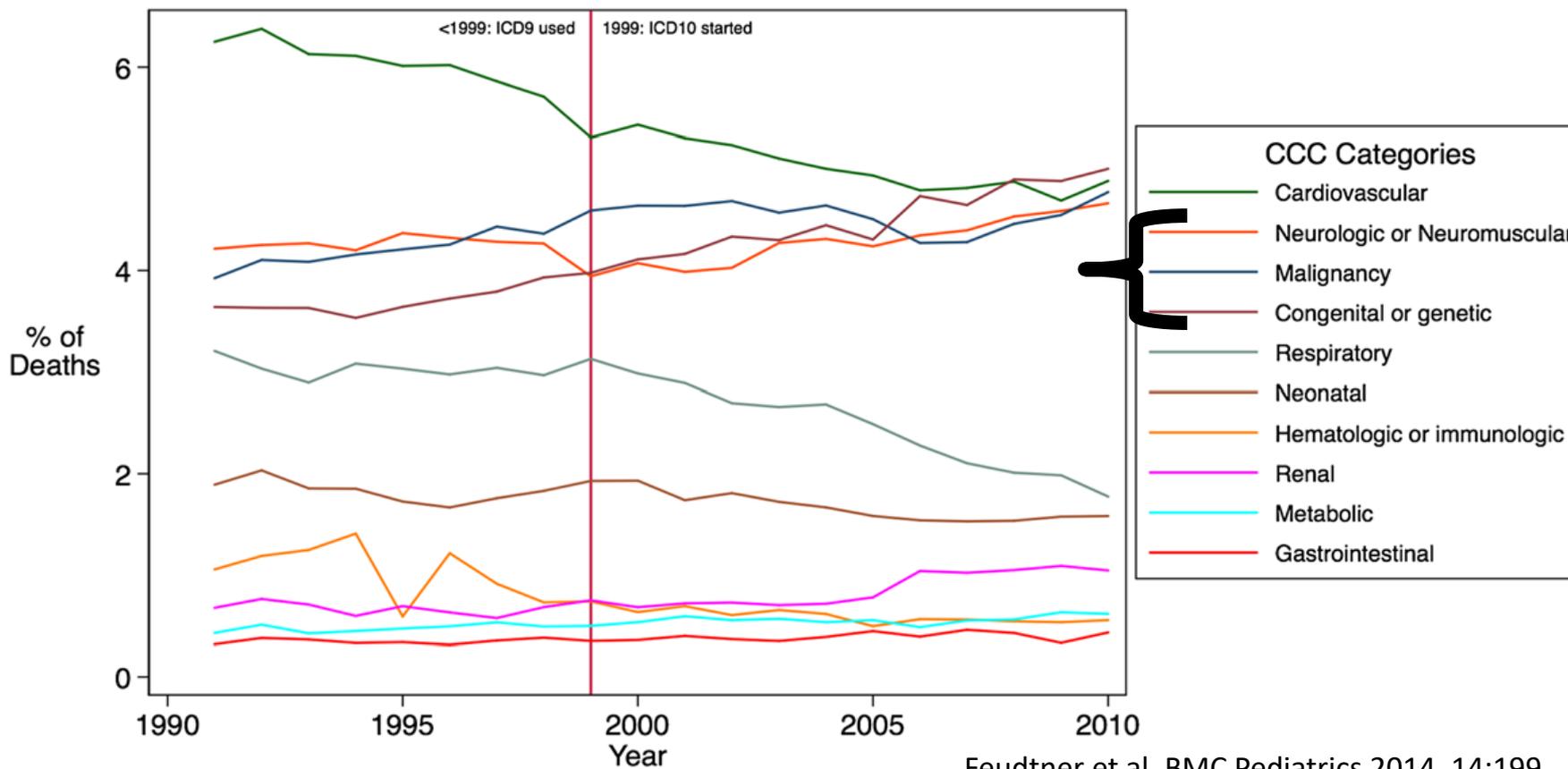
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Drivers

- Variable child mortality in EU 27
 - (Romania 4X Sweden)
- Care complexity has increased with
 - Improved technology and survival (Feundtner 2014)



Trends of complex chronic conditions categories in CDC Multiple Cause of Death data 1991–2010



Feudtner et al. BMC Pediatrics 2014, 14:199



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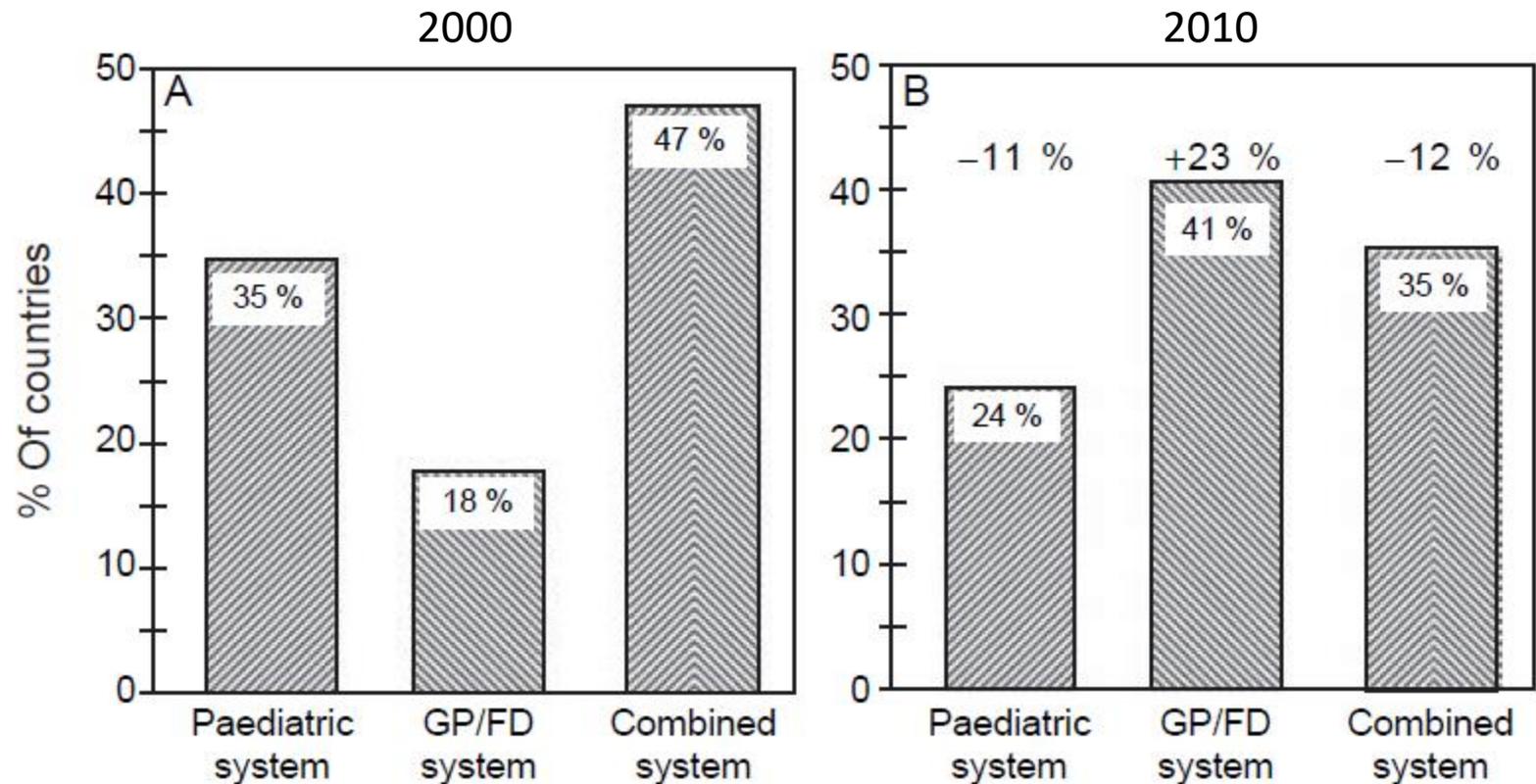


Drivers

- Sociodemographic changes
- Changing patterns of primary care provision
(Van Esso 2010)



Primary Child Health Care Systems



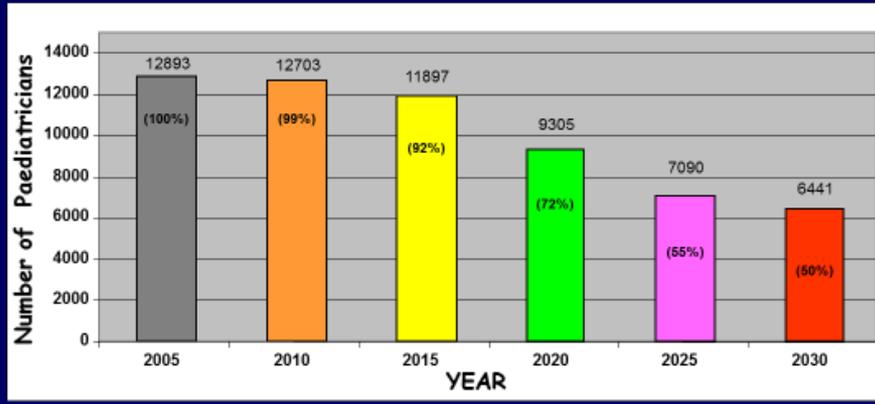
Arch Dis Child 2010;**95**:791–795



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Prospects for the Future

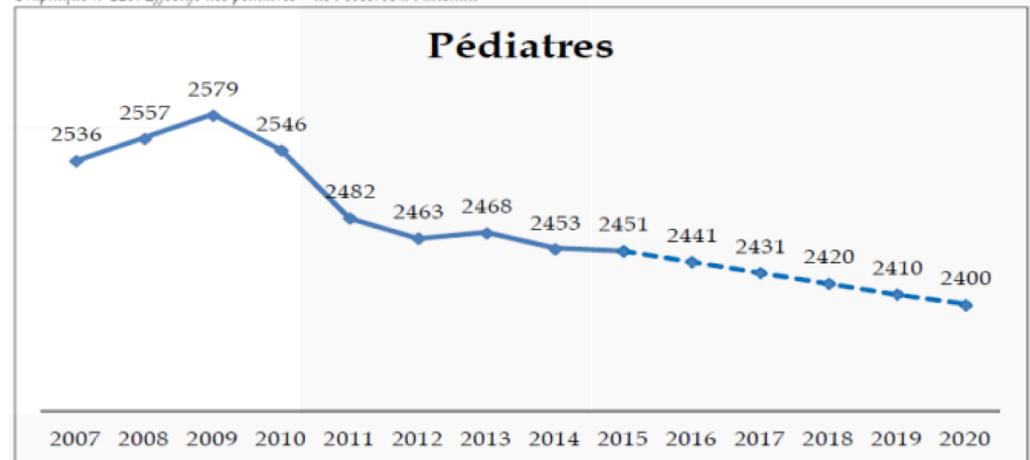
Paediatric work force in Italy
(number of paediatricians and percent) in the next 20 years



ITALY

FRANCE

Graphique n°110: Effectifs des pédiatres - de l'observé à l'attendu



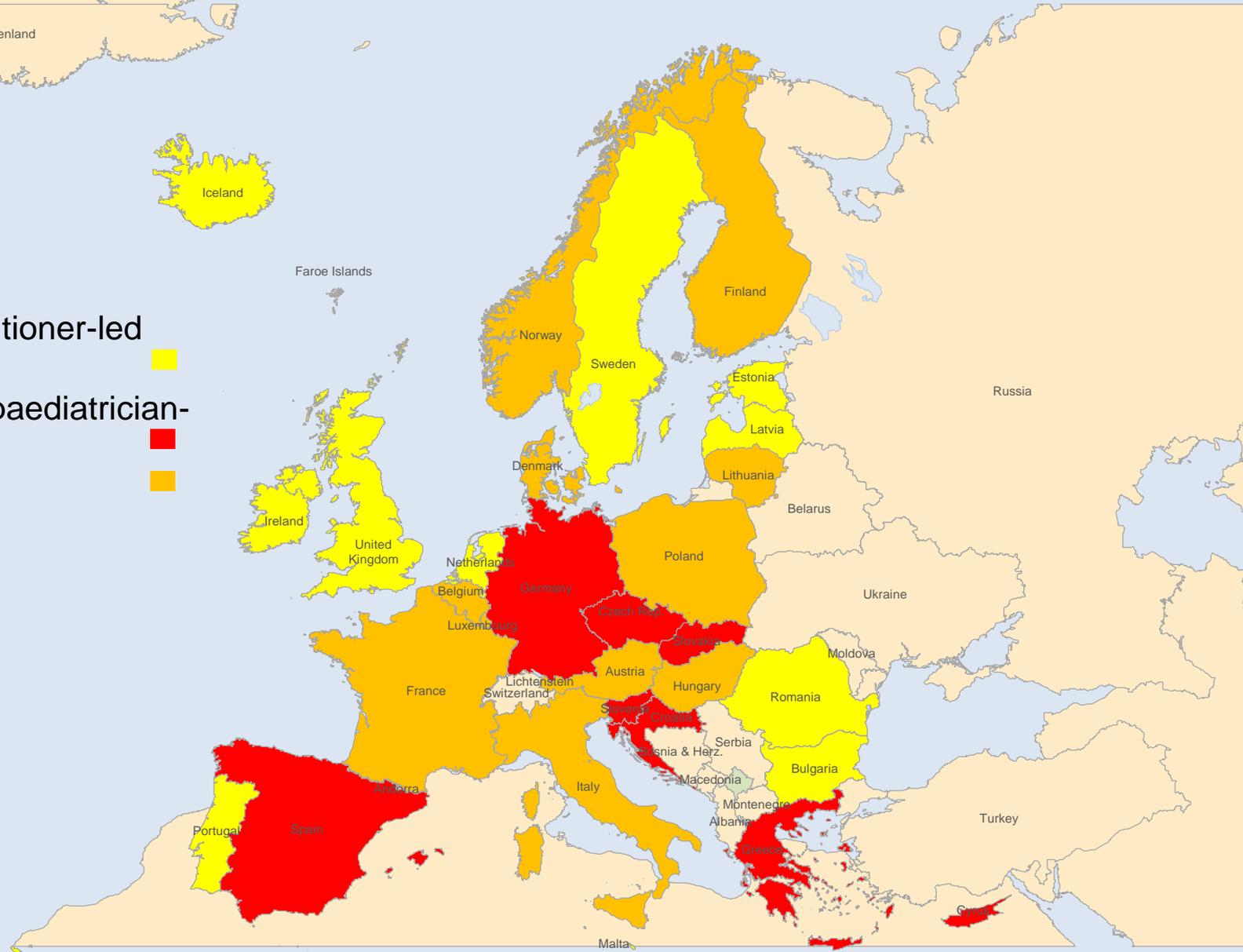
With thanks to Stefano Del Torso and Eric Van Melkebeke



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Key:

- General Practitioner-led service ■
- Primary care paediatrician-led service ■
- Mixed service ■



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SYSTEM NOT THE SAME FOR ALL!



