Η Διακήρυξη της Astana και η θέση του Γενικού Οικογενειακού Γιατρού

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Γενικός/ Οικογενειακός Ιατρός

Αντιπρόεδρος Β' ΕΛΕΓΕΙΑ

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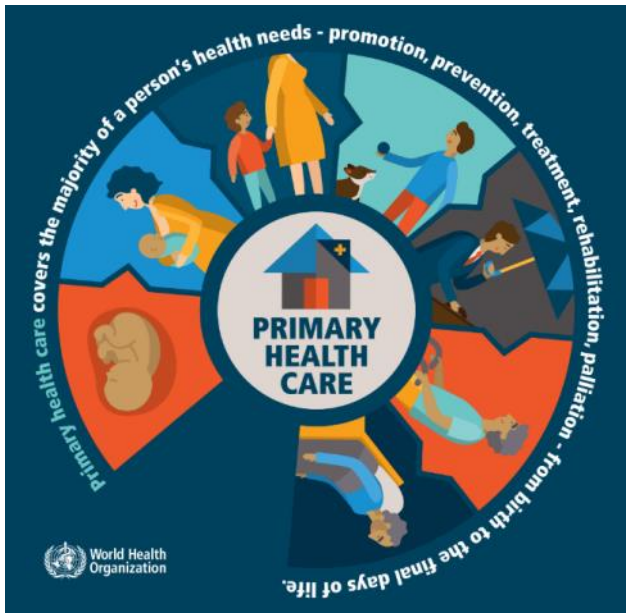


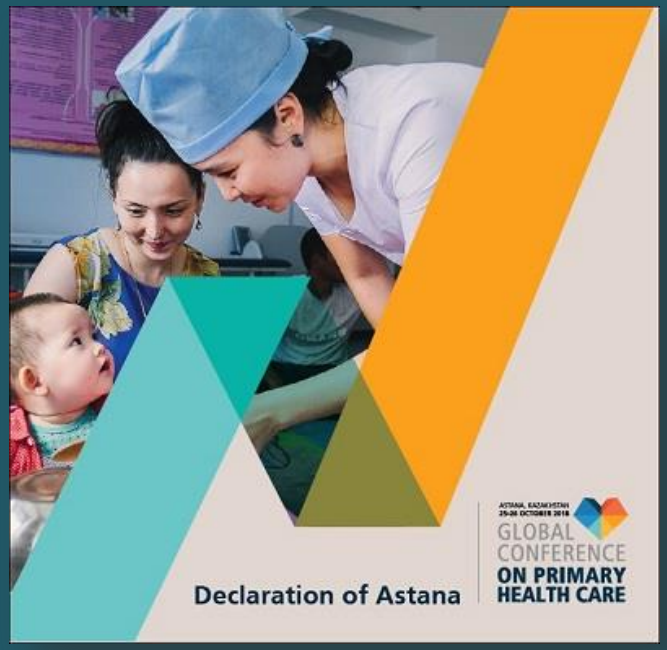
1978: WHO Declaration Alma-Ata

***A main social target** of governments, international organizations and the whole world community in the coming decades should be the attainment **by all peoples** of the world by the year 2000 of **a level of health that will permit them to lead a socially and economically productive life**.*

Primary health care** is the key to attaining this target as part of development in the spirit of **social justice.”

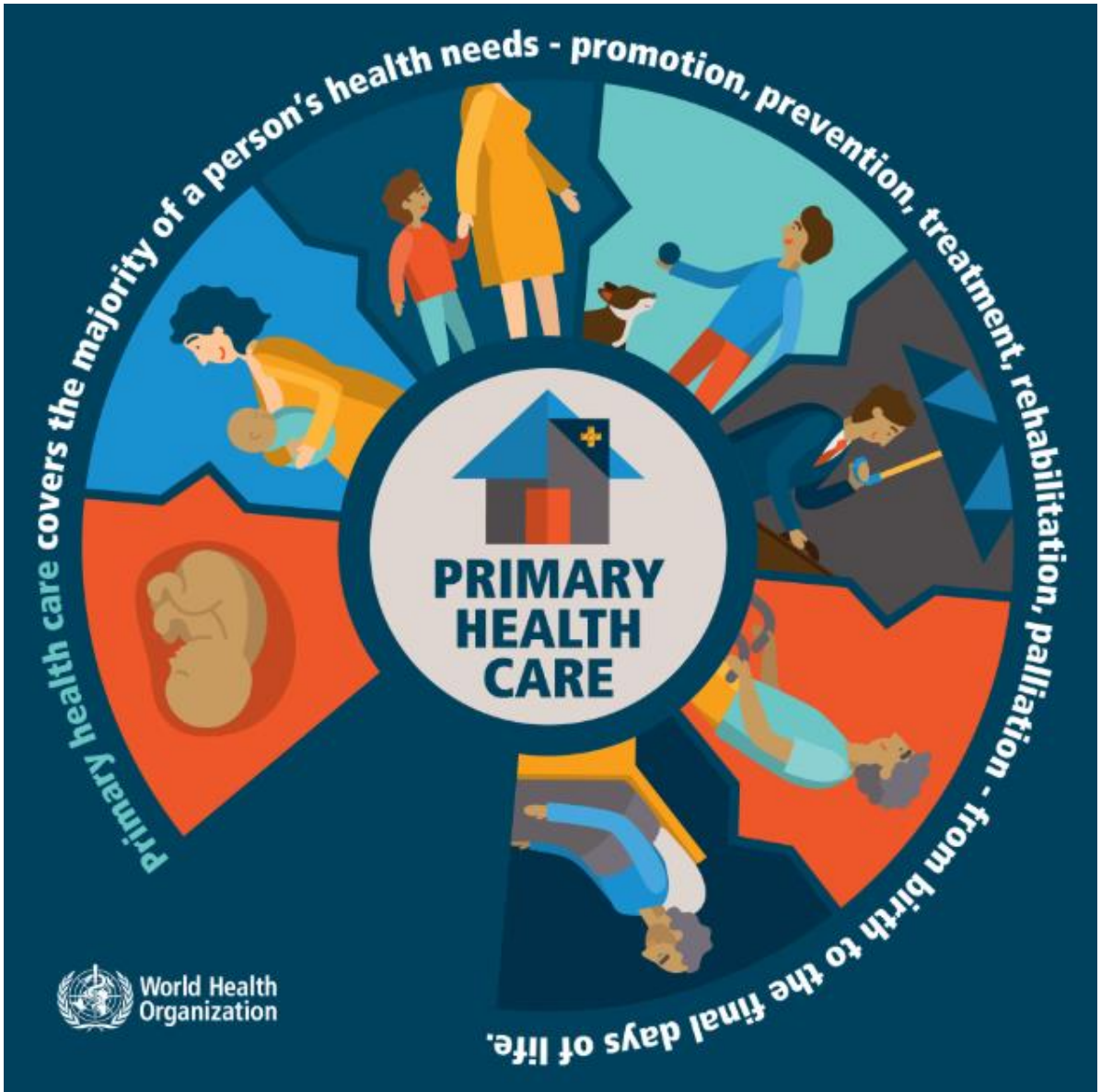
ASTANA, KAZAKHSTAN
25-26 OCTOBER 2018

GLOBAL CONFERENCE ON PRIMARY HEALTH CARE



*"**strengthening PHC** is the **most inclusive, effective and efficient approach** to enhance people's physical and mental health, as well as social well-being, and that PHC is a **cornerstone** of a sustainable health system for **UHC** and **health-related Sustainable Development Goals."***

