Πρωτοβάθμια Φροντίδα Υγείας
Πρωταρχικό μέλημα σε ένα μεταβαλλόμενο κοινωνικό-οικονομικό περιβάλλον

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17th ANNUAL CONFERENCE
HEALTHWORLD 2018
Health in the Post-Memorandum Era

MINISTRY OF HEALTH
efpia
MedTech Europe
ΣFEE
SEIU
Pressures on health systems

- **demographic change**
  (the effects of population ageing)

- **changing epidemiology**
  (the rising burden of chronic disease)

- **new technologies**
  (plus their interoperability and standardisation)

- **patient empowerment**

- the effects these various pressures have on **health spending**
I. Primary Health Care is essential to improve health

II. Primary Health Care is essential to the success of and sustainability of health systems

III. Primary health care is essential to achieving Universal Health Coverage and Sustainable Development Goals
Primary Health Care is essential to improve health

- Decades of evidence demonstrate that health systems based on primary health care provide **better population and individual health**.

- Countries that successfully implement quality primary health care reap health benefits beyond what would be expected for their level of development.
Primary Health Care is essential to the success of and sustainability of health systems

Health systems focused on quality primary health care improve
- health equity
- coverage of services
- cost-effectiveness and efficiency
- people’s experience of care
compared with those that over emphasize specialty care.

For Universal Health Coverage to be effective and sustainable, health services must be organized in an integrated fashion, with quality primary health care delivering the vast majority of care, thus stewarding critical health resources and enabling progressive realization of coverage.

Reorientation of health systems away from overemphasis on curative care, disease-specific programs, highly-specialised services, and commercialization.

The unregulated expansion of the private sector, fragmentation of services, less access to care for those who need it most, rising costs and over-medicalization must be reversed.

DRAFT Declaration
Second International Conference on Primary Health Care: Towards UHC and the SDGs
Astana, Kazakhstan 25-26 October 2018
Universal attributes of high-quality primary health care, fit for the 21st century

• addresses the health problems of individuals **in the context of their family** circumstances, their social and cultural networks, and life in the local **community**

• geographically and financially **accessible**, people’s **first access point** to the health system for most needs

• context-appropriate **comprehensive** care for the majority of health needs people experience throughout their lives

• foundation to **integrated** service delivery, **coordinating** with other levels of services and other sectors including specialized care, acute inpatient care, long term care facilities, traditional and complementary medicine, public health and social services

• **continuous**, enabling enduring and empowering relationships between people and their providers and promoting self-care

• **people-centred**, respectful of and responsive to individual and social preferences, needs, goals and values, and sees the **individual as a whole**, within their biological, psychological, and community context
ΠΦΥ στην Ελλάδα, υπάρχει;

Ο Prof. Wim Van Lerberghe
(WHO, Chief Editor WHO 2008 World Report “Primary care, now more than ever”) ανέφερε στο ελληνικό Κοινοβούλιο (2014) αυτό δεν μπορεί να συμβεί, διότι πολύ απλά η Ελλάδα δεν είχε αναπτύξει ποτέ Πρωτοβάθμια Φροντίδα Υγείας” αυτό δεν μπορεί να συμβεί, διότι πολύ απλά η Ελλάδα δεν είχε αναπτύξει ποτέ Πρωτοβάθμια Φροντίδα Υγείας”

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όταν βουλευτές ορισμένων κομμάτων, αλλά και συνδικαλιστές διαμαρτύρονταν ότι όταν βουλευτές ορισμένων κομμάτων, αλλά και συνδικαλιστές διαμαρτύρονταν ότι με το παρόν νομοσχέδιο η κυβέρνηση καταστρέφει την ΠΦΥ”
Primary Health Care, Now more than ever. WHO World Health Report 2008
Fragmented healthcare system

Patients can access any service they wish to

Problems in continuity and co-ordination...