Van Esso et al PSWG

- **Conclusions** Systems and organisations of paediatric primary care (PPC) in Europe are heterogeneous. The same is true for paediatric training, school healthcare involvement and adolescent care. **More research is needed to study specific healthcare indicators in order to evaluate the efficacy of different systems of PPC.**



MOCHA- Models of Child Health Appraised

- 6.8m Euro project funded by Horizon 2020 ;June 2015 – **November 2018**
- **19 Scientific partners** from 11 European countries plus USA , Switzerland and Australia-
 - Paediatrics and adolescent medicine , nursing, social work, family practice, political and social scientists, economists , psychologists, statisticians, health policy and management, informatics
- **30 Countries** (EC and EEA) involved via agents to answer questions about a number of work streams
- Leads Prof Mitch Blair and Prof Michael Rigby- **Imperial College London UK**



Primary care for children and young people

- What services exist in your country?
 - (multiple settings; school, adolescent services, pharmacy and dental, apps, websites and hotlines)
- How are things done ?
- How is the system organised ,funded regulated and monitored ?
- Appraisal of which systems (or sub-systems) work best ?



Appraisal approaches ?

- Primary care clinical measures (prevention, early diagnosis, treatment)
- Professional standards of training/care
- Patient views/expectations
- Economic investment
- Child Rights
- Public and Political acceptability



Which appraisal frameworks exist?



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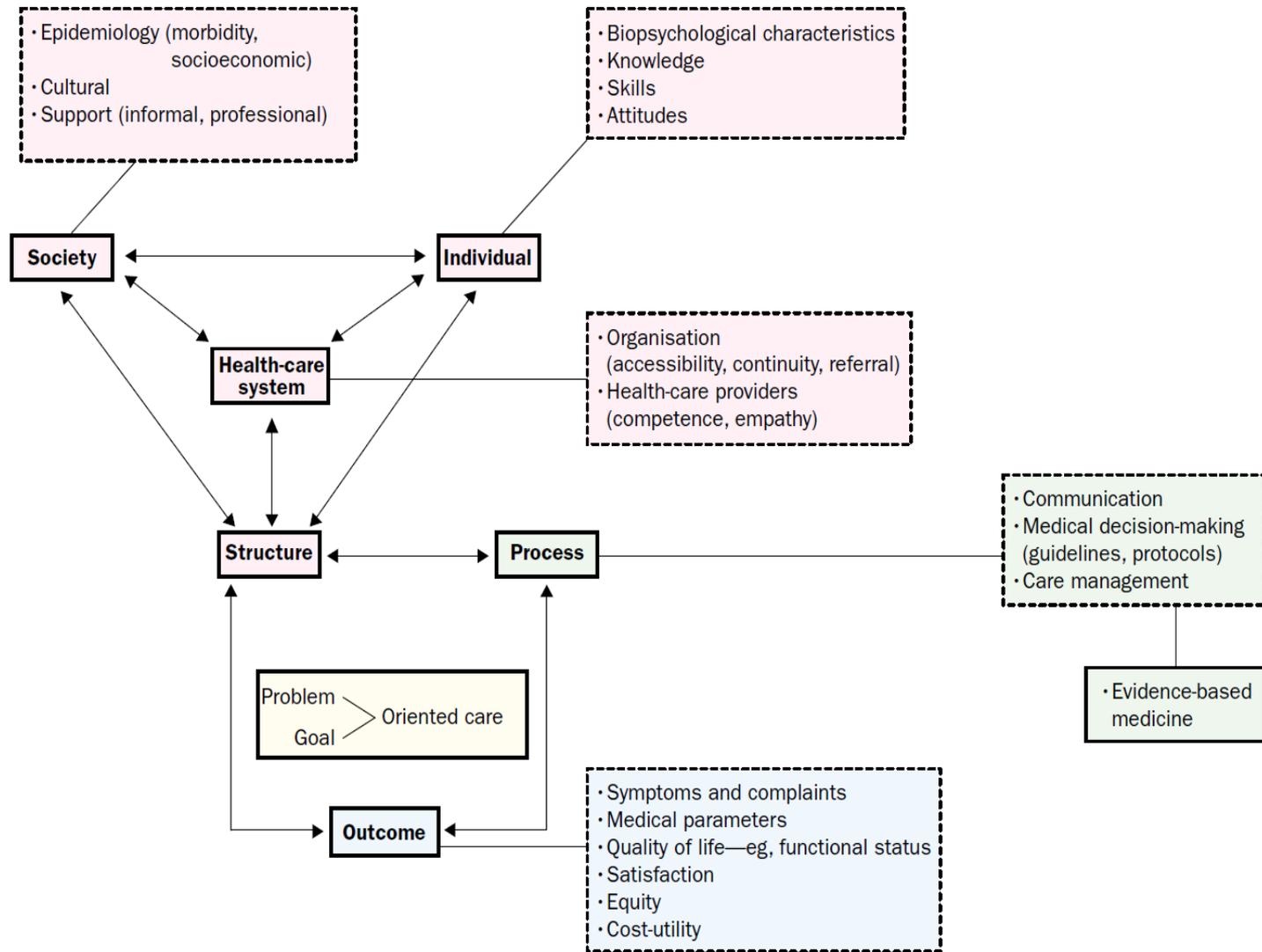
	Starfield (1998)	Sibthorpe & Gardner (2007)	Kringos et al. (2010)	van Olmen (2010)	Wong et al. (2010)	Tham et al. (2010)	Jahanmehr et al. (2015)	Veillard et al. (2017)	Total
Improved health status, wellness, functioning / effectiveness	x	x	x	x	x	x	x	x	8
Access / accessibility ¹	x	x	x	x	x	x	x	x	8
Health system's use / Service delivery / clinical activities ²	x	x	x	x	x	x	x	x	8
Human resources ³	x	x	x	x	x	x	x	x	8
Governance / stewardship / policy development	x	x	x	x	x	x		x	7
Physical resources (facilities, medical products, vaccines and equipment)	x	x		x	x	x	x	x	7
Efficiency / value for money		x	x		x	x	x	x	6
Responsiveness / public satisfaction	x	x		x	x	x		x	6
Continuity	x	x	x		x	x		x	6
Health system management	x	x		x	x	x		x	6
Financial resources / expenditure / cost	x		x		x	x	x	x	6
Equitable outcomes (equity)		x	x		x		x	x	5
Political and socio-economic factors ⁴	x			x	x		x	x	5
Appropriateness		x			x	x			3
Comprehensiveness			x		x			x	3
Coordination			x		x			x	3
Equitable access to health services (equity)		x	x				x		3

Autran M et al 2018



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Theoretical framework of structure, process, and outcome



De Maeseneer et al Lancet 2003

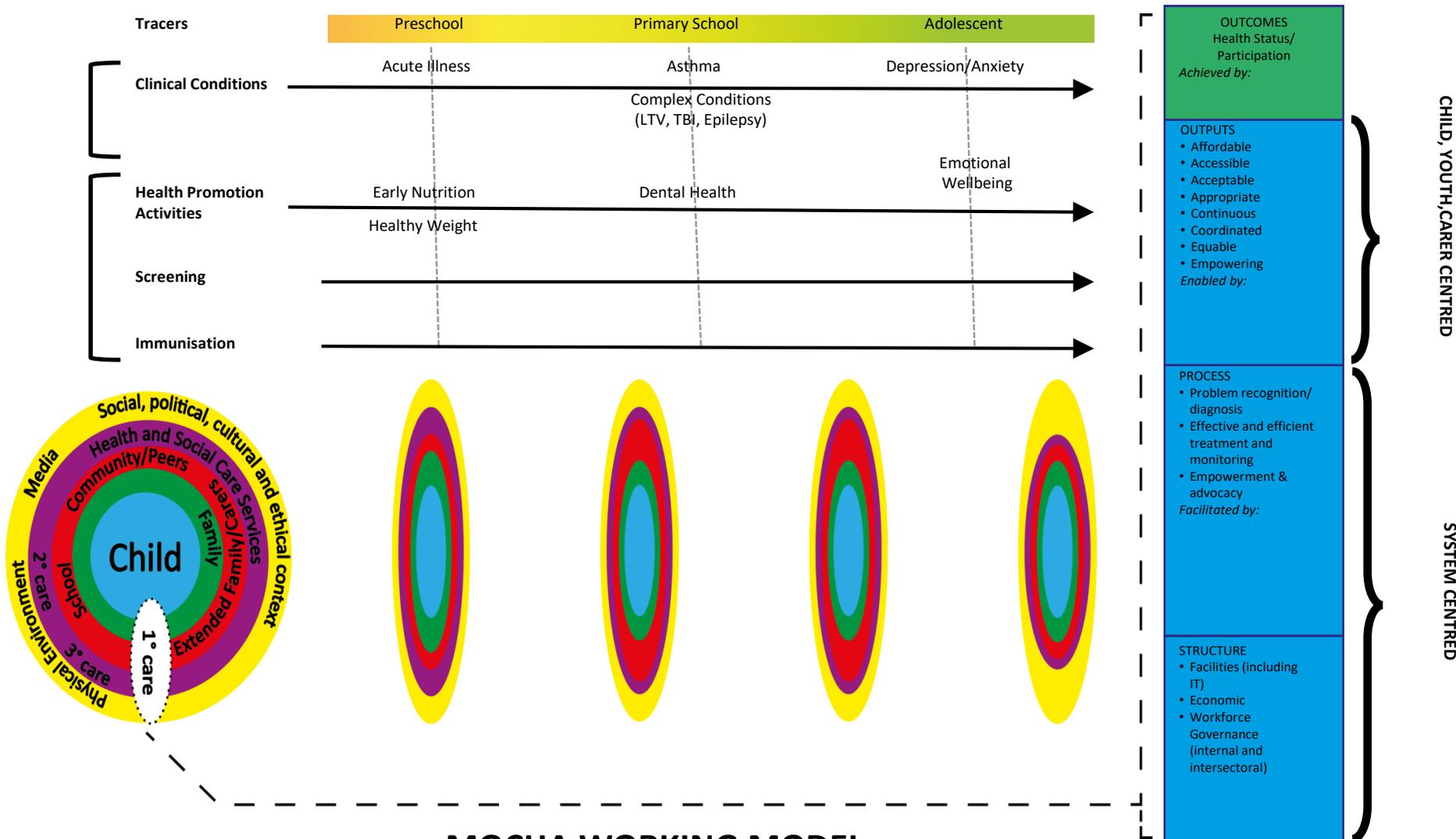


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MOCHA WORKING MODEL

Life course determinants of child health and primary care quality





MOCHA WORKING MODEL
Life course determinants of child health and primary care quality

PRIMARY CARE FOR CHILDREN AND ADOLESCENTS* IN EUROPE

		Setting														
		General practice			Primary community pediatric			Well baby clinic			School health services			Community specialist AHS		
Function		P & S	PC / D	T & M	P & S	PC / D	T & M	P & S	PC / D	T & M	P & S	PC / D	T & M	P & S	PC / D	T & M
Structure	Governance															
	Economic conditions															
	Workforce															
Process	Access															
	Comprehensiveness															
	Continuity															
	Coordination															
Interface	Secondary care															
	Complex care															
Outcomes	Quality															
	Efficiency															
	Equity in health															
	Transferability															
Culture																

OPTIMAL MODEL(S) OF PRIMARY CARE

Legend

- * Healthy child; vulnerable child with social needs; child with single long-term condition; child with complex health needs; acutely mild-to-moderately unwell child; acutely severely unwell child
- P & S Prevention and surveillance
- PC / D Problem recognition / diagnosis
- T & M Treatment and monitoring



Methods

- **Country agents** /information gatherers (multi source)
 - Use of clinical scenarios
 - Policy surveys
- **Data:-** Routine national statistics (Eurostat, GBD)
- National/Regional registries
- **Interviews (DiPEX)**



Methods

Data triangulated with other sources where possible (EU professional associations, conferences, published sources)

- **Analysis** – quantitative (descriptive, regression, SEM) and
- qualitative (thematic analysis)



Themes explored about the what and how (structure and process)

- Case scenarios /tracer conditions
 - Acute care: fever, asthma
 - Complex care :-Traumatic brain injury/ Long term ventilation/Epilepsy
- Equity – migrants and children looked after by the State
- School and adolescent health services
- Workforce structure and training
- Economics
- Electronic health records
- Incentives and Penalties
- Context and culture
- Preventive care schedules



Donabedian 1966

- “More often one needs to ask, ‘What goes on here?’ rather than, ‘What is wrong; and how can it be made better?’



