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Special Article

Primary Health Care in Paediatrics

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Abstract This article reviews the changes in children's health care in the developed world as a result of improved physical health, increasing incidence of psycho-social disorder, rising public expectations, increasing levels of parental anxiety and lifestyle changes among parents and professionals.

Key words Children; Primary care; Psychological disorder

The challenges now being faced by paediatricians in the UK are similar to those being reported from a number of other developed countries from around the world. Although the health care systems of these countries may differ very widely, in all of them the changing patterns of morbidity and changing parental expectations are evolving more rapidly than the ability of health professionals to adapt their training and practice.

Demographic Changes

The UK has a population of some 60 million people. In 1971, roughly one quarter of the population was under 16 years of age. In 1996, this had shrunk to one fifth, and current projections suggest that by the middle of this century only one sixth of the population will be under 16 years of age. This means that there are fewer young people entering the labour market and a serious shortage of well educated young people is becoming apparent.

In parallel with this demographic change, the proportion of elderly people is rising and many more people are living into extreme old age. This change inevitably is accompanied by increasing demands for health care, and there is a political imperative to provide this in response to the power of the 'grey vote'. In the UK at least, there is a strong sense that the needs of the elderly population are taking precedence over the health care needs of children.

A related phenomenon is the increasing tendency of women to defer child bearing until their careers are well established, so that in middle class families many children are now born when their mothers are in their mid or late thirties or even forties. If this child should happen to be disabled and in need of life-long care by the family, we can predict that in view of the considerably increased survival of even the most profoundly handicapped child, we will within the next ten to twenty years have a number of families in the UK who are caring for a thirty or forty-year-old severely disabled adult while they themselves are in their seventies or eighties.

There are also changing patterns of morbidity. Many of the killer diseases of even twenty or thirty years ago have all but disappeared. Immunisation, better nutrition, better primary care and more aggressive secondary and tertiary care together mean that at least in physical terms our child population is healthier than ever before.

Changing Morbidity

There has however been an increasing awareness of other forms of morbidity. While there is no doubt that dramatic advances in neonatology have occurred over the past quarter

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century, the quality of life for many very low birth weight infants is impaired to a significant degree by a variety of subtle but very significant neurological deficits. Infants and children with a wide variety of congenital syndromes, biochemical disorders, and acute neurological insults are far more likely to survive. Much more is known about the needs of these children and young people than even a decade ago and much more can be done to improve their quality of life.

The most significant increase in morbidity is in psychosocial disorders. Emotional and behavioural problems have always been part of childhood and adolescence, but there is a strong perception that these are increasing, in response to the stresses of modern life, family disruption, changing attitudes to discipline, and the pervasive atmosphere of violence within modern western society. Problems of child abuse and neglect in a myriad of forms, conduct disorder, hyperactivity, depression, suicide, bullying etc affect a very substantial proportion of our child population.

Parental Expectations

Although the risk of a child dying from an infectious disease is probably lower than at any time in history, parental anxiety is very high. Stories in newspapers about meningitis and other killer diseases keep parents constantly in a state of tension about their children's health. The result is that although serious illness is actually less common, attendance rates at hospital emergency rooms have risen and many more children are admitted for increasingly short periods of observation in order to reassure parents. Recognising the genuinely sick child amidst this torrent of minor self-limiting illness becomes increasingly difficult.

There is an increasing tendency of parents to have only one child, carefully planned for and nurtured, often quite late in their own life and career; this means that every child is even more precious than was the case in the past and it is correspondingly more difficult for parents to accept that no medical care system is ever perfect and some conditions can not be treated or cured. This results in rising demand, increasing anger when things go wrong, more complaints, and more litigation. This in turn puts paediatricians under greater pressure and leads to an increasingly defensive attitude to practice.

Parents also expect a great deal more in the way of information now that they can access medical data so easily on the Internet. Thus whereas parents were once happy to accept medical advice that a child needed an immunisation or that their deceased child should have a post-mortem, now they expect a prolonged and lengthy discussion as to the pros and cons of various courses of action.