Table 1: Directly accessible health services providing first contact care

<table>
<thead>
<tr>
<th>Health service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient departments of public hospitals</td>
<td>134</td>
</tr>
<tr>
<td>Rural health centres</td>
<td>201</td>
</tr>
<tr>
<td>Regional rural clinics</td>
<td>1460</td>
</tr>
<tr>
<td>Special regional rural clinics</td>
<td>38</td>
</tr>
<tr>
<td>EOPYY clinics</td>
<td>150</td>
</tr>
<tr>
<td>Diagnostic centres</td>
<td>4000</td>
</tr>
<tr>
<td>Private physicians</td>
<td>25,500</td>
</tr>
<tr>
<td>Private dentists</td>
<td>12,586</td>
</tr>
<tr>
<td>Private clinics</td>
<td>175</td>
</tr>
<tr>
<td>NGO health foundations</td>
<td>400</td>
</tr>
<tr>
<td>Municipal clinics</td>
<td>80</td>
</tr>
</tbody>
</table>

Source: presentation by N Bechrakis.²³
Η μη ικανοποιούμενη ανάγκη για ιατρική περίθαλψη είναι πολύ υψηλή, ειδικά για τους αδύναμους...
Αυξανόμενο χάσμα ανισότητας στην αυτοαναφερόμενη μη ικανοποιούμενη ανάγκη λόγω κόστους.
• Improve population health

• Accessible for all

• Effective in terms of quality outcomes and experience

• Resilient to changing environments and future challenges

*The debate has shifted from how to invest more to how to invest better*

State of Health in the EU. ec.europa.eu/health/state
5 key conclusions

• **Health promotion** and **disease prevention** pave the way for a more effective and efficient health system

• **A strong primary care guides patients through the health system** and helps avoid wasteful spending

• **Integrated care** tackles a labyrinth of scattered health services to the benefit of the patient

• **Proactive health workforce planning** and forecasting make health systems resilient to future shocks

• **The patient is at the centre** of the next generation of **better health data** for policy and practice

State of Health in the EU. ec.europa.eu/health/state
Prevention is better than cure

- Prevention is the key to avoid ill health and achieve a high level of mental and physical well-being effectively and efficiently.

- A shift in focus from sickness and cure to prevention and the social determinants of health is needed.

State of Health in the EU. ec.europa.eu/health/state
Figure 1.1. Regular physical activity is less common amongst low income groups in the vast majority of Member States

Source: Eurostat. Note: Indicator shows the 2014 share of 18- to 64-year-olds in the lowest (first) and highest (fifth) income quintile spending at least 150 minutes per week on (non-work-related) physical activity.

Figure 1.2. Education strongly determines the likelihood of having had a breast exam in over a half of the Member States.

Source: Eurostat. Note: Indicator shows the 2014 share of women aged 50 to 69 years that reported having had a breast examination less than two years ago. Low education is anything below upper secondary attainment (ISCED 0-2), whereas high education is tertiary attainment (ISCED 5-6).

Strong PHC

- affordable and accessible care
- coordinating care so that patients receive the right care in the right place
- reducing avoidable hospital admissions
- supporting primary and secondary prevention
- focusing on individual needs so as to offer tailored, person-centred care
- important role in reducing health inequalities and improving the conditions of disadvantaged groups

Primary care is team work, with the patient at its core

- evidence consistently shows the importance of support staffs, cooperation and multi-disciplinary team practice, so as to
  - improve accessibility
  - broaden the supply of services

- Practices that group different professions and promote multi-disciplinary team working are generally associated with
  - better patient outcomes
  - reduced hospitalisation
  - enhanced patient and staff satisfaction
  - better care coordination and quality.

The right incentives help shaping effective primary care

- It can guard against under-provision of primary care and other barriers to access, but also avoid inappropriate use of secondary care and hospital services.

- **only few countries rely on a single payment mechanism** for primary health care, since this creates challenges to achieving an optimal task profile and an optimal mix of services that will best improve health outcomes.

- **fee-for-service** may lead to inefficient over-provision of services
- **salary systems** tend to incentivise under-provision of services
- **capitation** may lead to a preference for less demanding patients, thereby reducing attention to clinical needs

- the trend in EU countries is toward **mixed solutions**, which best meet new **health care needs** and different **policy goals**.

- **innovative forms of payment mechanisms such as pay-for-coordination and bundled payment** to encourage care coordination and continuity, and improve care delivery for patients with chronic illnesses Profiles (e.g. France, the Netherlands and the United Kingdom)

Η περίπτωση της Πορτογαλίας στην ΠΦΥ δείχνει γιατί δεν πρέπει να προχωρήσουμε σε κρατικές δομές ΠΦΥ με μισθωτούς οικογενειακούς ιατρούς.