NEJM 375;3 2016



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Towards a child centric paradigm in health care

Kinga Zdunek¹, Denise Alexander², Michael Rigby², Mitch Blair²

¹ Medical University of Lublin, Poland

² Imperial College London , UK

MOCHA Final Conference
15-16 October 2018, Hague, Netherlands



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Background

‘children represent the future, and ensuring their healthy growth and development ought to be a prime concern of all societies’. (WHO, 2015)

- Attitudes towards the child have changed throughout the ages, as a consequence of socio-cultural shifts in the perception of the child as an intrinsic rather than an extrinsic value.
- Socio-cultural contexts have altered attitudes towards children and created their value in society, including towards their health.



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EVOLUTION OF ATTITUDES TOWARDS CHILDREN



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Ancient world: The child is seen as property, subservient to parental and societal position. Examples of this can be seen in the Christian bible, writings from Ancient Greece, Ancient Rome

Middle ages: A child was viewed as a 'small adult'. Evidence emerges of a change in attitudes towards children, and the child begins to be seen as an object of value, and the family is responsible for moral development.

Renaissance (1350-1700): Greater appreciation of a child's personality, focus on the needs of children such as public education for the poor. Philosophy of humanism develops the concept of education increasing human potential and dignity.

Enlightenment (1685-1815): recognition of a child's needs and interests, children are given rights, attention is given to marginalised children – as can be seen in the work of John Locke and in the ideas behind the French Revolution



19th Century industrialisation: High child mortality, poor living and working conditions – recognition of this led to philanthropic work to care for homeless, abandoned children; and to provide education for poor children

20th Century: Increased protection and educational directives for children. Establishment of organisations such as *Rädda Barnen* in Sweden, and the International Save the Children Union (UISCI), and Save the Children in the United Kingdom

1924 Geneva Declaration of the Rights of the Child adapted to protect vulnerable children and child victims of war. It is at this point that the child becomes regarded as having a value in itself.



Declaration of Geneva

By the present Declaration of the Rights of the Child, commonly known as “Declaration of Geneva,” men and women of all nations, recognizing that mankind owes to the Child the best that it has to give, declare and accept it as their duty that, beyond and above all considerations of race, nationality or creed:

- The child must be given the means requisite for its normal development, both materially and spiritually;*
- The child that is hungry must be fed; the child that is sick must be nursed; the child that is backward must be helped; the delinquent child must be reclaimed; and the orphan and the waif must be sheltered and succoured;*
- The child must be the first to receive relief in times of distress;*
- The child must be put in a position to earn a livelihood, and must be protected against every form of exploitation;*
- The child must be brought up in the consciousness that its talents must be devoted to the service of fellow men.*

(United Nations, 1924)



Children's rights

- **1948. The Universal Declaration of Human Rights** makes children's rights equal whether a child is born to married or unmarried parents; **Declaration of the Rights of The Child** supplemented the Geneva Declaration of 1924
- **1950. European Convention on Human Rights:** *"Spouses shall enjoy equality of rights and responsibilities of a private law character between them, and in their relations with their children"*
- **1961. European Social Charter** includes *the Right to social protection for mother and child and the Right of children and young persons to protection*
- **1966. International Covenant on Civil and Political Rights. Art. 23. Protection of the family and Art. 24. Protection of the rights of the child**
- **1976. International Covenant on Economic, Social and Cultural Rights** *Family as the natural and fundamental group unit of society, (...) is responsible for the care and education of dependent children (...). Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions.*



1989 UN Convention on the Rights of the Child

- Art. 3.2. States Parties undertake to **ensure the child such protection and care as is necessary for his or her well-being**, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her
- Art. 3.3. States Parties shall ensure that the **institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health**, in the number and suitability of their staff, as well as competent supervision
- Art 6.1. States Parties recognize that every **child has the inherent right to life**.
- **24.1.** States Parties recognize the right of the child to the **enjoyment of the highest attainable standard of health** and to facilities for the **treatment of illness and rehabilitation of health**. States Parties shall strive to ensure that **no child is deprived of his or her right of access to such health care services**.



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CHILD IN HEALTH POLICY. CHILD IN MOCHA



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A child's right to health

- Initiatives in health policy are not only directed to the population but also driven by the population, **including the needs of children.**
- Paradigm of health policy analysis used in MOCHA as a triangle framework. Attention on its content, processes affecting development and implementation of change, context and actors.
- Context in our understanding refers to systemic factors
- It can be considered through the perspective of four factors: **situational, structural, (socio)cultural and international**

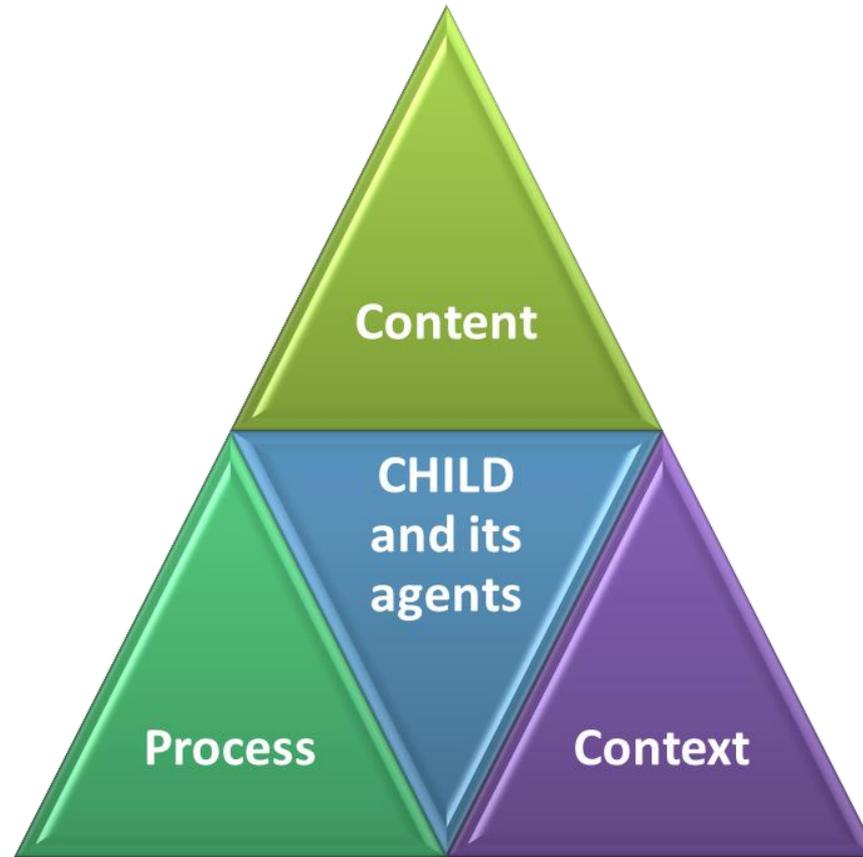


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Child health policy in MOCHA



Triangle adapted to MOCHA from Walt & Gilson (1994)



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Child in health policy. MOCHA assumptions

- The child is an **active player** empowered in the process of health care provision but also in defining health policy via the agents of the child,
- The child and the child's agents are embedded in particular **environment** which requires to adapt and respect the common principles and values,
- The environment is understood as the **wider context** of sociocultural, structural, external and internal background which interact between child and its proximal and distant environment on different levels.

Philosophy adapted to MOCHA from Bronfenbrenner (1979)

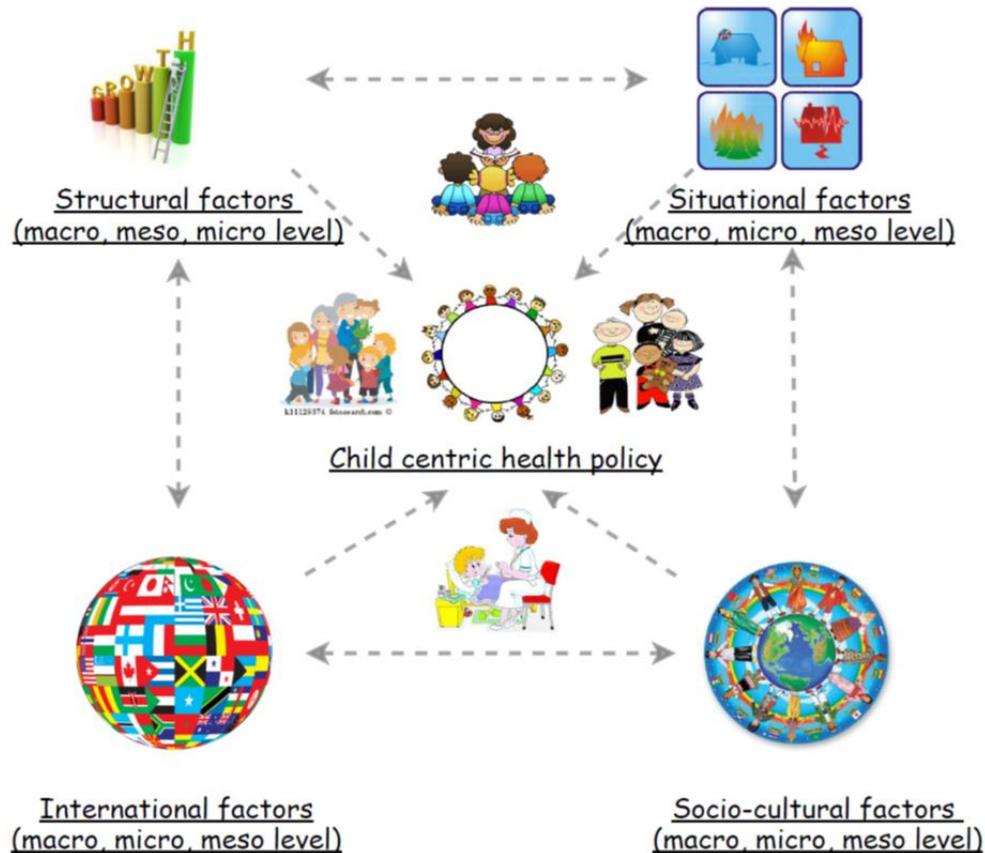


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Child oriented approach in MOCHA



Contextual determinants adapted to MOCHA from Leichter (1978)



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Child and his or her representatives