Similarly, parents are well informed about matters such as autism and chronic fatigue syndrome, and will not accept medical recommendations without contesting them and debating them at length.

All of these phenomena mean that the relationship between parents and professionals has changed very substantially. While this should be welcomed and has been comfortably absorbed as a new approach to practice by most paediatrians, it does nevertheless change the way in which professionals use their time, and leads to substantial increases in the workload.

Professional Attitudes

Professionals have accepted that the world is changing and that their style of practice must change with it, but at the same time they recognise that there is also a life outside medicine. The younger generation of health professionals now completing their training has no wish to work the long hours which characterised the lifestyle of their seniors. While they are eager and ready to give a high quality of clinical care, many of them are less willing to put in the additional long hours needed to develop academic research programmes, excellence in teaching, or the development of a large and complex paediatric service. These changing attitudes have to be accommodated in the way we plan our services.

Highly specialised care remains attractive to our brightest young doctors, particularly those with an interest in science and research. With increasing specialisation and a need to focus on a small area of work in order to advance scientific knowledge, it becomes increasingly important to have larger groups of specialists working together, so that the full range of disorders within a specialty can be covered by a team.

Inequalities in Health

A major theme of the UK government over the past 5 years has been inequalities in health. There is a great deal of evidence that social class has a major impact on health. Examples include a social class gradient in accidents and injuries, in admissions to hospital for a range of conditions, and the amount of time lost off school through illness. The

children of highest risk of poor outcomes are those in public care ('looked after' in UK terminology).

In order to address these inequalities, an important plank of UK government policy is to attempt to distribute health care and resources in such a way as to preferentially improve the lot of those in poverty. To do this there are a number of health and social care programmes, where the emphasis and leadership comes from social services and education, but health is an important player nevertheless.

New Patterns of Service

In the UK, most children are managed by general practitioners (family doctors) who work in population-based practices and are supported by a team including health visitors, school nurses and community midwives. This system is capable of delivering an admirable standard of care, but increasing difficulties in recruitment, the rising demands of patients in general and the elderly in particular, and uncertainties about how quality can be maintained, together contribute to much current anxiety as to whether this model is best for the 21st century.

We envisage that over the next twenty years, children will continue to receive non-acute care in the first instance from a general practitioner with sound paediatric training together with the practice nursing team. However, emergency and out of hours care will increasingly be delivered on a more centralised basis, initiated through a telephone triage system (NHS direct) followed up by face to face assessment in the majority of cases, at a Primary Care centre. The most effective and cost affective models for the emergency Primary Care centre seem to be those where the service is provided either in a very large health centre or within or close to an accident and emergency department.

In smaller towns and country areas, it will become increasingly difficult to sustain a traditional round the clock service run by fully trained paediatricians. Other models are being considered, such as a daytime assessment service and a nurse-led ward for minor illnesses, but with sick children being transferred to the nearest larger unit. Various forms of skill mix are being examined, such as the enhanced training of general practitioners to take on more paediatric duties, and the use of advanced nurse practitioners, particularly in neonatal units and perhaps also in accident and emergency departments.

There is an increasing need to bridge the gap between acute hospital care and long term care of disabling and chronic disorders in the community and several different training models are being examined to address this issue.

There is a need for population planning on a large scale to ensure that highly specialist and tertiary care services can be provided in the most economic and efficient way possible, generally based within a university teaching centre but with extensive arrangements for outreach, so that families do not have to travel long distances unless the child needs inpatient treatment or investigation. The support of these teams by nurses and parent advisors who can run a telephone hot line appears to greatly enhance the quality of care.

Finally, there is a major need to strengthen the provision of care for children and young people with emotional and behavioural problems. This cannot be achieved solely by expanding child psychiatry services and the use of other forms of professional such as the child mental health worker looks attractive. Closer links with education and social services are needed in order to provide the best possible forms of care for these young people, who in most instances do not have mental illness in the strict sense of the term but rather are distressed due to their circumstances.

Conclusion

Professionals have two options – to relish the changing demands on our services and see them as exciting new challenges that maintain the stimulus to learn and improve throughout one's career – or to imitate the ostrich and put one's head in the sand.