Λειτουργούν στην Πορτογαλία παράλληλα:

- κρατικές δομές με μισθωτούς ΟI (UCSP) - κατάλοιπα από το παρελθόν και

- νέου τύπου κρατικές δομές με συμβεβλημένους ΟI που αποζημιώνονται με σύγχρονα μικτά συστήματα αποζημίωσης, ευαίσθητα στην απόδοση σε σειρά δεικτών (USF A, B) - προϊόντα της μεταρρύθμισης στην ΠΦΥ

- Τα αποτελέσματα υπέρ των δεύτερων απέχουν παρασάγγας.
Ποσοστό γυναικών 26-65 ετών που έχει υποβληθεί σε παπ-τεστ την τελευταία τριετία
Ποσοστό γυναικών 50-70 ετών που έχει υποβληθεί σε μαστογραφία τα τελευταία 2 έτη.
Ποσοστό υπερτασικών ασθενών με ρυθμισμένη Αρτηριακή Πίεση

<table>
<thead>
<tr>
<th>Χώρος</th>
<th>2012</th>
<th>2013</th>
</tr>
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<tbody>
<tr>
<td>UCSP-M</td>
<td>35,4</td>
<td>37,8</td>
</tr>
<tr>
<td>USF-A</td>
<td>52,6</td>
<td>53,8</td>
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<tr>
<td>USF-B</td>
<td>64,0</td>
<td>65,2</td>
</tr>
<tr>
<td>Todas ARS</td>
<td>45,3</td>
<td>48,0</td>
</tr>
<tr>
<td>Todas UF-M</td>
<td>45,3</td>
<td>48,0</td>
</tr>
</tbody>
</table>
Ποσοστό ρυθμισμένων διαβητικών

<table>
<thead>
<tr>
<th>Εργαστήριο</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCSP-M</td>
<td>37.8</td>
<td>41.5</td>
</tr>
<tr>
<td>USF-A</td>
<td>59.8</td>
<td>61.6</td>
</tr>
<tr>
<td>USF-B</td>
<td>68.6</td>
<td>70.3</td>
</tr>
<tr>
<td>Todas ARS</td>
<td>49.3</td>
<td>53.0</td>
</tr>
<tr>
<td>Todas UF-M</td>
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</tbody>
</table>
Φαρμακευτική δαπάνη
Two-tiered system with increasingly divergent levels of care quality

- **Primary Care Quality** doesn’t appear to be evenly distributed across the Portuguese system, with some concerning disparities in quality and outcomes between PHCUs and FHUs.

- **Balance between traditional Primary Health Care Units and the innovative Family Health Units** is now needed to ensure that high quality care can be accessed by the whole Portuguese population.
Gatekeeping and referral function of PC

- can ensure the most appropriate level of care to patients and reduce wasteful spending

- associated with a lower overall utilisation of health services and lower expenditure

- not primarily about cost-containment or rationing care, but rather about properly navigating the patient across the health system, contributing to effectiveness, accessibility and resilience along the way-

- particularly essential for patients with complex needs, who are likely to navigate between different parts of the health system over a longer period of time

2014 report of the Expert Panel on effective ways of investing in health.
"using financial incentives to encourage patients to register with a general practitioner (GP) or family doctor and using a referral system to define a cost-effective path of care: from GP, to outpatient specialist, to hospital, to emergency care, while encouraging patients to have less recourse to unnecessary care and emergency services”

Suggested measures for Investing in Sustainable Health Systems two clear recommendations for Member States:
• Reducing the unnecessary use of specialists and hospital care
• Improving primary healthcare services

“Investing in Health - Key Messages”, European Commission, DG Health and Consumers; February 2013
Figure 2.3. Mandatory primary care referrals indicate strong gatekeeper systems in half of the Member States

Source: Health at a Glance: Europe 2016 (based on Table 2.1).
When a patient consults a specialist to whom he has been referred by his doctor, the Health Insurance covers 70% of the "Safely" rate less the fixed contribution (€ 1).

Outside this care path, the level of support for a consultation by the Health Insurance is only 30% instead of 70%.

This difference in level of care is intended to encourage patients to use their doctor. The role of the personal doctor is indeed to guide his patient, according to his need, in his course of care.
Integrated Care

- The rising burden of chronic disease and multimorbidity requires tackling the complexity and fragmentation of services.
- Includes any initiatives seeking to improve outcomes of care through linkage or coordination of services and providers along the continuum of care.