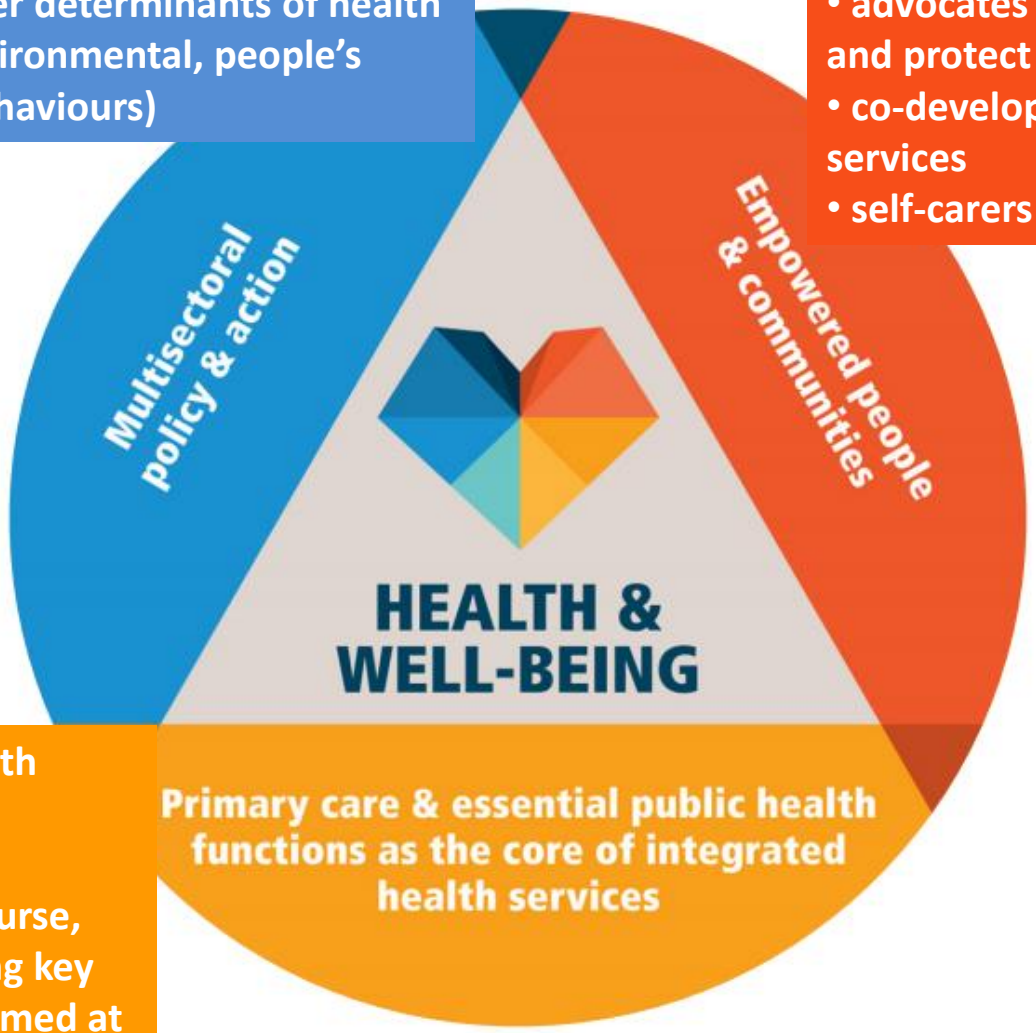
PHC can cover the majority of a person's health needs throughout their life



The components of PHC

Addressing the broader determinants of health (social, economic, environmental, people's characteristics and behaviours)

- advocates for policies that promote and protect health and well-being
- co-developers of health and social services
- self-carers and care-givers to others



Meeting people's health needs through comprehensive care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions

A whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities

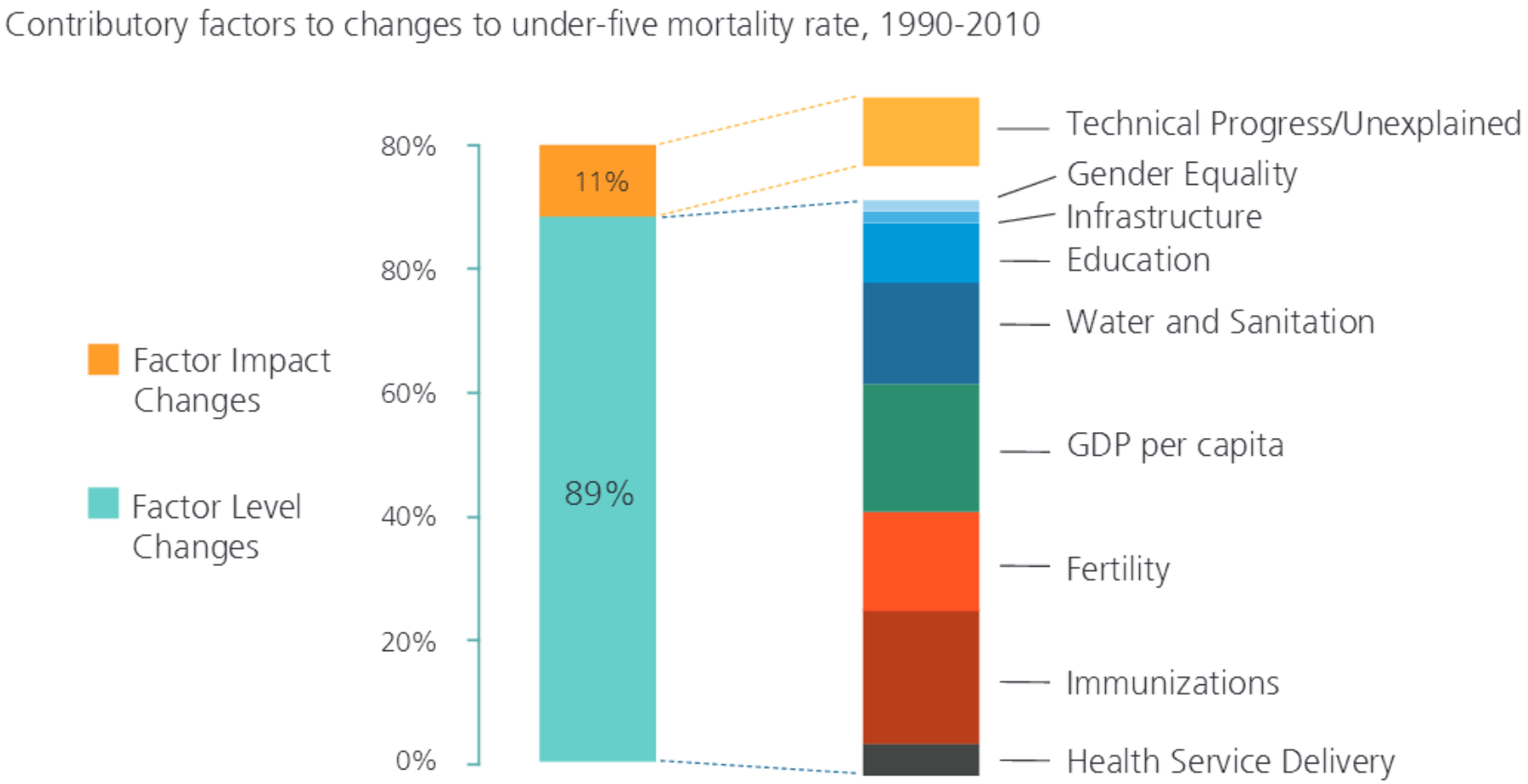
Why is PHC important?