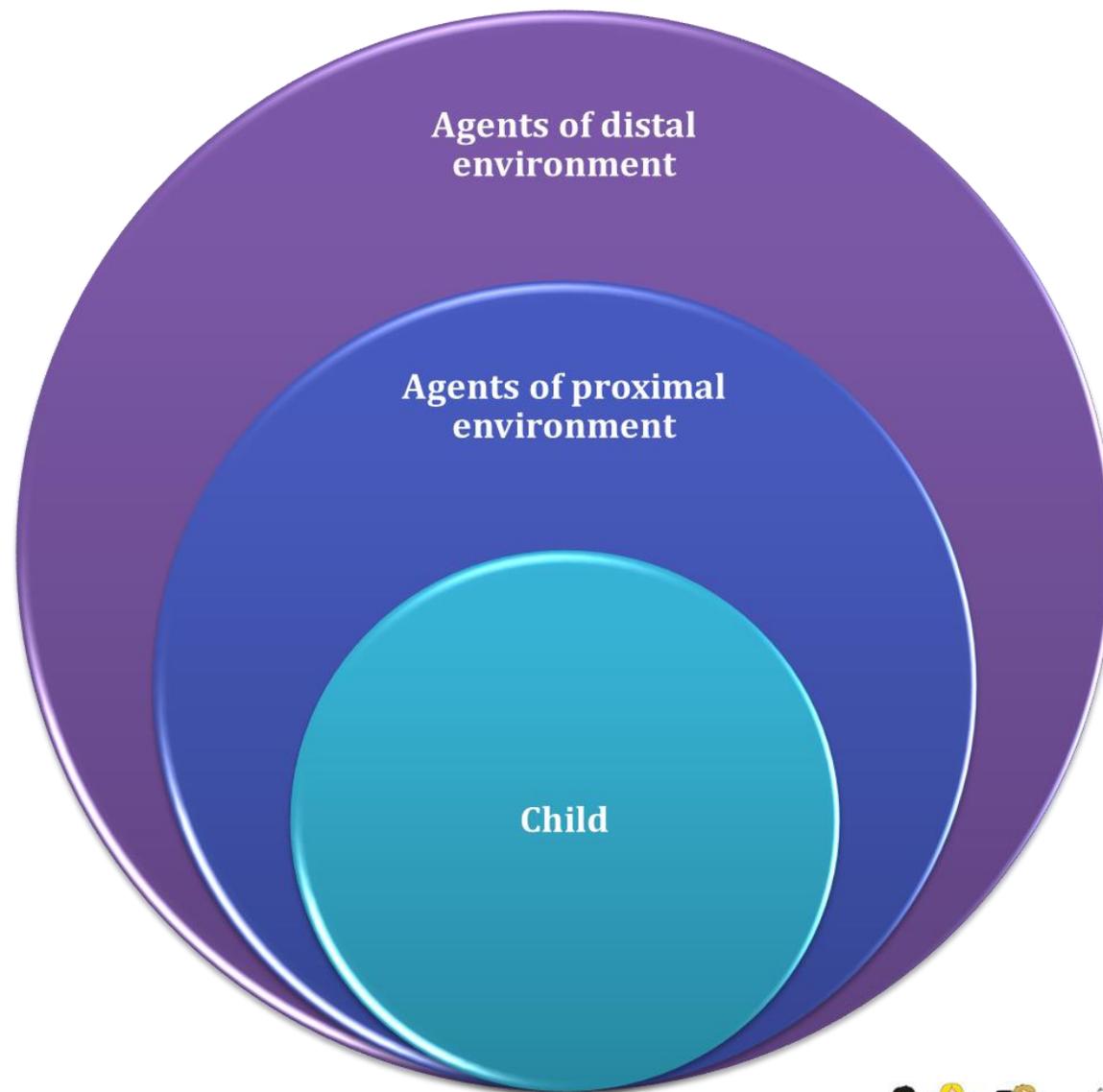
- Child as a **causative actor**
 - The child is not an active participant in discussions;
 - The child is the subject and often the cause of a societal movement or change in policy
- Child is surrounded by an extensive network of representatives – **executive actors**
 - They are able to act and represent the interest of the child



The concept of an 'agent' for the child

- These individuals (executive agents), who may be parents, teachers, nurses, physicians or other adults can be considered as **agents of the child** in the proximal or distal child's environment of the child.





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Proximal and distal child environment

- The **proximal environment of the child** is defined as the micro-level, or the direct milieu of the child's environment (such as a parent or other family member);
- **Distal environments** are defined as the indirect surroundings, on the meso- and macro- level.
- The difference between the distal and proximal environment of the child is expressed by the type of relationship.
 - In the proximal perspective, the agents are capable of constructing a direct relationship
 - The agents of the distal environment are generally acting on the basis of indirect contact

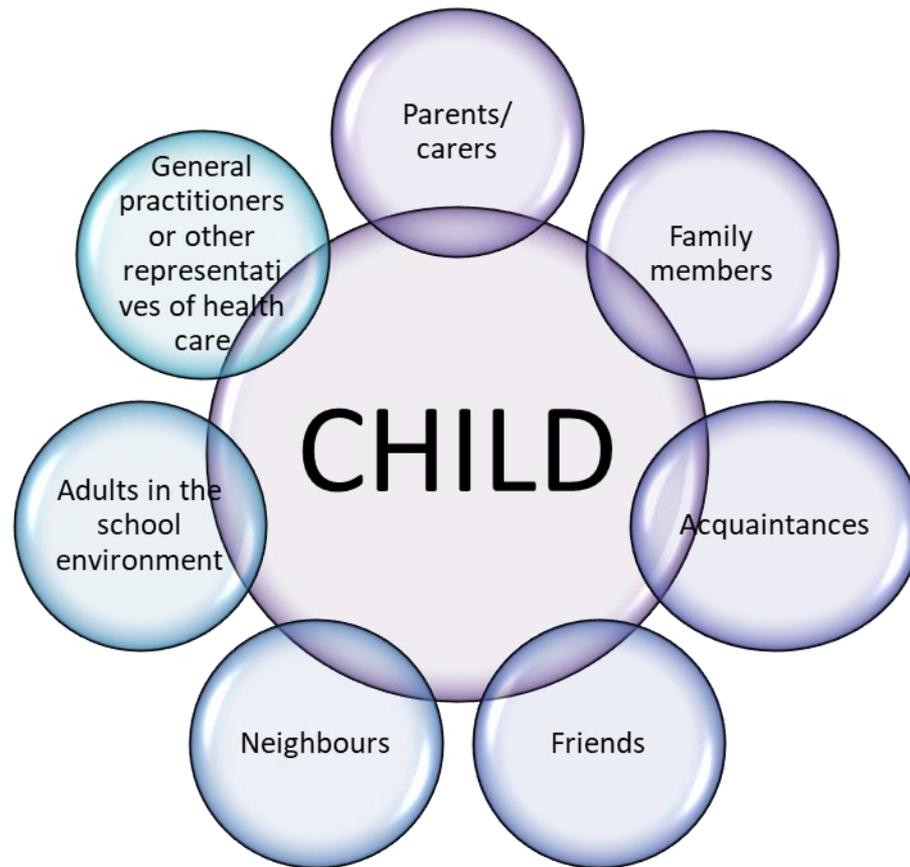


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Examples of proximal environment of the child

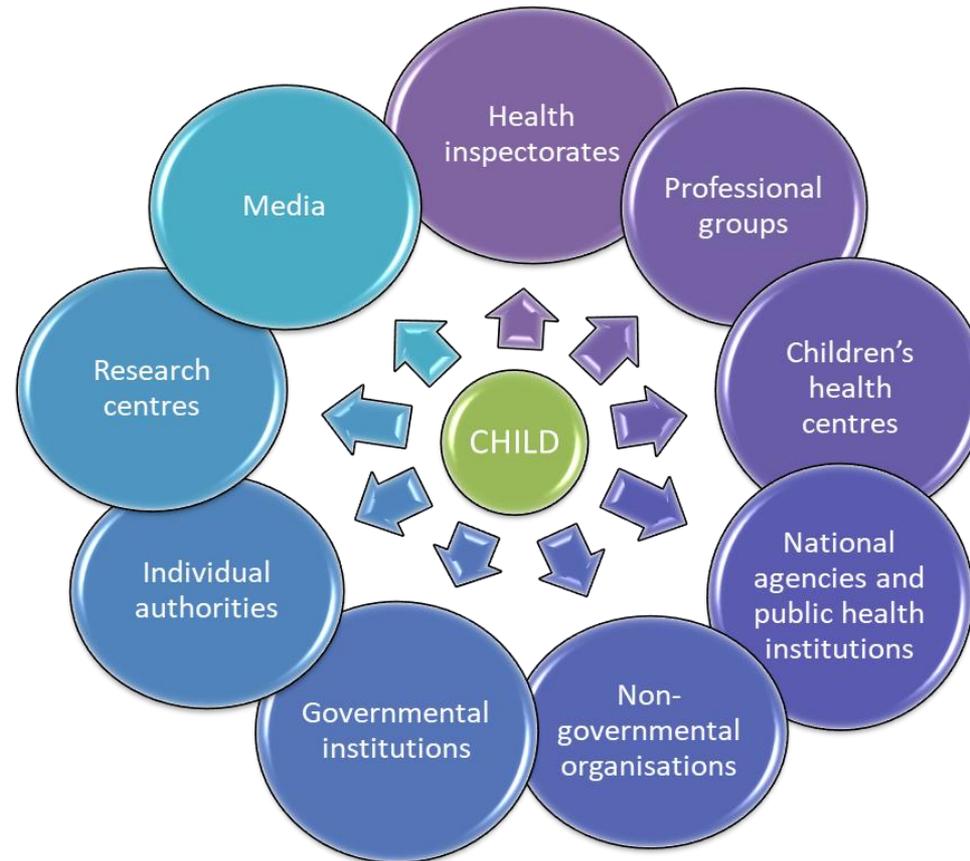


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Examples of distal environment of the child



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SUMMARY



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Emergence of child centric paradigm

Traditionally children's rights and needs were defined by parental representation and duty, child was considered through the adults lenses



The awareness of children's rights and needs has been increasing towards the holistic perspective



Nowadays the child rights are not only respected but the care provided must be responsive to individual preferences, needs, values, and ensure that patient values (or the values of the agent of the child) guide all clinical decisions

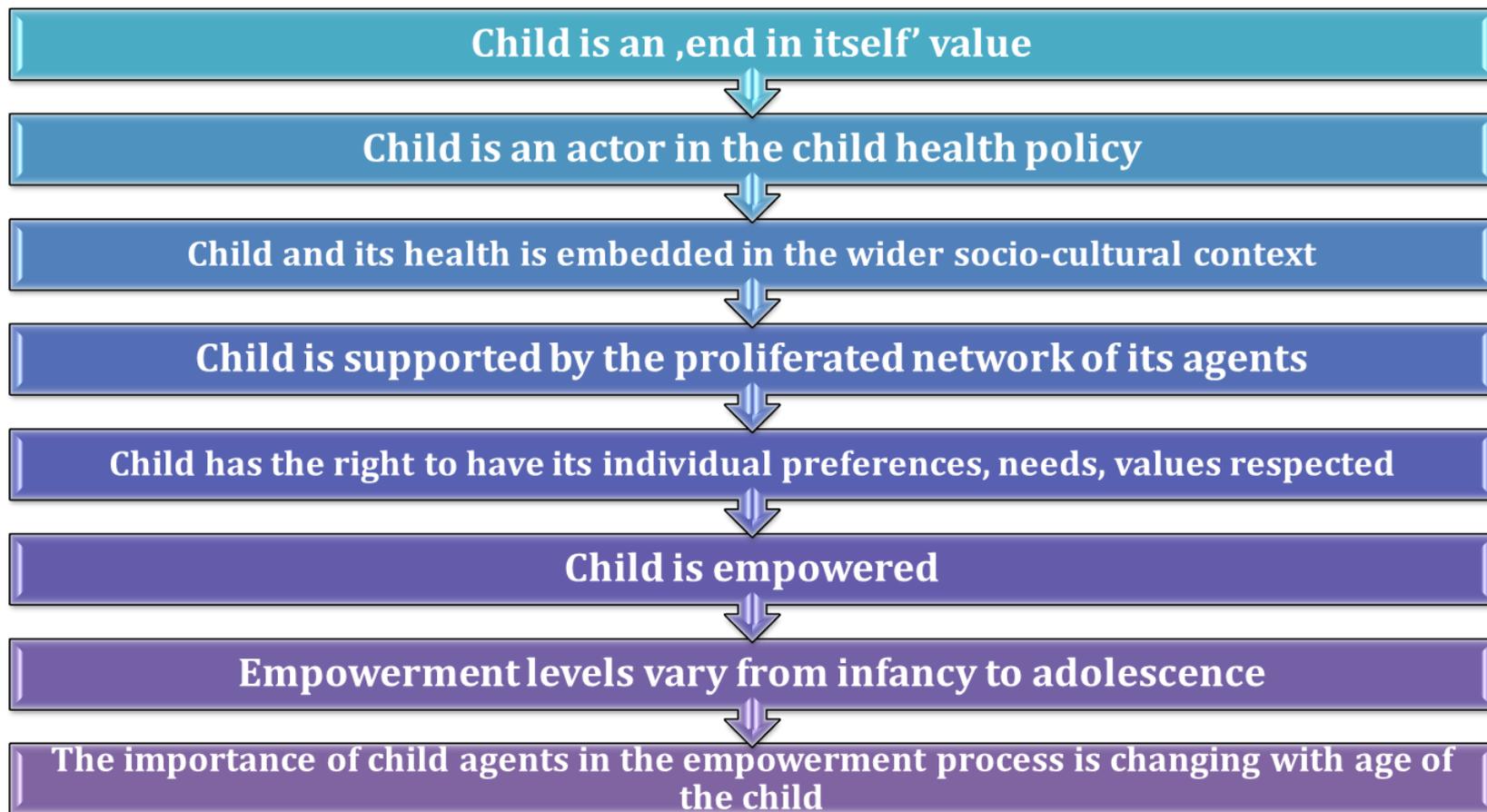


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Child centric paradigm in MOCHA



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Thank you



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Listening to young people

Results from the DIPEX study

Dr. Manna Alma,
University Medical Center Groningen, Dept Health Sciences

*MOCHA final conference
16th November 2018*



Models of Child Health Appraised
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Listening to young children

- MOCHA principle: Child-centric
- Children are the focus – their experiences and voices matters
- Important evidence to run and provide services
- Qualitative inquiry into children's and parent's experiences