Creating a health workforce resilient to future challenges

• depends on a health workforce of **sufficient capacity** and with the **right skills and flexibility** to meet the changing demands of health care.

• many countries are confronted with **critical health workforce problems** such as supply, distribution and a traditionally oriented skill mix.
Ελλείψεις σε νοσηλευτικό προσωπικό, δυσανάλογα μεγάλος αριθμός ιατρών
GPs <<< specialists....


8.7. Generalists and specialists as a share of all doctors, 2015 (or nearest year)

1. Generalists include general practitioners/family doctors and other generalist (non-specialist) medical practitioners.
2. Specialists include paediatricians, obstetricians/gynaecologists, psychiatrists, medical, surgical and other specialists.
3. In Ireland and Portugal, most generalists are not GPs ("family doctors"), but rather non-specialist doctors working in hospitals or other settings.

The EU exodus: When doctors and nurses follow the money
Not every country can reward graduates equally, so medical professionals leave.

Ginger Hervey, 9/27/17, Politico
Dear Doctor:

We are currently starting a Training and Recruitment programme for European Family Medicine Doctors interested in working in the United Kingdom.

Here is the summary of the programme:
- Sponsored by NHS England
- £30,000 GBP per salary during first 3 months training and full salary of 79,000 GBP in excess after training
- Option to work as Locum with rates up to 100 GBP per hour
- No IELTS required to join
- Full support with GMC Registration and getting on the National Performers List

First interviews will be already held in May 2018.

Please let me know here or by e-mail if you would be interested?

kind regards:

Greg

dr Grzegorz Chołkowski
CEO | MedPharm Group
E: greg@medpharmgroup.net
T: +48 690 536 971

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**JOB OFFER: FAMILY DOCTORS IN SOUTH SWEDEN**

The GP clinics in South Sweden are looking for specialists in Family Medicine. The primary care centres are modern and well-equipped.

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2. The salary

In general, doctors in Scandinavia are paid better than in other parts of Europe. GPs in Sweden are not only paid better than in other parts of Europe but better than the rest of the specialists in Sweden. Most doctors in Sweden get paid between €6K and €6,5K per month, whereas a GP gets paid around €1K more because they have one of the most important roles in **Swedish healthcare.**
Better health data contributes to patient outcomes whilst reducing wasteful spending in health care

**Addressing an important knowledge gap with better, patient-centred data**

From more data to better data
### Examples of comparative key-indicators along its key domains

<table>
<thead>
<tr>
<th>Domains</th>
<th>Examples of Indicators</th>
</tr>
</thead>
</table>
| 1) Universal and accessible | • % of population fully covered or insured for PC costs and medicines prescribed in PC  
• Total expenditure on PC as % of total expenditure on health  
• Amount patients have to pay for a GP consultation and amount reimbursed  
• % of patients who rate GP/PC Team care as not very or not at all affordable  
• Difference between region, province or state with highest and with lowest GP/nurse/social worker/... density  
• Average number of days waited to see a GP/PC provider when confronted with a health problem |
| 2) Integrated               | • Extent to which GPs/PC Teams carry out preventive activities such as: Testing for STDs; Screening for HIV; Influenza vaccination for high-risk groups; Cervical cancer screening; Breast cancer screening; C/V risk assessment.  
• Is there a structured cooperation between PHC and social care?  
• Does the pharmaceutical care integrate the contribution by GP/community pharmacist/nurse e.g. through an integrated pharmaceutical record?  
• to what extent are disciplines like occupational therapy, physiotherapy, speech therapy,... integrated in PC Teams? |
| 3) Person-centred           | • Duration of regular visit (minutes) of different types of providers  
• % of patients who rate that they -i) trusted the GP/nurse/social worker/...;  
- ii) were involved in shared decision making ;  
- iii) were satisfied with PC visit. |
## Examples of comparative key-indicators along its key domains