- Primary health care is well-positioned **to respond to rapid economic, technological, and demographic changes**, all of which impact health and well-being.

- A primary health care approach draws in a **wide range of stakeholders** to examine and change policies **to address the social, economic, environmental and commercial determinants of health** and well-being.

- Treating **people and communities as key actors** in the production of their own health and well-being is critical for understanding and responding to the complexities of our changing world.

The complex interplay of factors that lead to improved health



Approximately half of the gains in reducing child mortality from 1990 to 2010 were due to factors outside the health sector (such as, water and sanitation, education, economic growth)

Bishai DM, Cohen R, Alfonso YN, Adam T, Kuruvilla S, Schweitzer J (2016) Factors Contributing to Maternal and Child Mortality Reductions in 146 Low- and Middle-Income Countries between 1990 and 2010.

Why is PHC important?

- has been proven to be a **highly effective and efficient way to address the main causes and risks of poor health** and well-being today, as well as handling the emerging challenges that threaten health and well-being tomorrow.

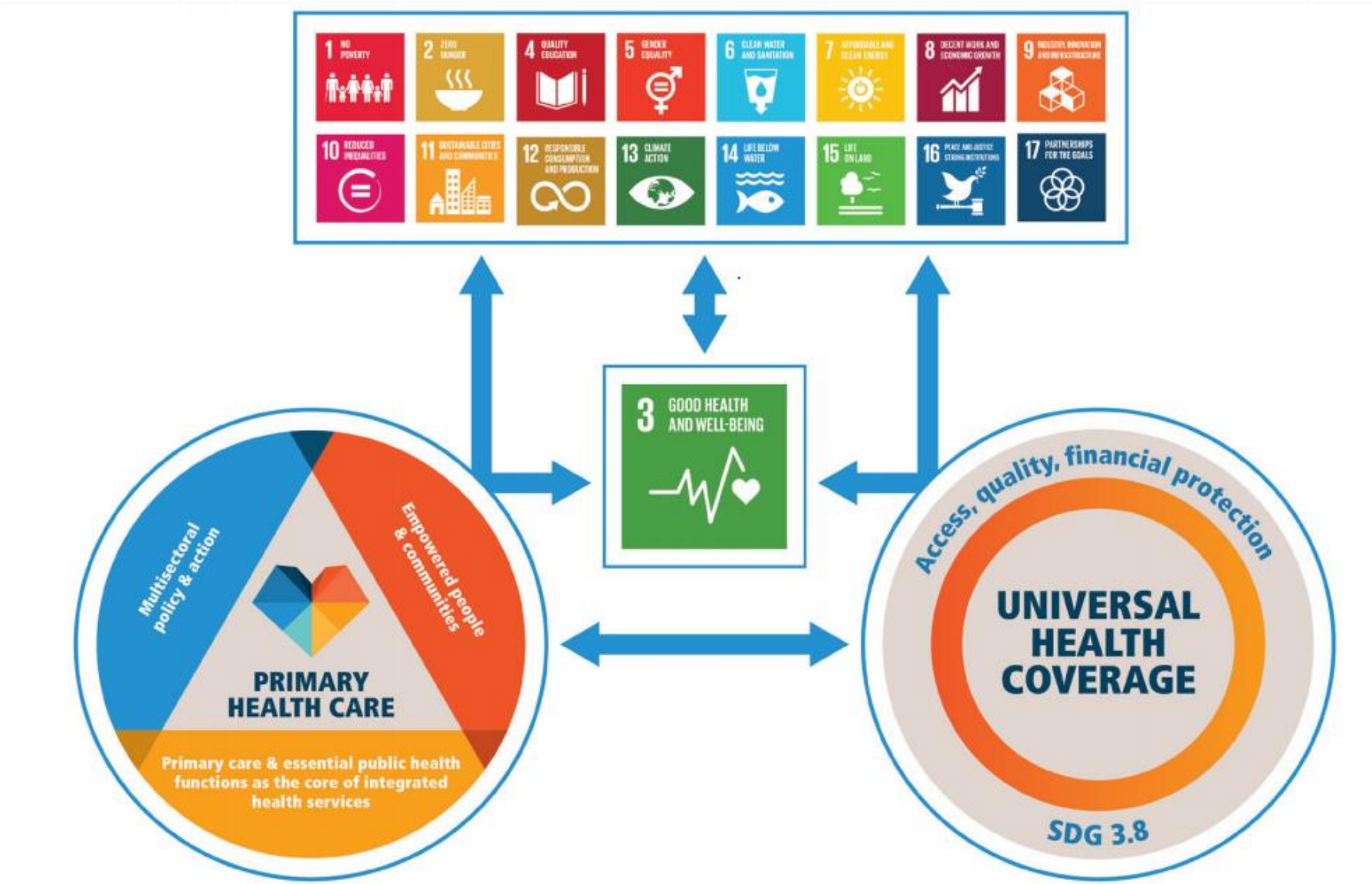
- It has also been shown to be a **good value investment**, as there is evidence that quality primary health care **reduces total healthcare costs** and **improves efficiency** by reducing hospital admissions.

- Addressing increasingly complex health needs calls for a **multisectoral approach** that integrates health-promoting and preventive policies, solutions that are responsive to communities, and health services that are people-centred.

Why is PHC important?