DIPEX International

- Network of researchers conducting qualitative research into patient experiences
- Aim: Promote spread worldwide of well researched data on people's experiences of health and illness
- Qualitative research methodology
 - Health Experiences Group, University of Oxford



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DIPEX within MOCHA

- Aim: To explore and understand children's and parents' experiences of primary health care for children in Europe

- 5 EU/EEA countries



- Focus on patient narratives



Participants

- Study population:
 - Children aged 10 - 18 (n=84)
 - Parents of children age 0 - 18 (n=88)
- Maximum variation sampling
 - “Healthy” children
 - Children with mental health conditions
 - Children with physical health conditions



Data collection

- (Videotaped) Face-to-face narrative and semi-structured interviews
- Focus group interviews
- Secondary analysis of existing interview collections

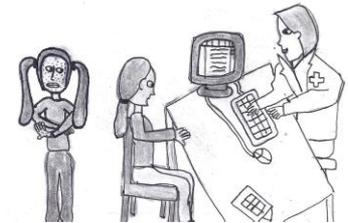
- Alternatives when children were interviewed^d

- Pictures
- Statements

(e.g. I always visit the same doctor and nurse)

- Writing a letter

(e.g. Dear doctor, what I really like about the primary care center is)



Data analysis

- Verbatim transcription
- Qualitative interpretative approach
 - Thematic analysis
 - Constant comparison
- Monthly skype meetings + face-to-face workshops
- Researcher conducted separate thematic analysis of own data
- Checked for similarities and differences



of interviews and participants

CHILDREN	Total	CZ	G	NL	S	UK
# in-depth interviews	38	13	1	7	6	11
# focus group interviews	5 (26)	1 (5)	2 (14)	-	1 (3)	1 (4)
# interviews secondary analysis	20	-	14	-	-	6

PARENTS	Total	CZ	G	NL	S	UK
# in-depth interviews	42	10	1	18	13	-
# focus group interviews	4 (26)	1 (9)	1 (4)	-	1 (8)	1 (5)
# interviews secondary analysis	20	-	9	11	-	-



Themes

- Reasons for using primary care services
- Accessing primary care services
- The surgery environment
- Relationships with primary care professionals
- Continuity of care
- Independence and autonomy
- Medical records
- Health information
- The role of schools
- Financial issues



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Communication and relationships

- Key quality component
- More similarities than differences between countries
- Positive values:
 - Communication skills:
 - Being empathetic
 - Easy to talk to
 - Really listening
 - Openness to discussion
 - Positive attitude
 - Respecting child
 - Professionalism:
 - Informed about the patient
 - Thoroughness
 - Special education to work with children



“What I think they should do – they should be relaxed. I know being a doctor's really stressful but I feel like they should be relax themselves. They should interact, if you tone down the professionalism to some extent and to more of a social...to more of an informal sort of stance, then ...you'll definitely engage with teenagers that way. Because teenagers don't like formality, and I feel like it's important to engage with teenagers and so it'll be a bit more...chilled.” (UK, M, child)



Continuity of care

- Importance building a trusting relationship
- Importance seeing same professional

“I think it is better to see the same doctor every time, especially the same GP. Because I know, the doctors ask you about your medical history every time. And then you do not have to tell them the same things all over again.” (G, F, child)

- Helps to feel more at ease
- Perceived lack of continuity of care
 - Distress



“They don’t tell you when they change your doctors. Like some...like I've got...they’ve changed my doctors how many times now and I don’t like changes and they know that, but they keep changing my doctors and I don’t like it. So I don’t...I did have trust in this one doctor and then they left and they keep changing my doctors around and I don’t like it.... There's some doctors I know there cos I've done with them before and I had more trust in them. And then they just give me doctors I don’t know and I don’t feel safe round them....”
(UK, F, child)



Involvement and participation in care

- Should be involved in managing own care
- Variation in how much parental involvement
- Influencing factors:
 - Age
 - Reason for visit
 - Level of control by parents
 - Accessibility and transport
- Being part of the conversation



“I can remember thinking I hope this goes away but also that I was slightly annoyed that they had not paid any attention on mine to what I'd been saying.” (UK, M, child)

“So I think the GP, or the health professional in general, should really just ask the young people what they feel like they need.” (UK, F, child)

“I think the doctors should speak more with the child. (...) I don't know why they cannot ask the child directly. When I am ill and I go to the doctor, I lie down, the doctor examine me, leave me lying there and then he speaks with my father about everything. ‘Since when does she feel sick?’ and I could be sick earlier, I just didn't say that at home, right? And I think it is wrong, they should talk to the child who is sick. (...)” (CZ, F, child)



Conclusions

- Many children were satisfied
- Not a universally good picture
- Analysis of patients' subjective experiences highlighted:
 - What is working well
 - What needs to be changed
 - How to go about making improvements



“Tips for health care professionals: try to pay sufficient attention to your patients, and if it is a child, try to explain him or her everything as clear as possible. If the child is older, please evaluate what the child already knows and anticipate.” (NL, F, child)



Thank you!

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STAKEHOLDERS' VIEWS ON SCENARIOS ON EUROPEAN CHILD HEALTHCARE SYSTEMS AND HOW POTENTIAL CHANGES MIGHT BE ACHIEVED

Eline Vlasblom - TNO, Leiden, Netherlands

Gaby de Lijster - TNO, Leiden, Netherlands

Magda Boere-Boonekamp - University of Twente, Enschede, Netherlands

Paul Kocken - TNO, Leiden, Netherlands



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This presentation reflects the author's view; the Commission is not responsible for any use that may be made of the information it contains.



Introduction

MOCHA AIM:

Describe and appraise various models of primary child health in Europe and make recommendations as to optimal components of provision of child health care.

CURRENT STUDY AIM:

Analyze stakeholders' views on imaginary scenarios of child healthcare systems' components in the future, and how potential changes might be achieved.



Methods

Online Questionnaire: 80 stakeholders of 22 EU countries
policy makers, nurses, paediatricians, GPs, researchers
representatives of end-users

Scenario	Key components	Function of healthcare system	Tracer	Age group
1. Specialized preventive health services	Access Comprehensiveness Continuity of care Coordination of care	Prevention of communicable diseases	Comprehensive infant measles vaccination coverage	0-4 years old
2. Working in multidisciplinary teams	Coordination of care Workforce Continuity of care	Treatment and monitoring of a chronic condition	Asthma care Care for children with complex needs	4-12 years old
3. Confidential access for adolescents	Access	Problem recognition/early diagnosis	Early identification of mental health disorder	12-18 years old

Online Focus Groups: 13 stakeholders of 8 EU countries



Models of Child Health Appraised
(A Study of Primary Healthcare in 30 European countries)

Country classification

- **Open access countries:**

countries with an open access referral process and any lead practitioner

Austria, Belgium, Cyprus, Germany, Iceland, Luxembourg, Malta, Slovakia.

- **Gatekeeper and mixed led countries:**

countries with a partial or usual gatekeeper and either a paediatrician led primary care, or a mix of paediatrician led and GP-led primary care

Croatia, Czech Republic, Finland, France, Greece, Hungary, Italy, Lithuania, Norway, Poland, Portugal. Slovenia. Spain.

- **Gatekeeper and GP-led countries:**

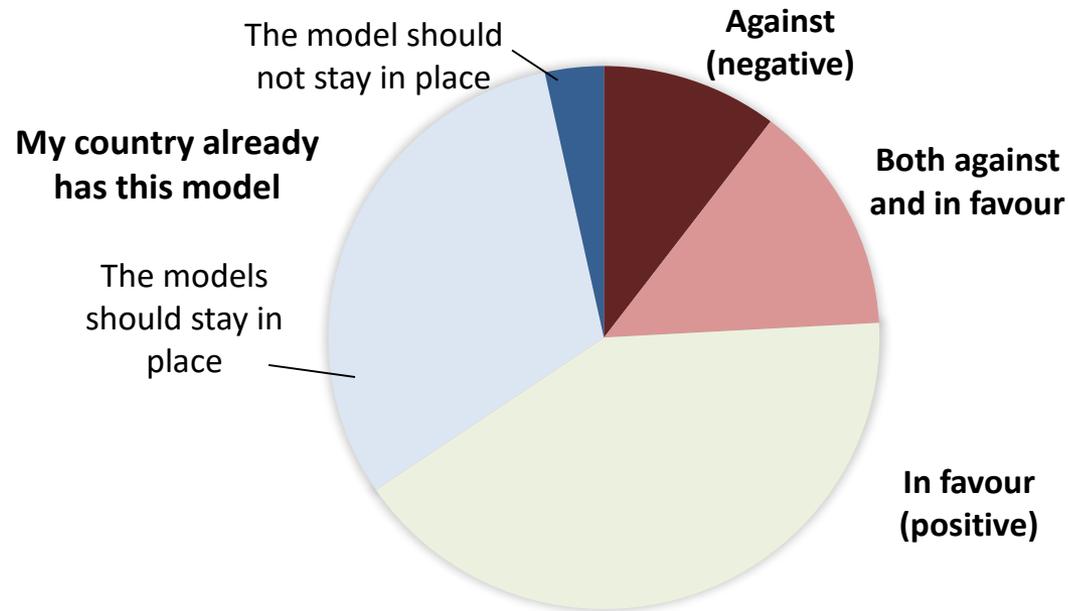
countries with a partial or usual gatekeeper, and primary care led by a GP

Bulgaria, Denmark, Estonia, Ireland, Latvia, Netherlands, Romania, Sweden, United Kingdom.



Results Scenario 1

Specialized preventive health services for infant measles vaccination.

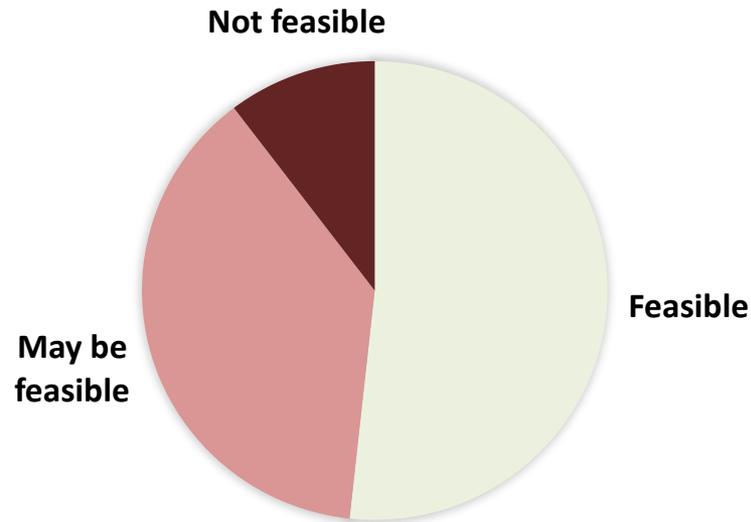


N = 29



Results Scenario 1

Specialized preventive health services for infant measles vaccination.



N = 29



Results Scenario 1

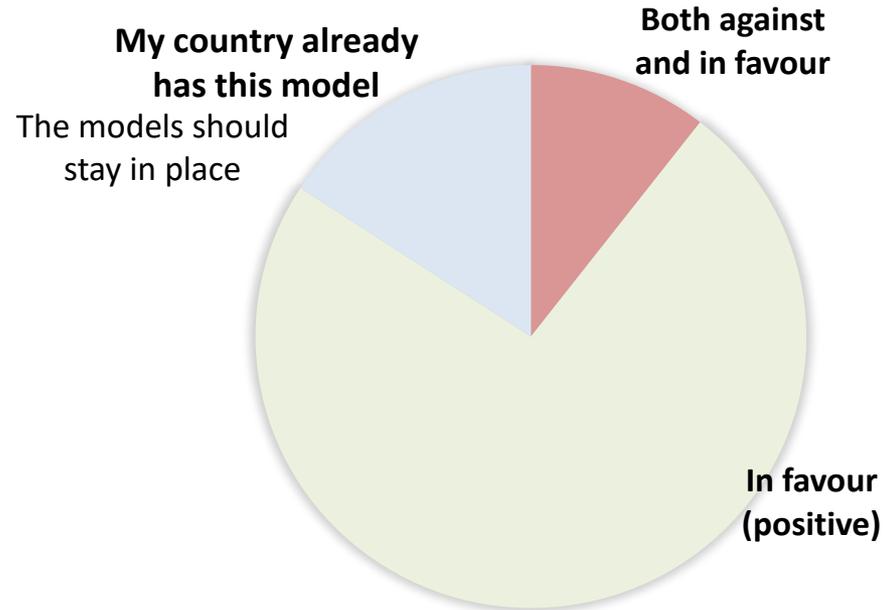
Specialized preventive health services for infant measles vaccination.

“In addressing the issue of declining vaccination rates, communication to vaccination hesitant parents is more important, than changing characteristics of the primary care system, including the availability of a specialized preventive service.”



