Examining Novel Health Care Delivery Innovations in Other Nations

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The article “Identifying Health Problems Using a Novel Triage Approach to Child Health Assessments” by Bezem et al is interesting for highlighting just how different patterns of health care delivery and utilization are across Western industrialized nations. In the specific arena of child health, different norms and expectations for health care services exist for both parents and health care professionals in different countries. This does not imply that one country’s system is “better” than another for the care of children. The nature of different populations, the history and philosophical outlook of societies and the priorities of spending of public funds all play a role in the structure and function of the health care system in each nation. As such, one must be cautious in identifying novel approaches in one country and attempt to implement them in another country that has fundamental differences in overall health system structure.

Both the baseline methods of assessment and the novel approach tested by Bezem and colleagues present a fundamental contrast to the US health system for children. In the United States, there is a highly variable approach to the delivery of screening and other preventive services in schools. This is due to many reasons, including the variation of funding for such programs across states as well as philosophical differences among parents, health professionals, and policy makers regarding the appropriate venue for the delivery of care. Although there are some school screening programs active today, with the exception of vision and hearing screening, they affect a relative minority of American children. Historically, the most common utilization of schools for health screening was associated with public health and communicable diseases, rather than individual health as in the Dutch example. For example, screening for tuberculosis was ubiquitous in the 1950s, and screening for lice was common in many schools. Likely because of its link to school performance, hearing and vision screening are the only widespread screening programs for individual conditions administered in schools across multiple states.

School-based health centers in the United States currently function mostly as a safety net provider and uncommonly provide population-based services. Furthermore, when these centers provide treatment of either acute or chronic conditions, concerns have often been raised as to whom would be responsible for ensuring the access to care for any child who screened positive for a specific condition. Lacking a national health care system, coordination of care in such a setting is difficult.

A second contrast is that, as in many European nations, the health care system in the Netherlands uses general practitioners to provide primary care to the entire population regardless of the age of the patient. In contrast, in the United States, primary care for ~80% of children is provided by general pediatricians. Although pediatric nurse practitioners and physician assistants provide care to children, they almost always do so

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within pediatric practices and under the supervision of a physician. However, the most fundamental philosophic difference between the US and Dutch health systems that make the widespread use of school screenings for individual health conditions problematic is the American emphasis and prioritization on the medical home for children. Pediatricians believe strongly that there is benefit to having a place where both preventive and acute primary care services are provided and coordinated. Some of those beliefs are based on practical issues such as the centrality of the medical record. Although there is a national goal to develop a medical record system that can share information seamlessly across sites of care, no such system currently exists. More fundamental is the belief that the medical home provides for an ongoing relationship among parents, patients, and pediatricians. This type of relationship is thought to create an environment of both trust and confidence in the disclosure of information that may be sensitive in nature. Specifically in the Dutch example, some behavioral problems may be more likely to be disclosed in an environment where a long-standing relationship with a provider in a specific practice, either physician or nurse, exists.

Different nations and different populations have different expectations of their health care system based on multiple issues, including its financing and structure as well as cultural norms. Although some aspects of systems may appear more or less rational than others across state or national boundaries, there is no perfect system. Learning about new systems of care in other nations can be illuminating, both for the potential of gaining ideas for the incremental improvement of our own system and also for the challenge of continually attempting to improve the lives of children worldwide.

REFERENCES

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