<table>
<thead>
<tr>
<th>Domains</th>
<th>Examples of Indicators</th>
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</thead>
</table>
| 4) Comprehensive and community oriented     | • Extent to which patients visit a GP for first-contact care for specific health conditions; people with a first convulsion; suicidal inclinations; alcohol addiction problems.  
  • Is FP/GP the only medical discipline in PHC?  
  • Are there activities related to Community Oriented Primary Care?  
  • Is there palliative care at home organised? |
| 5) Addressing personal health needs (provide high quality PC) | • % of infants vaccinated within PC against e.g. DTP; measles; hepatitis B; MMR; % population aged 60+ vaccinated against flu; HPV vaccinations  
  • The defined daily doses of antibiotics use in ambulatory care per 1000 inhabitants  
  • % of individuals with COPD or asthma who have had a lung function measurement during the last year  
  • % of diabetic population with blood pressure >140/90 mm Hg observed in the last 12 months  
  • % of patients stating that the treatment contributed to achievement of their life-goals |
| 6) Sustained partnership with patients and informal caregivers | • % of informal caregivers who receive support from primary care  
  • % of patients reporting help by informal caregivers  
  • Presence of organisations of informal caregivers in a community |
<table>
<thead>
<tr>
<th>Domains</th>
<th>Examples of Indicators</th>
</tr>
</thead>
</table>
| 7) Coordination of people’s care | • Is there a gate-keeping system (access to specialists through referral)?  
• Do patients need a referral to access the paramedical and nursing disciplines, to access social care?  
• Is it common for GPs to have regular (electronic) face-to-face meetings (e.g. at least once per month) with the following professionals? Other GP(s); Practice nurse(s); Nurse practitioner(s); Home care nurse(s); Midwife/birth assistant(s); PC physiotherapist(s); Community pharmacist(s); Social worker(s); Community mental health workers; medical specialists |
| 8) Continuity of people’s care | • Do GP-practices have a patient list system? Or another form of defined population?  
• % of patients reporting to visit their usual PC provider for their common health problems  
• % of GPs/PC Teams keeping electronic clinical records for all patient contacts routinely.  
• % of patients who are satisfied with their relation with their GP/PC provider  
• Do PC practices receive information within 24 hours about contacts that patients have with out-of-hours services? |
| 9) Primary care organisation | • PC payment system, revenues, and operating costs  
• % of income of GPs through FFS, Capitation, Salary, P4P  
• Average income of GP compared to average income of specialist; of PC nurse compared to hospital nurse,...  
• Quality control audits  
• Clear Vision and Mission statements of PC Teams  
• Existence of continuous quality improvement processes  
• Is there an organisation at meso-level of the support structures for PC, e.g. in Primary Care Zones,...  
• Is there an organisation at macro-level of PC e.g. a regional/national Institute for PC? |
| 10) Human resources in primary care | • Average number of working hours per week of GPs/nurses/pharmacists/social worker.  
• Average age of practising providers in PC  
• Total number of active GPs as a ratio to total number of active physicians  
• Total number of nurses active in PHC compared to total number of nurses in PHC, secondary and tertiary care |
EOPYY will change the way it provides primary health care by introducing **compulsory patient registration** with a **family doctor**, who will act as a **Gatekeeper** in charge of **referrals to specialists**. This shall become fully operational (key deliverable) by 1st January 2018.

**Roll out of Primary Care**

The authorities will adopt the necessary legislation of the roll-out of Local Health Units (**TOMYs**) by May 2017.

Establishment of at least 240 **TOMYs** by June 2018, thereby achieving coverage of 35% of the total population.
Βήμα προς ισχυροποίηση της ΠΦΥ

• εγκαθίδρυση του θεσμού του οικογενειακού ιατρού (ΟΙ)
• δωρεάν πρόσβαση στον ΟΙ για όλους τους πολίτες
• καθορισμένο πληθυσμό ευθύνης
• με λειτουργία gatekeeping- υποχρεωτική η παραπομπή από τον οικογενειακό γιατρό προς εξειδικευμένη φροντίδα, περιπατητική ή νοσοκομειακή.

προάγουν τις θεμελιώδεις αξίες της ΠΦΥ- 4C’s (Starfield)
• προσβασιμότητα πρώτης επαφής (first Contact accessibility)
• συνέχεια στη φροντίδα (Continuity)
• ολιστική φροντίδα (Comprehensiveness)
• συντονισμό στη φροντίδα (Coordination)

Βάζουν σε τάξη στις άναρχες ροές ασθενών στο μέχρι τώρα κατακερματισμένο σύστημα με τα πολλαπλά σημεία εισόδου.

Επιτυγχάνουν την καθολική κάλυψη υγείας του πληθυσμού σε επίπεδο ΠΦΥ - παγκόσμια προτεραιότητα – Sustainable Development Goal και ιδιαίτερα κρίσιμη για τη χώρα με τη μαζική απασφάλιση
Δημόσιο vs κρατικό...