Results Scenario 2

Working in multidisciplinary teams in the chronic care for children with asthma and complex needs

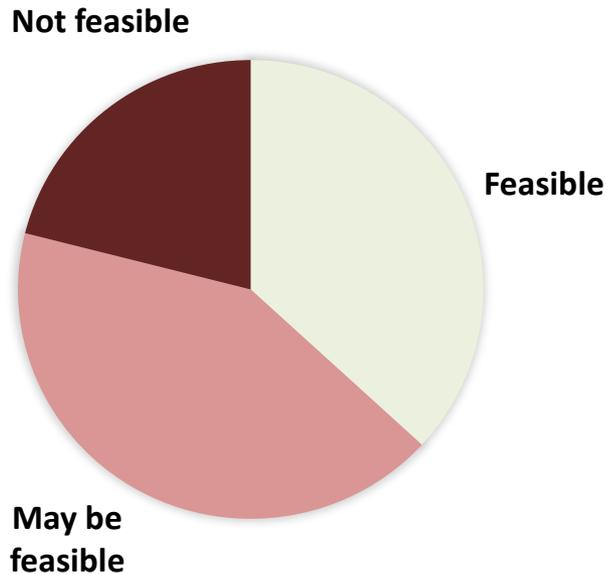


N = 19



Results Scenario 2

Working in multidisciplinary teams in the chronic care for children with asthma and complex needs



N = 19



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(A Study of Primary Healthcare in 30 European countries)

Results Scenario 2

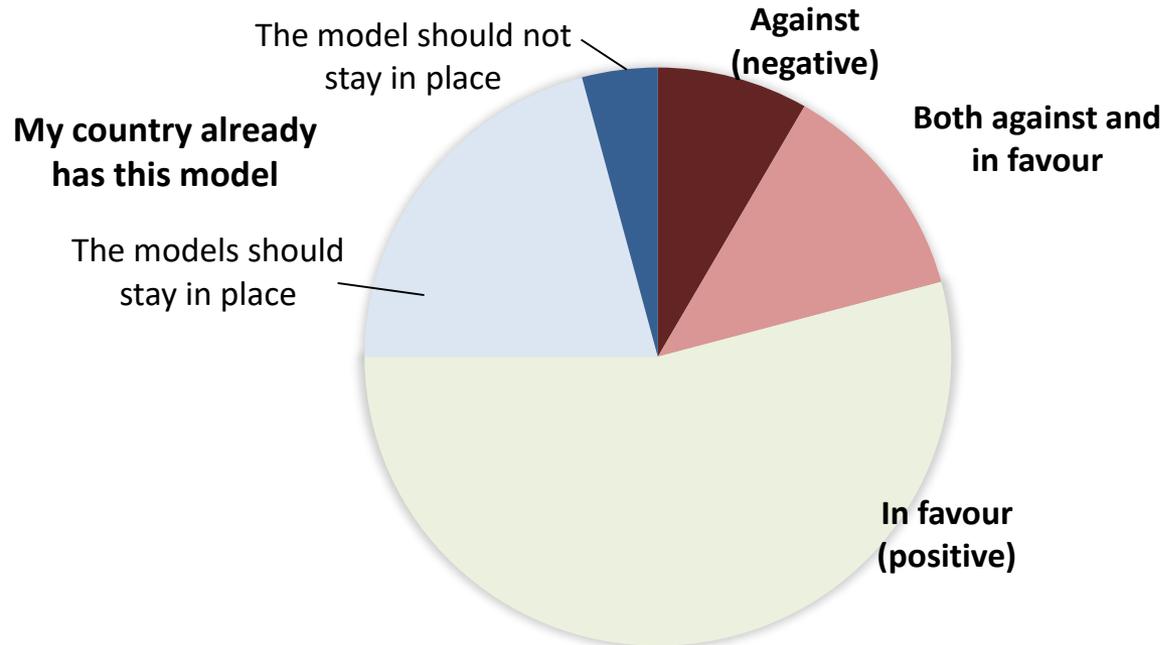
Working in multidisciplinary teams in the chronic care for children with asthma and complex needs

“Working in multidisciplinary teams is important. Clear task descriptions of team members working in the same setting/centre are important. Despite a willingness to cooperate and work in MDTs, a barrier might be the funding.”



Results Scenario 3

Confidential access for early identification of mental health disorders in adolescents

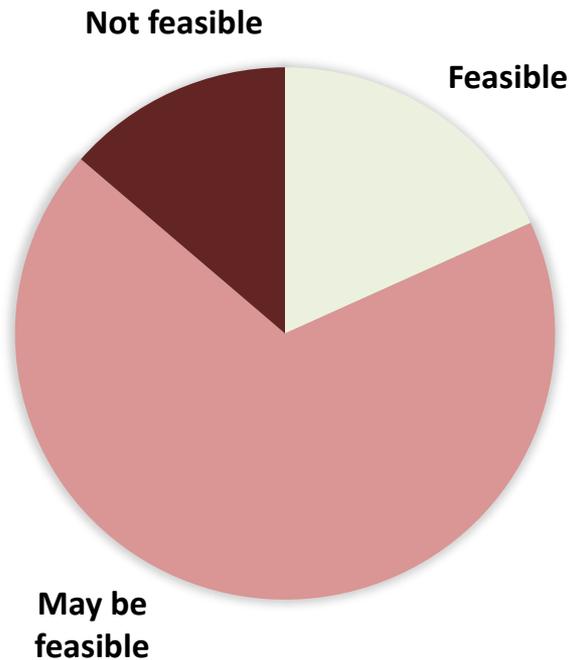


N = 24



Results Scenario 3

Confidential access for early identification of mental health disorders in adolescents



N = 24



Results Scenario 3

Confidential access for early identification of mental health disorders in adolescents

“Exchange of examples and good practices in the EU on open access to services for children with mental health problems helps to bring forward the harmonization of legislation and practices with regard to confidentiality.”

N = 24



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(A Study of Primary Healthcare in 30 European countries)

Conclusion

Specialized preventive health services	Working in multidisciplinary teams	Confidential access for adolescents
Quite positive	VERY positive	Quite positive
Quite feasible	Quite feasible	Not very feasible

- Need for improvements to the child healthcare system
- High level of agreement on three potential scenarios for improvement
 1. public access to information about vaccination
 2. open access to services for adolescents and confidentiality until treatment is in place
 3. coordination and continuity of care
 4. continuity of information on children's health status
 5. increase and training of the workforce.



Conclusion

- Primary care systems with open access seemed to have the highest demand for changing system components.
- GP-led gatekeeper systems, generally rated as strong primary care systems, felt the least urgency for transforming system components.
- Clear policy making and increase of resources could benefit systems' changes.



Public priorities for primary healthcare for children in five European countries

M.M. Boere-Boonekamp, J.A. van Til, C.G.M. Groothuis-Oudshoorn

Part of WP9: Validated Optimal Models of Children's Prevention-Orientated Primary Health Care



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Aim and Research questions

- Aim: to elicit formative values from the general public in European countries, to determine public priorities in the assessment of the quality of a child-oriented primary health care system
- RQ's:
 - What is the performance of currently provided primary care for children according to European citizens?
 - What are the priorities of European citizens in assessing the quality of primary care for children in Europe?



Method: Respondents

- Vehicle: Marketing agency, online recruitment and data collection
- Country selection: diversity in primary access point for primary care → ES, GE, NL, PL, UK (total n=2403)
- Attributes: accessible, affordable, appropriate, confidential, continuous, coordinated, empowering, equitable, transparent
- POCHA questionnaire:
 - background characteristics, health status, health care consumption
 - the perceived performance of the primary care system
 - the prioritization of the attribute-items



Performance: Satisfaction and Experiences

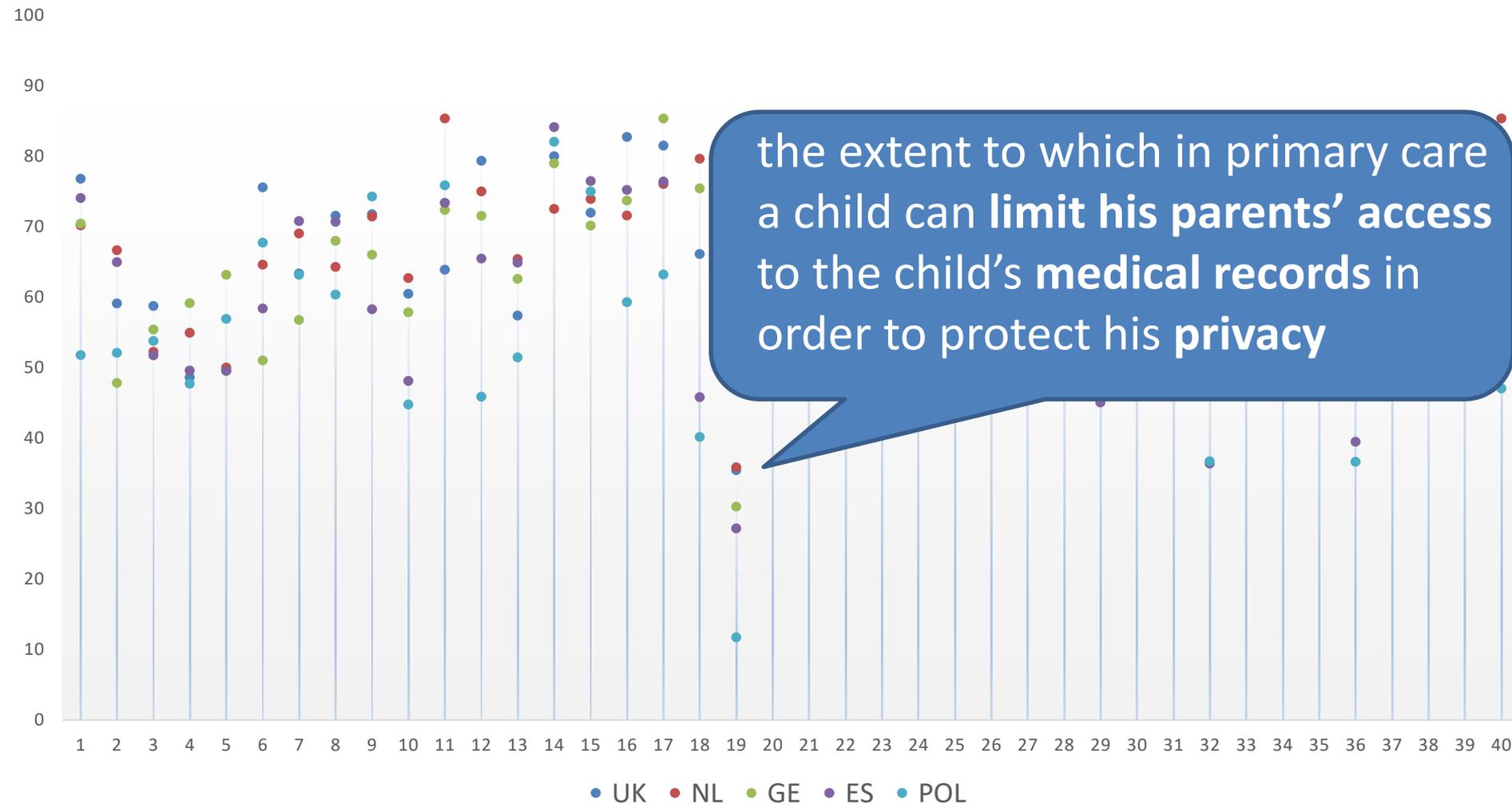
Satisfaction: “How satisfied are you with your current healthcare system?” → *scale of 1 (very dissatisfied) to 10 (perfectly satisfied)*

Experience/perception: “To what extent do you agree with the following statement?” → *5-point rating scale (strongly agree to strongly disagree)*

COUNTRY	OVERALL SATISFACTION SCORE		EXPERIENCE/PERCEPTION % agreement	
	Mean	SD	Average	Range
UK	6.99	1.72	68%	35-85%
NL	6.93	1.32	70%	36-86%
DE	6.94	1.73	64%	30-85%
ES	7.17	1.62	62%	27-84%
PL	5.47	2.20	56%	12-82%

Perceived quality per item per country

Normalized sum of respondents that either agreed or strongly agreed with the statement (1-40) on the high quality of care with respect to that attribute-item



Priorities

- Partial ranking technique of best-worst scaling
- 4 items per question, 2*10 questions; 8 versions of 10 BWS

Please select the characteristic that you consider most important, and the one you find the least important.