SDG 3 *"Ensure **healthy lives** and promote **well-being for all** at all ages"*

Target 3.8 *"Achieve **universal health coverage**, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"*



PHC is the foundation for UHC

*PHC oriented health systems provide **quality** services that are **comprehensive, continuous, coordinated** and **people-centered.***

*With these characteristics along with its **emphasis on prevention and promotion**, PHC **reduces inequities** in health, and is **highly effective and efficient**,*

***particularly for the management of chronic conditions** such as non-communicable diseases, including mental health.*

Tedros Adhanom Ghebreyesus @ ...

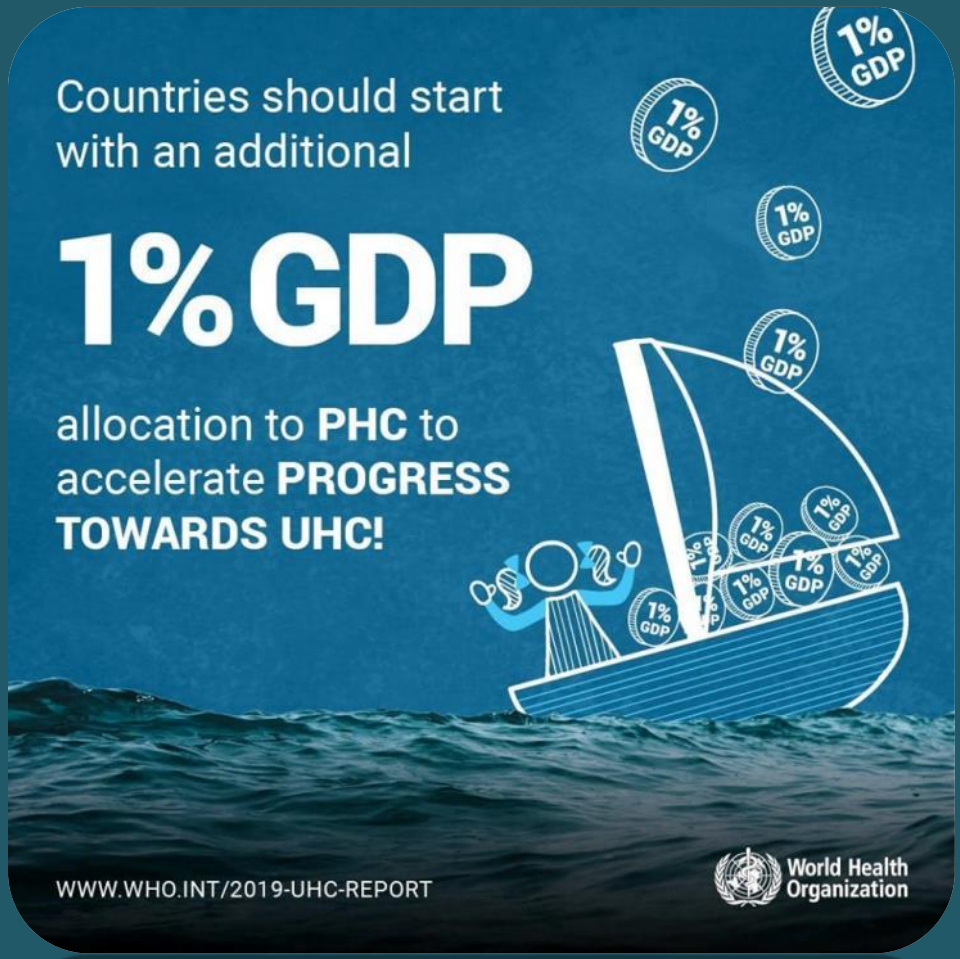
@DrTedros

Ακολουθήστε

Most countries can scale up #PrimaryHealthCare using domestic resources – either by increasing public spending on health, or by reallocating spending – or both... This is a political choice. #HealthForAll

8:14 μ.μ. - 22 Σεπ 2019

39 Retweet **71** επισημάνσεις "μου αρέσει"



WONCA reaction to Astana Declaration

*"WONCA notes that **the Declaration no longer includes the specific mentioning of family doctors or any other members of the primary healthcare teams.***

The prior public draft did include different disciplines needed in the Primary Health Care (PHC) team, but these have all been removed in the final version signed by Member States.

Put public health and primary care at the centre of UHC

We must enhance capacity and infrastructure for public health functions and develop quality primary care that is continuous, comprehensive, coordinated, community-oriented and people-centred. We will appropriately prioritize disease prevention and health promotion. We will ensure adequate public health and primary care workforce (including PHC nurses, family physicians, midwives, allied health professionals, and non-professional community health workers) working in teams with competencies to address modern health needs. We will promote management practices that ensure decent work including adequate compensation, meaningful opportunities for professional development and career progression. We will guarantee the availability of appropriate medicines, products and technologies. We will allocate sufficient resources to research, evaluation and knowledge management, promoting the scale up of effective strategies for multisectoral action, public health and primary care.

*While **we had hoped and strongly advocated for Family Medicine to be specifically included in the declaration,"***

Wonca

WONCA reaction to Astana Declaration

"we are encouraged that many of the documents supporting the Astana Declaration ***do include family doctors/general practitioners as key members of these teams****.*

Family medicine was mentioned multiple times *during the* ***plenary sessions****; in addition,*

several ***side events*** *during the Global Conference on Primary Health Care* ***highlighted the work and reach of family doctors"***

The vision document

Operational Framework - Draft for Consultation

Please provide your comments on the draft text here: Consultation on Operational Framework