- Το σύστημα της ΠΦΥ οφείλει να έχει δημόσιο χαρακτήρα, όχι όμως και κρατικό...

- Δίνεται προτεραιότητα στην κάλυψη του πληθυσμού μέσω των δημόσιων δομών και ΌΧΙ στις προτιμήσεις του πολίτη!

- Στη χώρα μας, με το πυκνότερο δίκτυο ιδιωτών ιατρών στα αστικά κέντρα στον κόσμο, φαντάζει πολύ πιο πρόσφορη λύση η σύναψη συμβάσεων του ΕΟΠΥΥ με αυτούς, παρά η δημιουργία εξ αρχής νέων κρατικών δομών με παράλληλα παροπλισμό των ήδη υπαρχόντων δομών και εξοπλισμών...

- Η χρηματοδότηση μέσω ΕΣΠΑ θα μπορούσε να αφορά την παροχή κινήτρων στους γιατρούς για συνενώσεις και δημιουργία group practices που αποτελεί διεθνώς την επιθυμητή δομή ΠΦΥ
Δημόσιο vs κρατικό...

• Αν αποφασίσεις να δημιουργήσεις κρατικές δομές ΠΦΥ, παράλληλα με τη λειτουργία ιδιωτικών δομών, και στόχος σου είναι η ποιότητα της φροντίδας, δώσε την ευκαιρία να παίξουν με ίσους όρους και να αναπτύξουν υγιή ανταγωνισμό μεταξύ τους...
Δεν επιτρέπεται η μεροληψία υπέρ του κρατικού...

• Στο τέλος της τετραετίας δες ΠΟΙΟΤΗΤΑ+ ΑΠΟΔΟΤΙΚΟΤΗΤΑ:  
- ποιες είναι οι προτιμήσεις και οι απόψεις των χρηστών για την κάθε μορφή  
- ποια τα αποτελέσματα τους σε υγειονομικούς δείκτες  
- ποιο το κόστος λειτουργίας τους  
για να αποφασίσεις την τελική μορφή του συστήματος....
Οικογενειακοί ιατροί

ΤΟΜΥ

- Μέλος διεπιστημονικής ομάδας υγείας (5 γιατροί, 2 νοσηλευτές, 2 επισκέπτες υγείας, 1 κοινωνικός λειτουργός, 2 διοικητικοί)
- Πλήρους αποκλειστικής απασχόλησης
- Σύμβαση 2+2 ετών, αποζημίωση μέσω ΕΣΠΑ Προοπτική?
- Μισθός επιμελητή Α’ - 1712 € / μήνα καθαρά - απουσία κινήτρων απόδοσης/ ποιότητας- Πεπερασμένο εισόδημα
  - 7 ώρες/ ημέρα- ραντεβού ανά 15 λεπτά- 2250 ασθενείς
  - Κόστος ανά ασφαλισμένο που θα εγγράφεται στις κρατικές ΤΟΜΥ 2,43€/ μήνα

Συμβεβλημένοι Ιδιώτες

- κατά βάση solo practices
- Σύμβαση με ΕΟΠΥΥ
- 20 ώρες την εβδομάδα- ραντεβού ανά 15 λεπτά?
- Per capita αποζημίωση, κατά μέσο όρο 1800 ευρώ μικτά
- 2250 ασθενείς Εξαιρετικά μεγάλη λίστα- απαιτεί ≥7 ώρες /εβδ
- Όλα τα έξοδα βαρύνουν τον ιατρό (προσωπικό, εξοπλισμός, δομή)
- Κόστος ανά ασφαλισμένο που θα εγγράφεται σε ιδιώτη συμβεβλημένο 0,8 €/ μήνα
- Χάστες αναμονής- κόστος χρόνου ή χρήματος- προάγει ανισότητες
- Μεγάλη απόσταση από καθολική κάλυψη...
- Απαράδεκτα χαμηλή αποζημίωση- per capita fee 0.8€/ pt/month- αποτυχία πρόσκλησης ενδιαφέροντος
- Μόνο κίνητρο στην είσοδο στο σύστημα- ποιότητα υπηρεσιών η προσέλκυση ιδιωτικής πελατείας
Λίστα οικογενειακού γιατρού ≤ 2250 πολίτες

• Η λίστα προάγει τη συνέχεια στη φροντίδα. Απαραίτητη για την ανάπτυξη ευθύνης/λογοδοσία για την υγεία ορισμένου πληθυσμού.