✓ ✓

Most important **Least important**

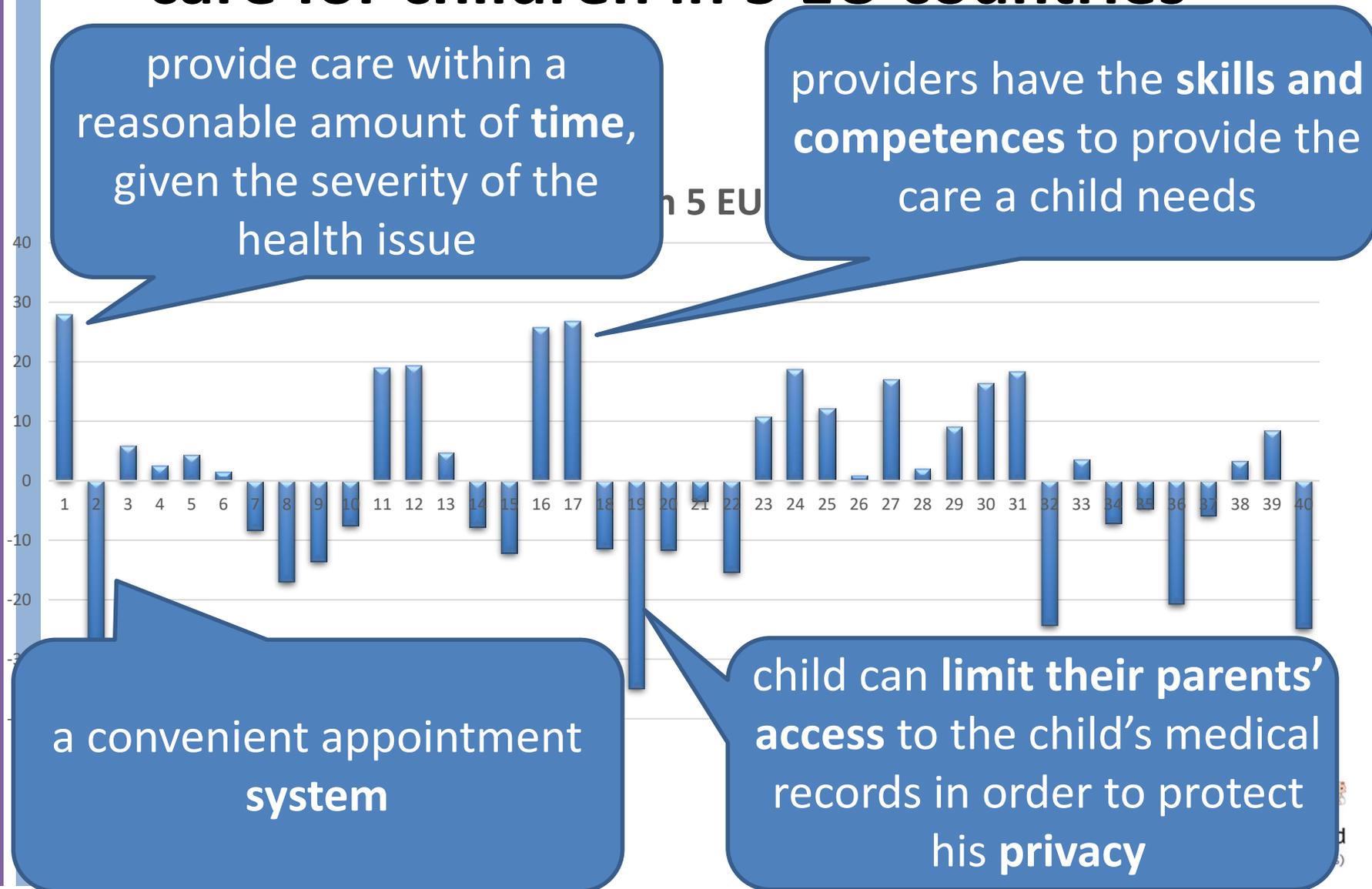
In primary care, a child's health problems are effectively managed

Primary care providers are easy to engage, considerate and non-judgmental of parents and children ✓

If a child needs specialised and long-term care, hospitals and primary care providers collaborate to offer care close to the child's home

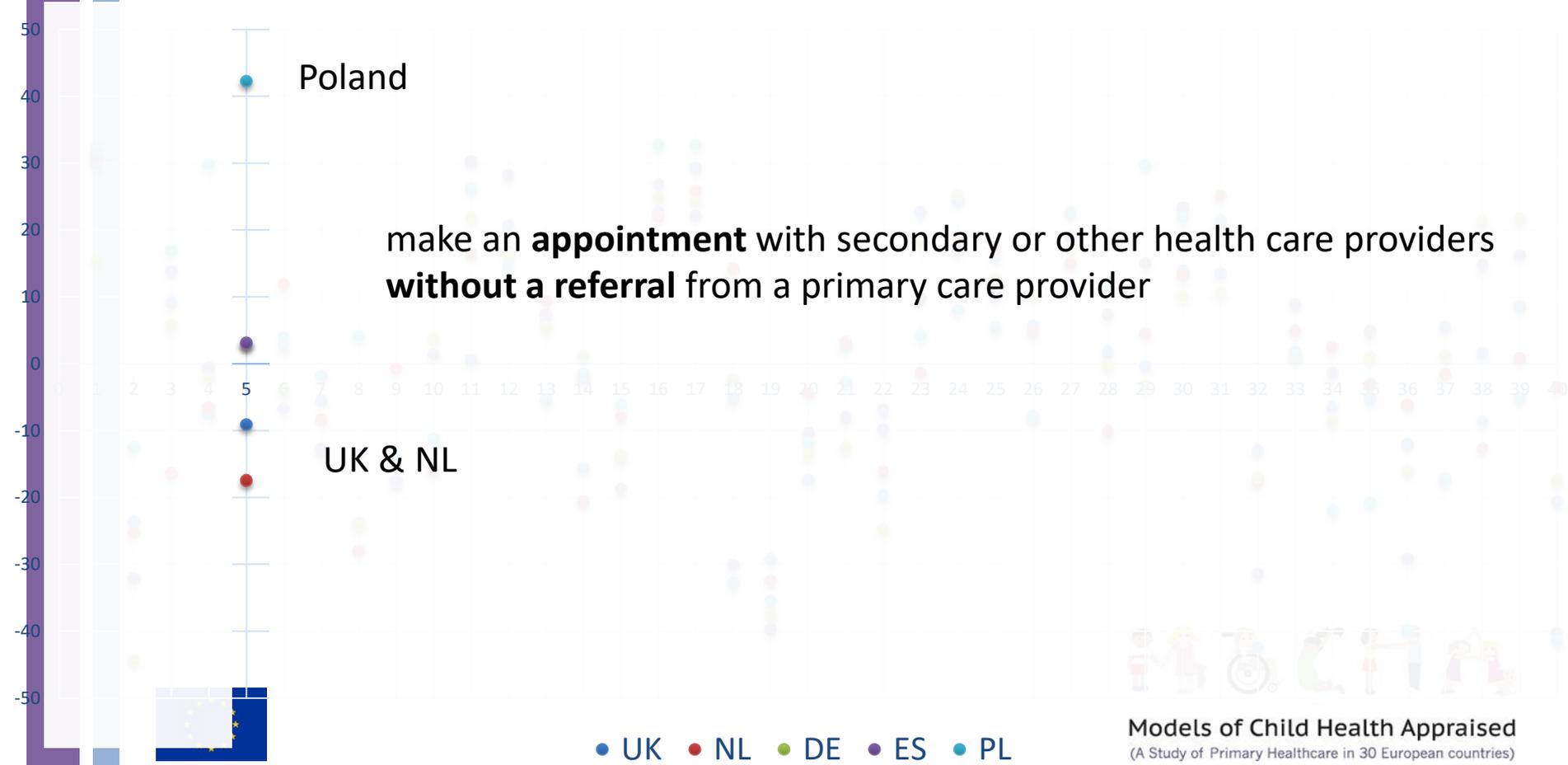
In primary care, children and/or their parents are involved in decisions about the management of the child's health ✓

Priorities for attributes of quality of primary care for children in 5 EU countries



Range of priority scores per attribute-item per country

Priority Scores per Item and per Country

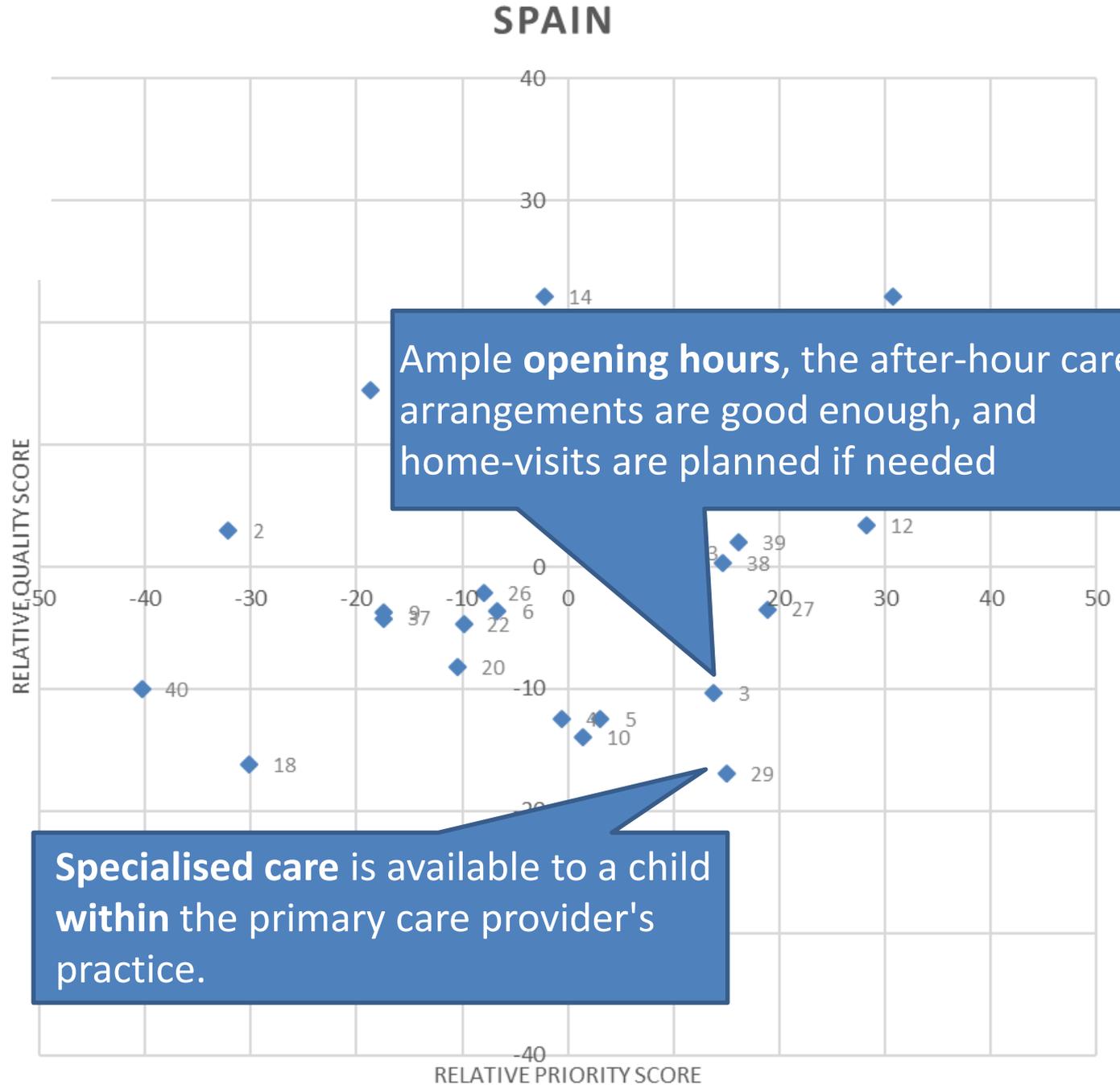


Range of priority scores per attribute-item per country

Priority Scores per Item and per Country



Example Spain: Priorities X Performance



Examples high priority & low performance:

UK | providers are able to dedicate enough time to working with a child

Germany | providers involved in the care of a child know about each other's involvement, trust each other and work well together

NL | children and/or their parents know about the range of services available in primary care and how they can access them

Poland | In primary care, the facilities and equipment are available to deliver the services that are needed for children

Conclusion

- Strengths and weaknesses of PC and public's priorities differ per country → potential for improvement differs per country





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Results Work Package 9 Task 5

Primary health care for children: how can policy makers facilitate good practice transfer?