Download the Framework

Making the case for PHC

The economic case

From vision to action

Multisectoral action
Health in All policies

PHC health workforce

The private sector

Quality in PHC

Digital technologies

Integrating public health and primary care

Integrating health services

The role of hospitals in PHC

Antimicrobial resistance

PHC and health emergencies

Meeting health needs through PHC

Sexual, reproductive, maternal, newborn, child & adolescent Health

Older people

Rehabilitative care

Palliative

Mental health

Communicable diseases

HIV/AIDS

Regional reports on PHC

Africa

Americas

Eastern Mediterranean

Europe

South-East Asia

Western Pacific

GLOBAL CONFERENCE ON PRIMARY HEALTH CARE

ASTANA, KAZAKHSTAN
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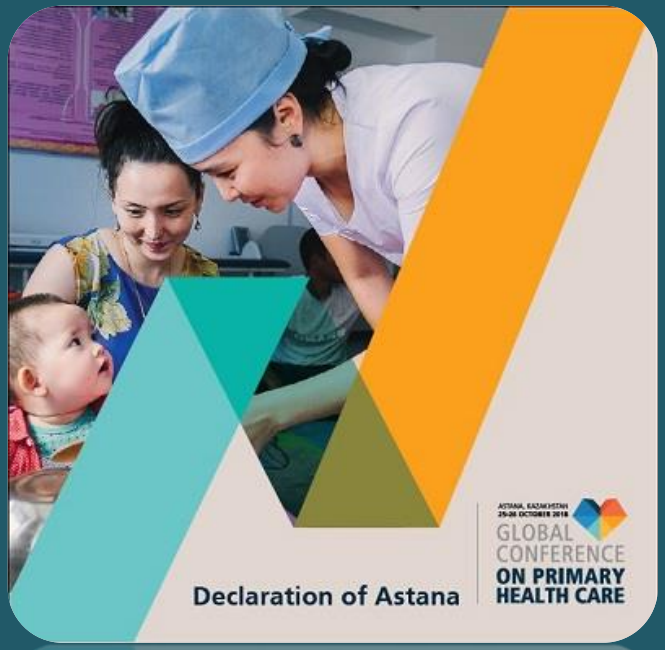
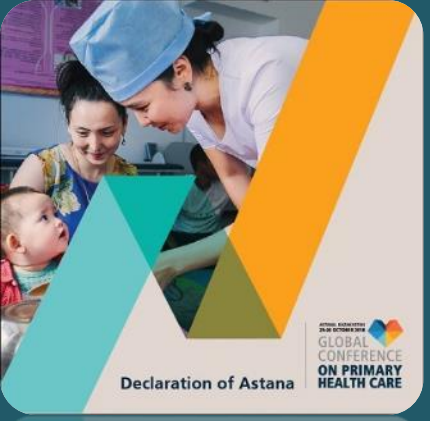


*"We envision **Primary Health Care** and health services that are **high quality, safe, comprehensive, integrated, accessible, available and affordable** for everyone and everywhere, provided with compassion, respect and dignity by **health professionals** who are **well-trained, skilled, motivated and committed**"*



V

Build sustainable primary health care

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health[2]. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks.

The Specialty of General Practice/Family Medicine

- *General practitioners/family doctors are specialist physicians trained in the principles of the discipline.*
- *They are **personal doctors**, primarily responsible for the provision of **comprehensive** and **continuing** care to every individual seeking medical care irrespective of age, sex and illness.*
- *They care for individuals **in the context of their family, their community, and their culture,** always respecting the autonomy of their patients.*
- *They recognise they will also have a **professional responsibility to their community**.*
- *In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts.*
- *General practitioners/family physicians exercise their professional role by **promoting health, preventing disease providing cure, care, or palliation and promoting patient empowerment and self-management**. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, **assisting patients where necessary in accessing these services.***
- *They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.*
- *Like other medical professionals, they must take responsibility for continuously monitoring, maintaining and if necessary improving clinical aspects, services and organisation, patient safety and patient satisfaction of the care they provide.*

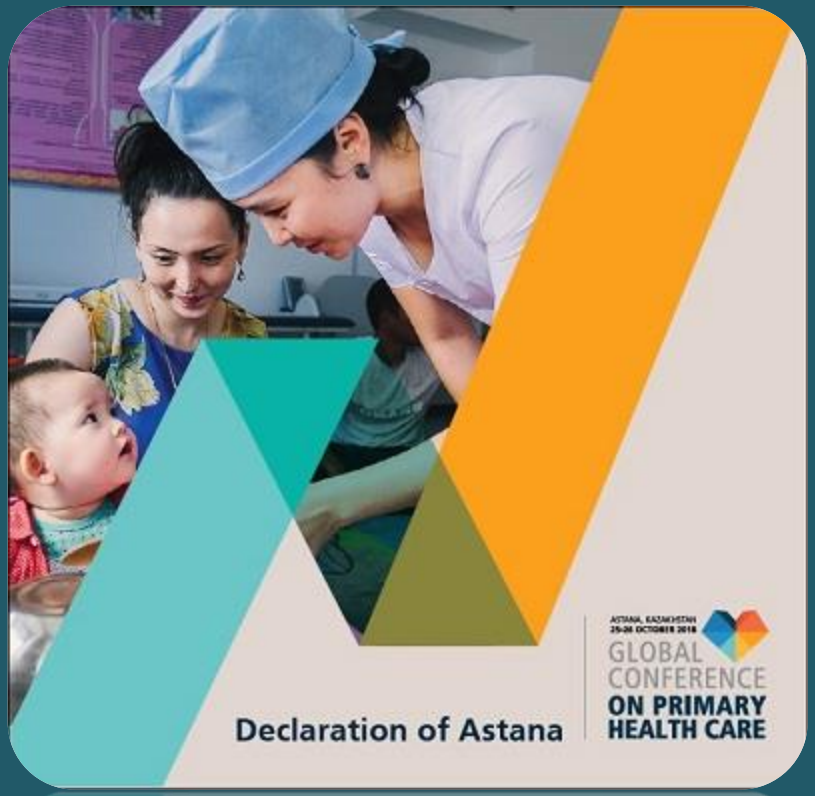
The 5 Star Doctor 2019

WONCA Europe is proud to announce the winner of the WONCA Europe Award of Excellence in Health Care – The 5-Star Doctor 2019:
Dr Anargiros Mariolis, Greece

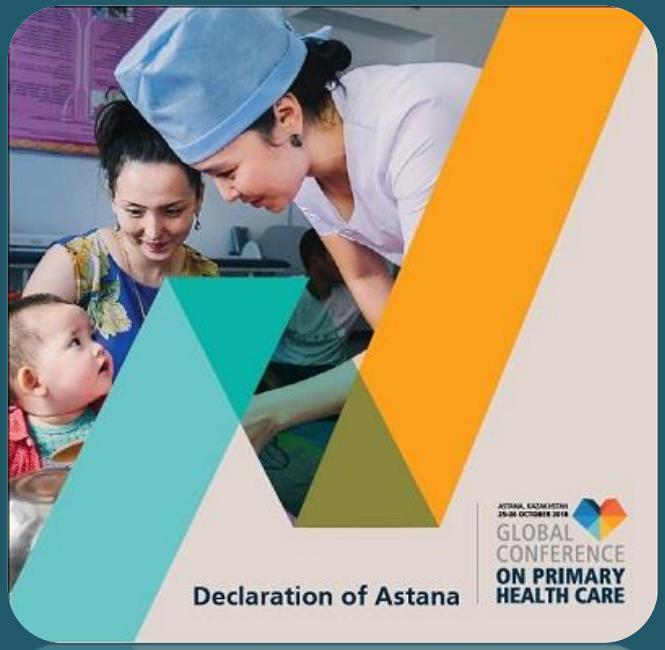
A short extract from Dr Anargiros Mariolis' application:

"The Hero of Primary Health Care in Greece", "The Role Model of General Practice", "The Samaritan on the ancient grounds of Sparta"... These flamboyant terms, quotes from journalists, patients and community

