

COMMENTARY

## Challenges to 21st century paediatrics

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In this issue of *Acta Paediatrica*, a working group at the European Paediatric Association and the Union of National European Paediatric Societies and Associations (EPA/UNEPSA) examines the challenges and goals of 21st century paediatrics (1). The report focuses on the future of primary paediatric care in Europe.

Paediatricians in the 19th century had a very limited ability to cure disease. However, their skill when it came to describing clinical symptoms was well developed and our 19th century colleagues were able to provide good supportive care. During the 20th century, we saw a dramatic change in morbidity and mortality as a result of the development of vaccines and new medicines, most importantly antibiotics. Today, we are not only able to diagnose and care, we can often also cure.

Over the next few decades, the challenge for paediatricians in primary care is not only to consolidate the achievements that have been made but also to develop preventive medicine and health care. To do this, physicians and health-care staff caring for children must have the appropriate training and skills. The presence of paediatricians in primary care varies between the European countries and also within countries. We believe that a strong presence of paediatricians in primary care is in line with what young families want, as well as being cost effective (2).

However, in most European countries, a large percentage of the children in primary care is seen by general practitioners, GPs. For this reason, it is essential to include a

satisfactory paediatrics curriculum in the training of all the doctors in primary care. As things stand, this differs substantially. So the time GPs spend on paediatric training needs to be increased in many European countries, including Sweden. It is important that GPs are well acquainted with the preventive aspects of paediatrics in their work at child healthcare centres and schools, as well as in outpatient paediatric practice (3).

### THE NEEDS OF THE CHILDREN SHOULD BE THE GUIDING PRINCIPLE

Which age limits for paediatric coverage should be recommended? In many European countries, the upper limit has been extended from 16 years to 18, or even 19 years. In times of economic restraint, like now, it could be tempting for government-funded paediatric clinics once again to lower the upper age limit to reduce the number of patients requiring care. We think this is unwise and that it would have an unfavourable impact on paediatric patients. It will certainly not save costs. It will simply transfer costs within the healthcare system. Instead, as pointed out by the EPA/UNEPSA committee, the timing of transition to adult medicine for adolescents with chronic diseases should be adapted to match the best interests of the patient. In patients with chronic diseases, a smooth transition is particularly important to ensure continuity in medical care. It is the needs of the children and the families that should be the guiding principle for the timing of the transition!

A new challenge is the transition to adult medicine for paediatric patients with 'new' diagnoses. In current paediatric care, we have several groups of patients that did not previously survive to adult age or even the neonatal period,

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but now do so. Well-known examples of these diagnoses include bronchopulmonary dysplasia, as well as patients with cystic fibrosis and successfully treated oncological or cardiac diseases, among others. As a result, new units often need to be established to take over the care of these patients when they reach adulthood. As a rule, close co-operation between the paediatric and adult teams is needed to ensure good continuity.

At the low-age end of the spectrum, contributions by paediatric specialists like paediatric cardiologists and paediatric surgeons are essential in foetal medicine in cases of diagnosable and treatable conditions. When does a foetus become an infant? This thin line is relevant in the light of the immense progress that has been made in neonatal care. However, we feel this is more a question for paediatric sub-specialists than for the primary paediatric caretaker. In spite of this, one core aspect of paediatrics is prevention and it is well known that adverse effects on the foetus, by tobacco, for example, may have consequences for the child.

Unfortunately, our increased ability to cure has an economic price. New drugs and treatments are expensive and this imposes a strain on medical budgets (4). For example, modern science has provided us with the opportunity to save the lives of extremely premature babies. As the cost of intensive neonatal care is high, this raises the question of how much we can afford to spend to save life? What we do not know, at least not fully, is what the quality of these lives will be. For this reason, it is easy to question some of the efforts in neonatal intensive care and to suggest that the

money might be better invested in, for example, the welfare of endangered teenagers and adolescent health care. The authors touch upon this question. We personally find it difficult to put one patient category against another. However, the debate must be permitted. In addition to the medical issue, the question has ethical and political dimensions.

Finally, the report comments on the challenges that are presented by immigration from underprivileged areas of the world. This means that European paediatricians meet children with diseases with which they were previously unfamiliar and which they must now be able to diagnose and treat. Furthermore, the current situation in the suburbs of many large European cities calls for large-scale social paediatric programmes.

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