Tamara Schloemer

on behalf of the team of Maastricht University



MOCHA Work package 9

Policy making for innovations in child primary health care

- **Overall task of WP9.5:** “Analysis of evidence based policy approaches and governance styles at the macro level in the area of primary child health care models to inform transferability”
- **Deliverables:**
 1. A governance framework for child primary health care
 2. A conceptual and a process model with systematized criteria for the assessment of transferability of child health care interventions





Deliverable 1

A Heuristic Governance Framework for the Implementation of Child Primary Health Care Interventions in Different Contexts in the European Union

Peter Schröder-Bäck^{a,b}, Tamara Schloemer^a, Timo Clemens^a, Denise Alexander^c, Helmut Brand^a,
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^f Public Health Department, Medical University of Lublin, Poland

Journal: [INQUIRY: The Journal of Health Care Organization, Provision, and Financing](#)

(under review)



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A Heuristic Governance Framework for the Implementation of Child Primary Health Care Interventions in Different Contexts in the European Union

Results:

Three dimensions of governance (GIM-governance):

Good governance

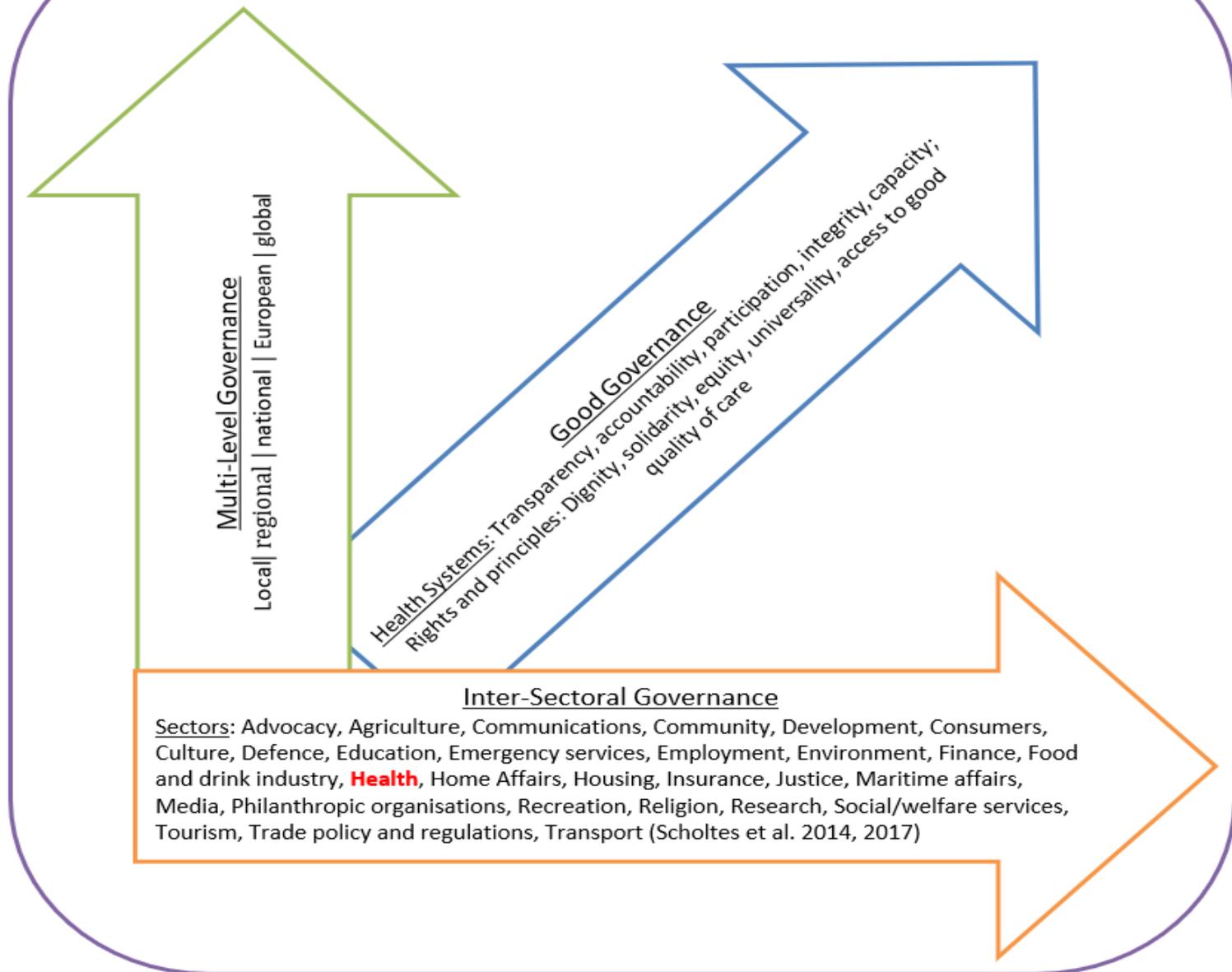
Intersectoral governance

Multi-level governance



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Goal: Effective relations & connections, policy coherence for the common good.



Deliverable 2

Systematic review | [Open Access](#) | Open Peer Review

Criteria for evaluating transferability of health interventions: a systematic review and thematic synthesis

Tamara Schloemer   and Peter Schröder-Bäck

Implementation Science 2018 **13**:88

<https://doi.org/10.1186/s13012-018-0751-8>  | © The Author(s). 2018

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<https://implementationscience.biomedcentral.com/articles/10.1186/s13012-018-0751-8>



Models of Child Health Appraised
(A Study of Primary Healthcare in 30 European countries)

Criteria for evaluating transferability of health interventions: a systematic review and thematic synthesis

Results:

Four themes for determining transferability:

Population

Intervention

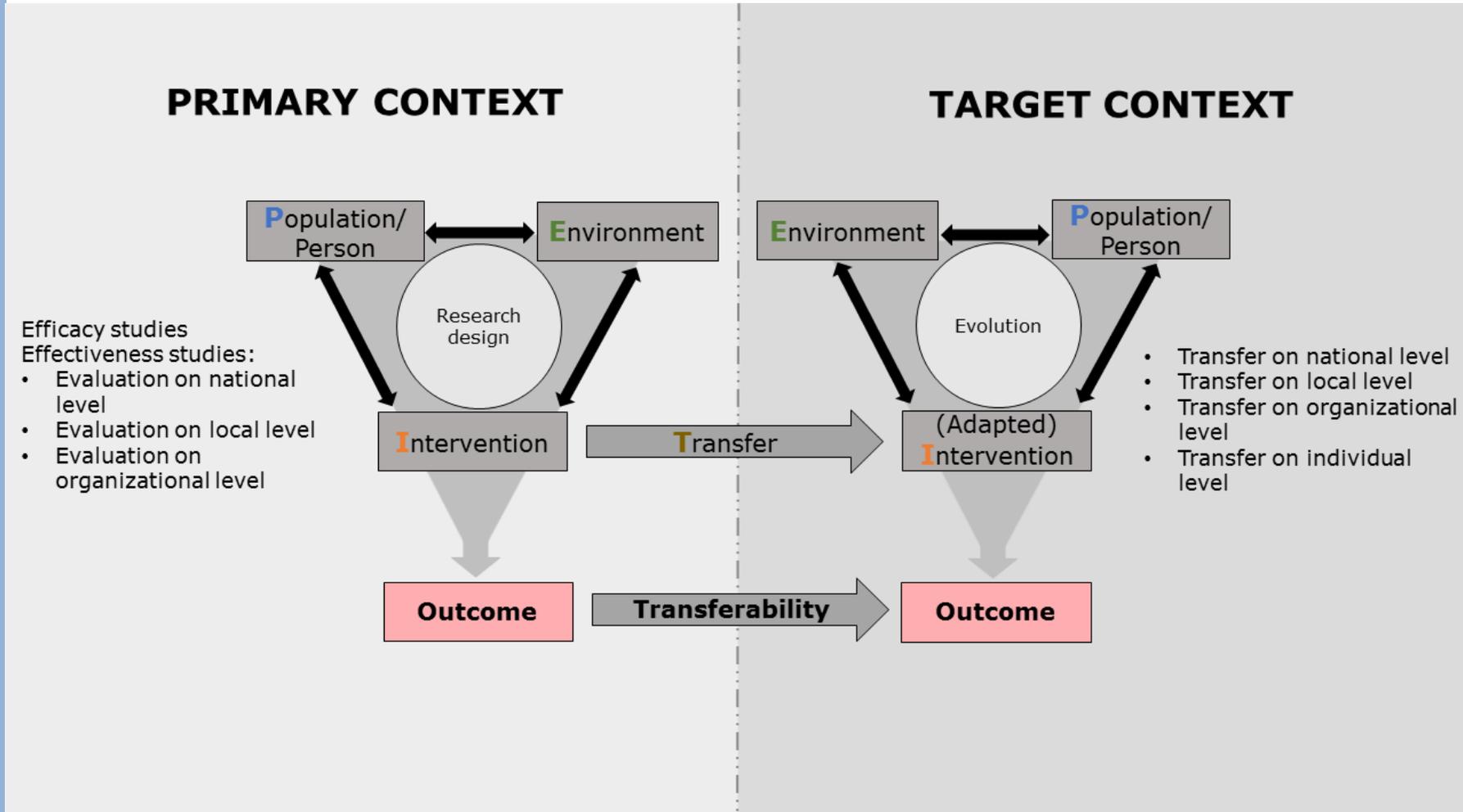
Environment

Transfer



Models of Child Health Appraised
(A Study of Primary Healthcare in 30 European countries)

Criteria for evaluating transferability of health interventions: a systematic review and thematic synthesis



P

Population characteristics

- Epidemiologic characteristics (health status)
- Sociodemographic characteristics
- Cultural/social (including individual) characteristics
- Cognitive characteristics
- Socio-educational characteristics

Perceptions of health and health services

- Health needs
- Cooperation between providers and recipients

Attitude towards the intervention

- Demand
- Motivation
- Acceptability

Local and organizational setting

- Physical/structural environment
- Synergistic/antagonistic interventions
- Local/organizational climate
- Organizational structure and practice
- Awareness and readiness in terms of organizational will
- Decision-makers'/leaders' perception of the intervention, skills, status, latitude for action
- Support of decision-makers/leaders and management
- Providers' perception and support

Coordination players

- Partners, networks
- Personal/professional interests of stakeholders

Policy/legislation

- National policy, programs
- Local policy
- Political climate/will
- Legislation

Health care system and service

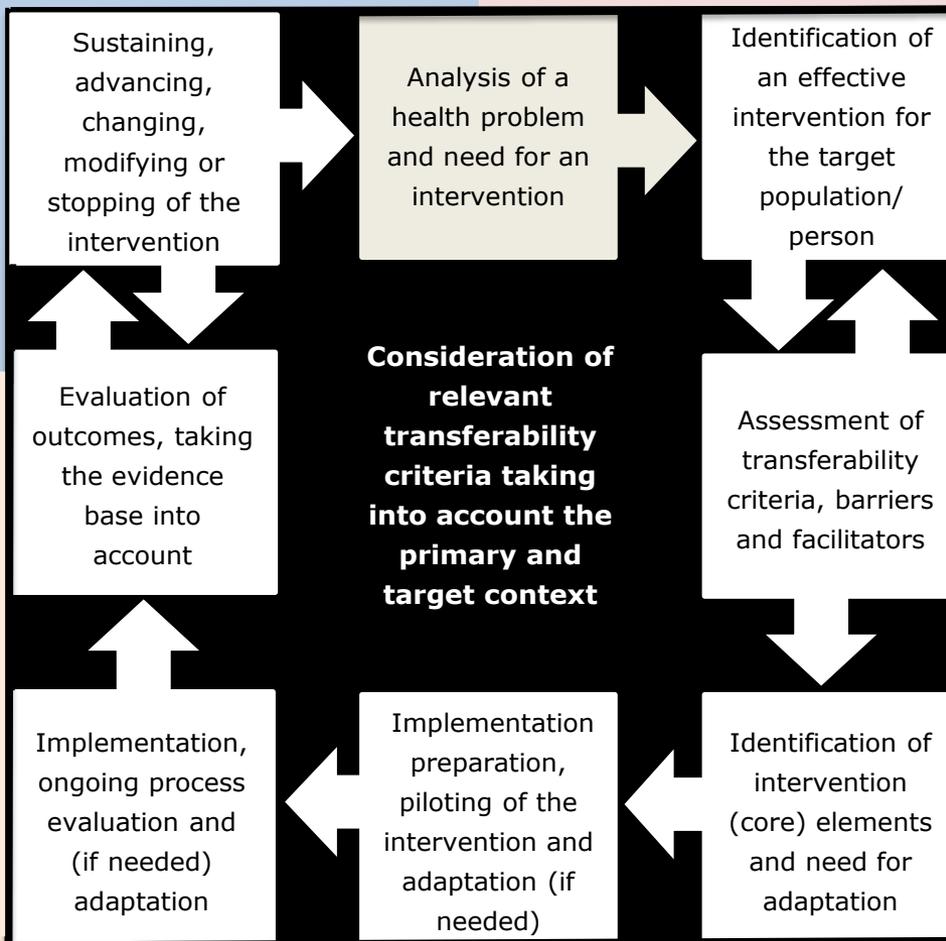
- Structure of the health care system and services
- Conditions of health service provision

Evidence base

- Utility/usefulness of primary evidence
- Quality of primary evidence

Intervention content

- Conception of the intervention in the primary and target context
- Possibility of adaptations by keeping the primary intervention's fundamental nature and intervention fidelity



Adoption/Implementation

- Strategies to reach the population
- Strategies to involve different stakeholders
- Addressing barriers/facilitators
- Strategies of service delivery
- Successful pilot-testing
- Process adaptations

Evaluation

- Evaluation/study design
- Assessment of processes and outcomes
- Similarity of determination of effects in both contexts
- Continuity/quality of evaluation

Sustainability

- Outcomes
- Practice change
- Key success factors
- Financing

Communication

- Overall communication by leaders for the coordination of transfer of an intervention
- Quality of communication in multidisciplinary work/teams

Knowledge transfer

- Existence of a knowledge transfer/ translation process regarding the intervention

E

T

Primary health care for children: how can policy makers facilitate good practice transfer?

Conclusions:

For realizing good practice transfer, policy makers

...should respect values for good governance in child primary health care

...need information about actors of multiple levels of governance and about intersectoral relationships of actors relevant for the effective implementation of innovative primary health care for children

...need well prepared information about transferability of child primary health care interventions



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This presentation reflects the author's view; the Commission is not responsible for any use that may be made of the information it contains.



Thank you for your attention!



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Enjoy your break!



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