Wonca



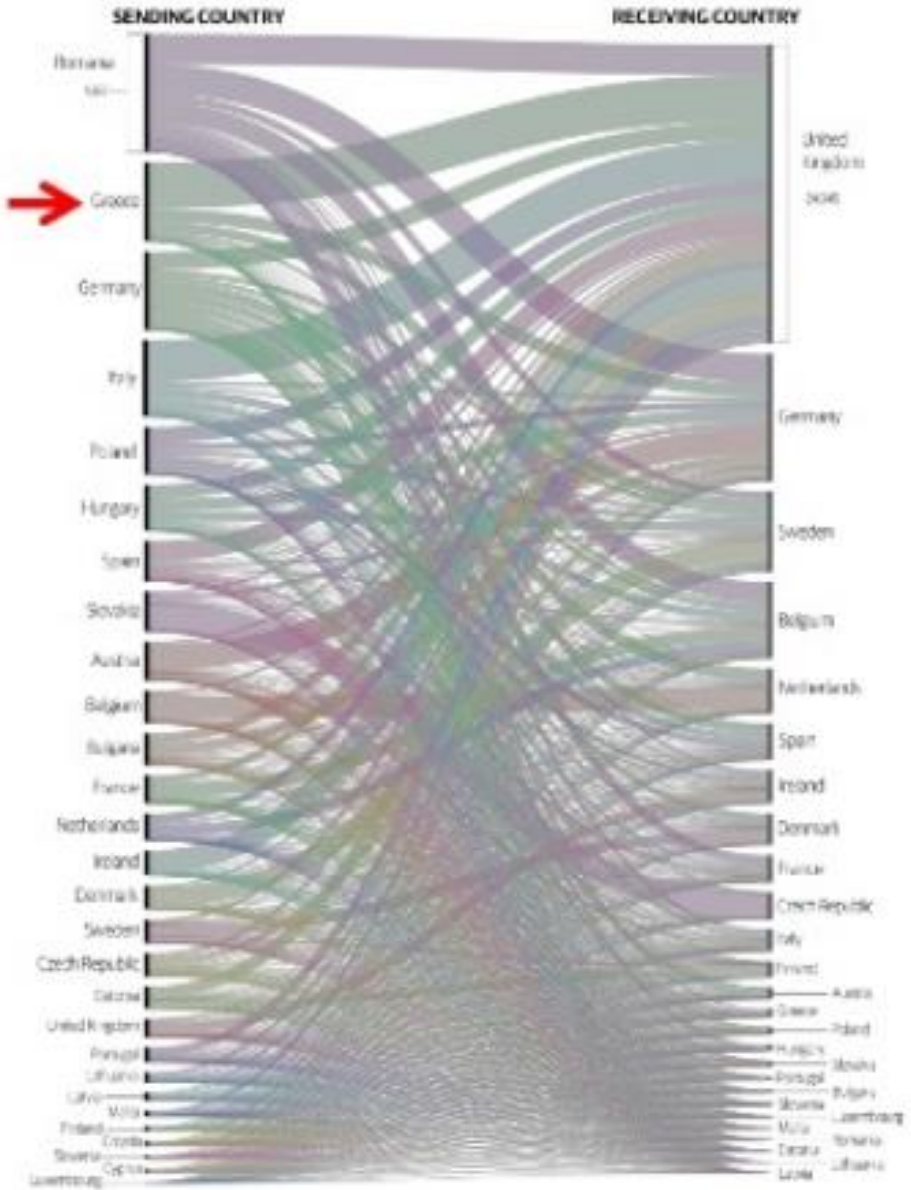
We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care.



*"We will create **decent work** and **appropriate compensation** for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context.*
*We will continue to **invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix.***
We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas.
We assert that the international migration of health personnel should not undermine countries', particularly developing countries', ability to meet the health needs of their populations."

WHERE DO THEY COME FROM, WHERE DO THEY GO?

72 314 doctors from EU countries applied to work elsewhere in the bloc between 1997 and 2016.* Here are the countries they sought to leave and those they wanted to join



SOURCE: European Commission regulated professions database

***ON METHODOLOGY:** The data includes all applications by EU doctors or nurses to work in other EU countries. A small percentage of these applications may have been rejected by the receiving country due to ineligibility. The period analysed is 1997-2016.

POLITICO

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
- 3000 GBP net salary during first 3 months training and full salary of 79 000 GBP gross after training
- Options to work as Locum with rates up to 100 GBP/ 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 Chodkowski
CEO | MedPharm Group
E: greg@medpharmgroup.net
T: +48 690 536 971

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.

"Family practice is the best way to provide integrated health services at the primary health care level.

*With an emphasis on **health promotion** and **disease prevention**, family practice helps keep people out of hospitals, where costs are higher and outcomes are often worse.*

Strong political commitment is essential to improve access, coverage, acceptability and quality of health services, and to ensure continuity of care."

Dr Tedros Adhanom Ghebreyesus,
Director General World Health Organization, October 2018

*The World Health Organization (**WHO**) and the World Organization of Family Doctors (**WONCA**) signed a **Memorandum of Understanding** on 28th January 2019, during the annual Executive Board meeting of WHO in Geneva, in which all WHO Member States participate.*

*The MOU reflects the **key role played by family doctors** and GPs in achieving the global goal of **Universal Health Coverage**, through **comprehensive, patient-centred, professional primary care**.*

World Health Organization

Wonca

WONCA signs landmark MOU with the WHO

Tedros Adhanom Ghebreyesus
@DrTedros

.@WHO is fully committed to #PrimaryHealthCare & recognizes the unique role of family doctors to achieve #HealthForAll. We will work with @WoncaWorld to realize the @GlobalGoalsUN & the Astana Declaration & fill the global 18 million health workforce gap.

149 11:03 PM - Jan 28, 2019

59 people are talking about this

a) The realization of Universal Health Coverage for All, with special focus on the role of family doctors, general practitioners, and primary care teams, including by facilitating understanding of the concept of UHC and proactive participation of the extended primary care team in its realization.

b) Promote the delivery of primary care, and the central role of family doctors in the delivery of that care.

c) Develop and implement specific programmes, in consultation with WONCA's member organizations, as appropriate, to strengthen and improve health services and family medicine programmes, with particular attention to medical professional teaching, undergraduate and post-graduate training programmes, continuing professional development, and programmes to encourage cross-disciplinary working. A separate workplan and exchange of letters will be established by all relevant parties to develop and implement such specific programmes.

d) Where necessary and to the extent feasible, making available personnel of one party for training by the other party in priority areas of health systems strengthening.

phcpi

Visit improvingphc.org

PHCPI is a partnership between the Bill & Melinda Gates Foundation, World Bank Group, and World Health Organization, with technical partners Ariadne Labs and Results for Development.