• Σε καμία περίπτωση πάνω από 2000 άτομα! Στοχεύοντας στην ποιότητα καλό θα ήταν ακόμα μικρότερο μέγεθος λίστας.

• Ο μέσος πληθυσμός ανά GP στην Ευρώπη: 1687

• Μέσο μέγεθος λίστας OI: Turkey (3687), Malta (2500), the Netherlands (2322), Slovakia (2163); Οι μικρότερες στο Luxembourg (500), Belgium (718), France (800), Italy (1094) και Norway (1219)
0,8 € / εγγεγραμμένο ασφαλισμένο στη λίστα / μήνα (μικτά)

“The level of payment of primary care professionals should be in line with their increased responsibilities”...

TECHNICAL ASSISTANCE IN THE FIELD OF HEALTH Report
‘A Future for Primary Care for the Greek Population’
Payment system for GPs

3. Health insurance companies (1 public, 2 private)
GP has contract with every HIC (mandatory for HIC)
Capitation fee....80% per capita, 20% fee for service.....fundamental problem
The fundamental problem is underfinancing (average capitation fee 2,8 Euro/pt/month) fee for service (preventive examination every 2 years, ECG - annual pt, arterial hypertension which was found by GP,...)
Primary Care in Italy

- **self-employed** working for the NHS through a **national agreement** that defines standards and objectives—mainly rewarded through capitation

- right to choose any GP or Family Paediatrician (FP)
- **patient list of \( \leq 1500 \) for GPs / \( 800 \) for FP**s
- **first contact**—provide most primary care—gatekeepers for access to secondary services

- National Agreement tends to reflect **national priorities**
  
  *(professional standards, immunization campaigns, EBM guidelines, etc)*

- **€40 fixed per capita** payment (2009 National Agreement)

- a variable **amount based on fees for services**
  
  *(e.g. minor surgery, preventive activities, immunizations)*
Αυτές θα είναι οι αμοιβές των γιατρών με το ΓεΣΥ

Οι συχνήσεις για το Γενικό Σχέδιο Υγείας (ΓεΣΥ) φέρνουν στο προσκήνιο το ζήτημα των αμοιβών των γιατρών την επόμενη ημέρα της εφαρμογής.

Όπως προκύπτει από τις δημόσιες τοποθετήσεις και δηλώσεις των αμοιβών πολιτικών ή μη, οι αμοιβές των προσωπικών γιατρών κατά μέσο όρο υπολογίζονται σε €100.000 ετήσιο εισόδημα για τους παιδιάτρους και περίπου €110.000 μέσο ετήσιο εισόδημα για προσωπικός ιατρός για ενήλικες.

- **900 pts/ παιδιάτρο → 100.000 € / έτος**
- **1.300 pts/ προσωπικό ιατρό για ενήλικες → 110.000 € / έτος**

- **Κατά κεφαλήν αμοιβή**
- **Αμοιβή για συγκεκριμένες πράξεις και**
- **Αμοιβή βάσει δεικτών απόδοσης**
Προτάσεις

• Ωράριο σε αντιστοιχία με λίστα ασθενών- ανάγκες τους

• Ελκυστική αποζημίωση

• Σύνδεση της αποζημίωσης με την απόδοση/ ποιότητα υπηρεσιών

• Κίνητρα στους solo GPs για διασύνδεση τους- λειτουργική/ οργανωτική- με στόχο τη δημιουργία group practices

• Απαραίτητη η εγγραφή σε οικογενειακό ιατρό- ακόμα και αμιγώς ιδιώτη- για να απολαμβάνει κάποιος παροχές που αυτός προκαλεί υπό ασφαλιστική κάλυψη (εξετάσεις, φάρμακα)- απαραίτητη η παραπομπή από τον οικογενειακό ιατρό στην εξειδικευμένη φροντίδα για κάλυψη των δαπανών που αυτή θα προκαλέσει
There is nothing so unequal as the equal treatment of unequals...

Προτιμότερη η συμμετοχή του ασθενούς στο capitation fee κατ’ αναλογία του εισοδήματος του από την ανεπαρκή χρηματοδότηση του εγχειρήματος, που θα το καταδικάσει...

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