BILL & MELINDA GATES foundation

WORLD BANK GROUP

World Health Organization

ARIADNE LABS

BRIGHAM HEALTH BRIGHAM AND WOMEN'S HOSPITAL | HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

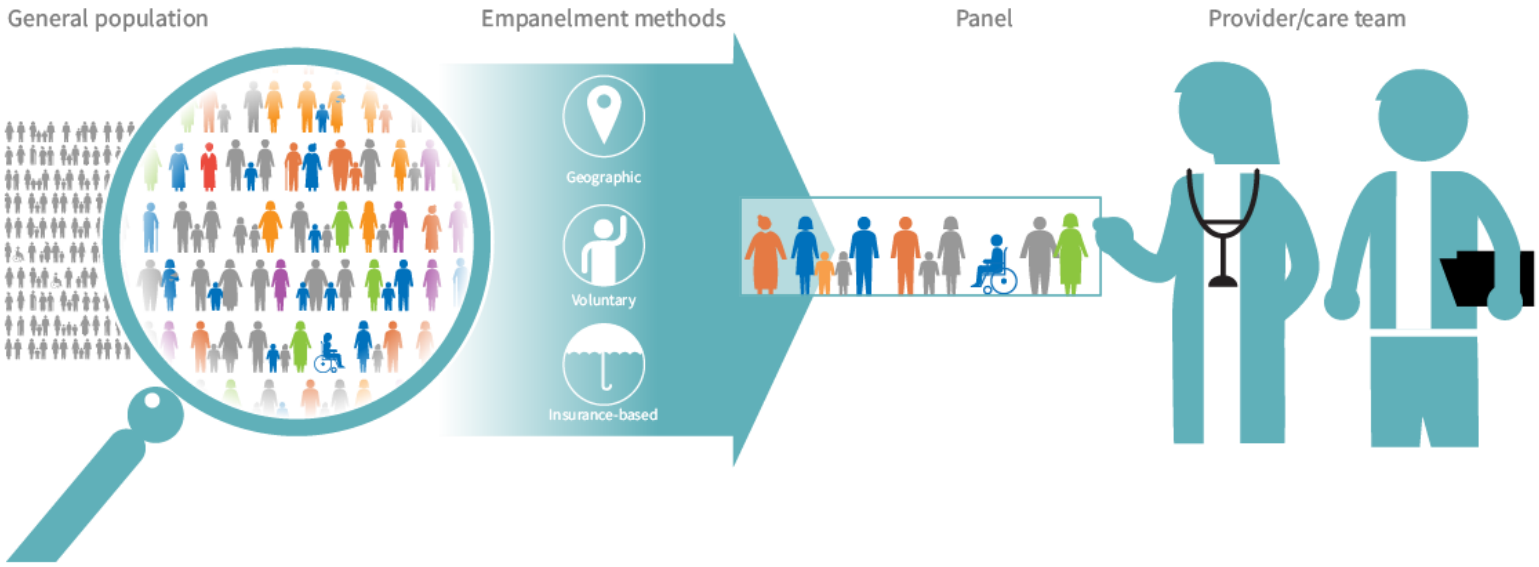
RESULTS FOR DEVELOPMENT

Empanelment

Assigning providers and care teams responsibility for an appropriately sized group of people, some of whom may be actively seeking care, and others not

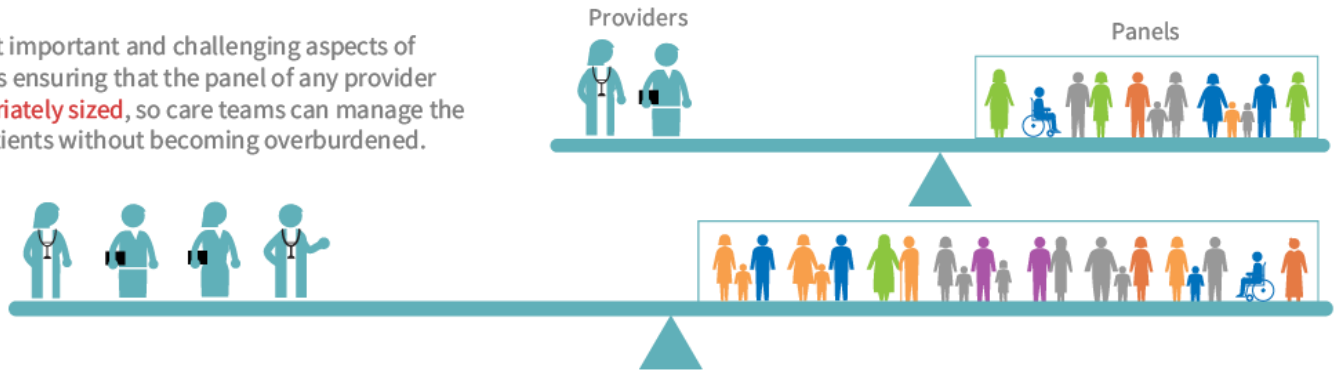
METHODS

Countries use **geographic, voluntary, or insurance-based** methods to form groups of people for providers or care teams.



BALANCE

One of the most important and challenging aspects of empanelment is ensuring that the panel of any provider team is **appropriately sized**, so care teams can manage the health of all patients without becoming overburdened.



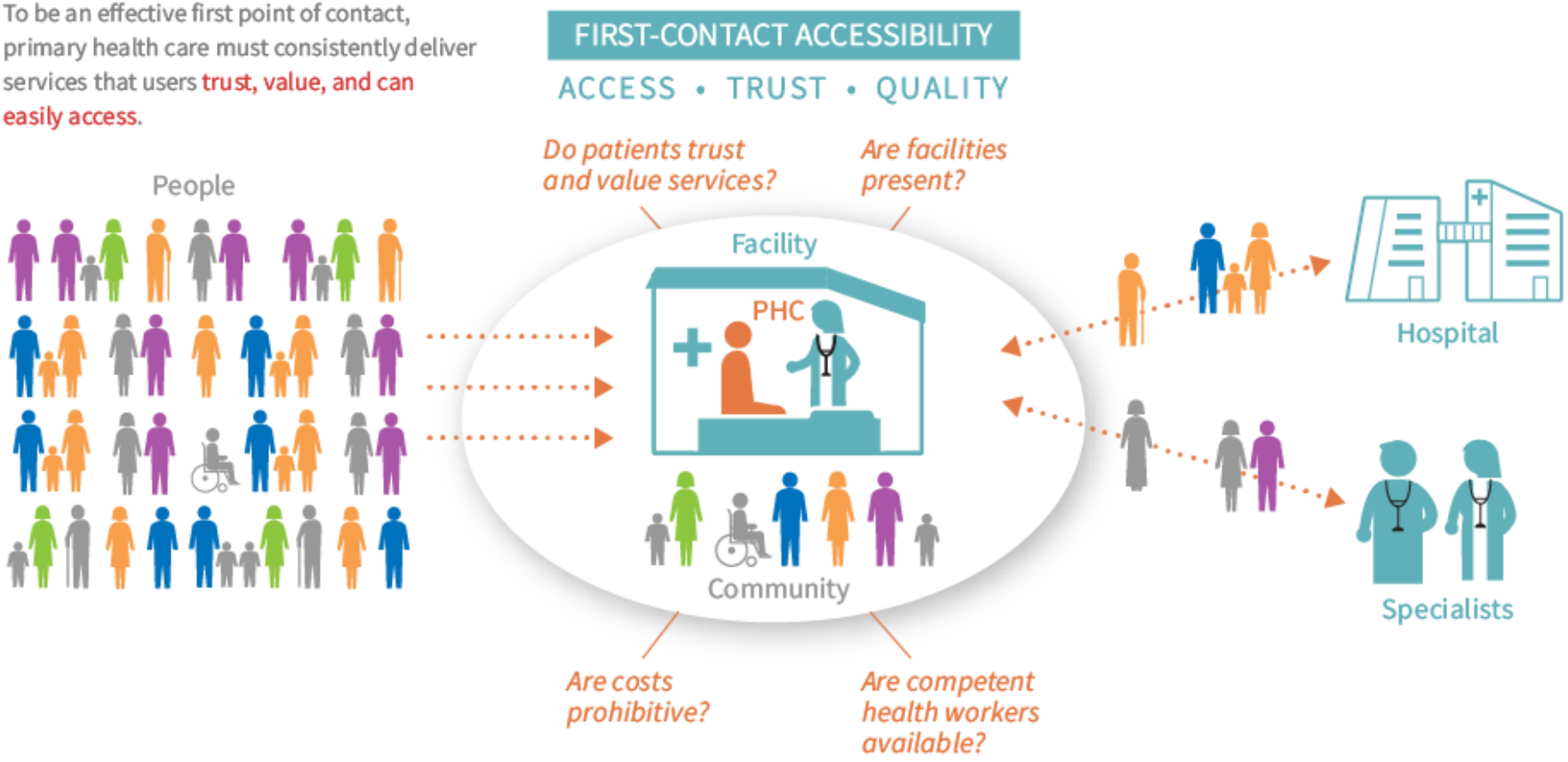
Effective empanelment, sometimes referred to as rostering, supports local priority setting and proactive population outreach by helping providers understand and enumerate the needs of the communities they serve.

HIGH-QUALITY PRIMARY HEALTH CARE IS

First-Contact Accessible

High-quality primary health care can meet 90% of population health needs and should be the first point of contact for most people and most health needs, most of the time

To be an effective first point of contact, primary health care must consistently deliver services that users trust, value, and can easily access.



HIGH-QUALITY PRIMARY HEALTH CARE IS

Continuous

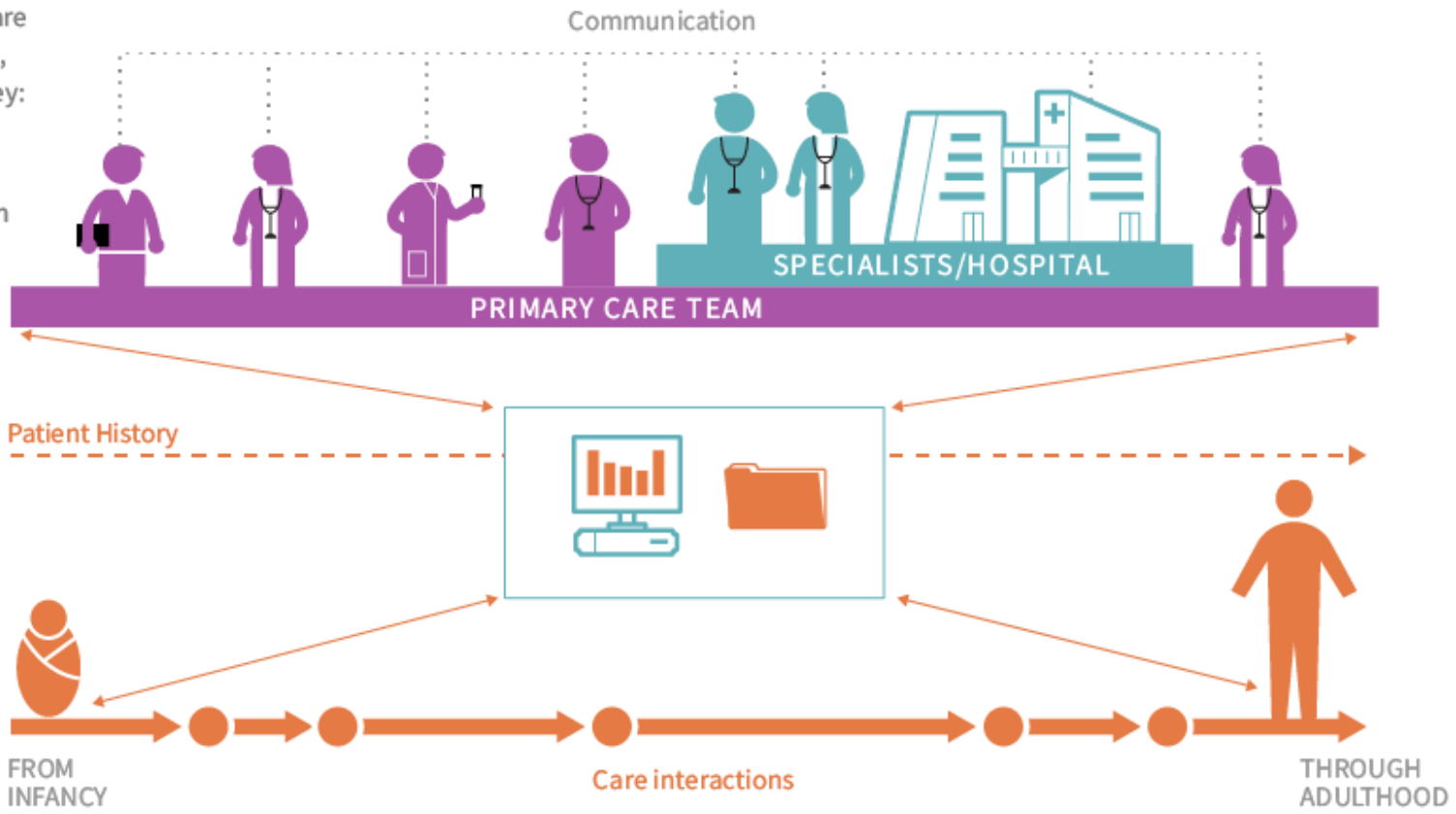
Continuity creates an environment in which patients experience discrete healthcare events as coherent, connected, and consistent with their medical needs and personal context

Continuity is critical for care teams, case management, and the full patient journey:

CARE TEAM
Every member of the team communicates fully

CASE MANAGEMENT
Patient information is constantly updated and accessible to all

PATIENT JOURNEY
Patient has a consistent experience at each care interaction



HIGH-QUALITY PRIMARY HEALTH CARE IS

Person-Centered

Person-centered care is organized around the comprehensive needs of people rather than individual diseases

It engages people in **full partnership with health care providers** in promoting and maintaining their health.

Person-centered care considers a patient's social, career, cultural, and family priorities as important facets of health.

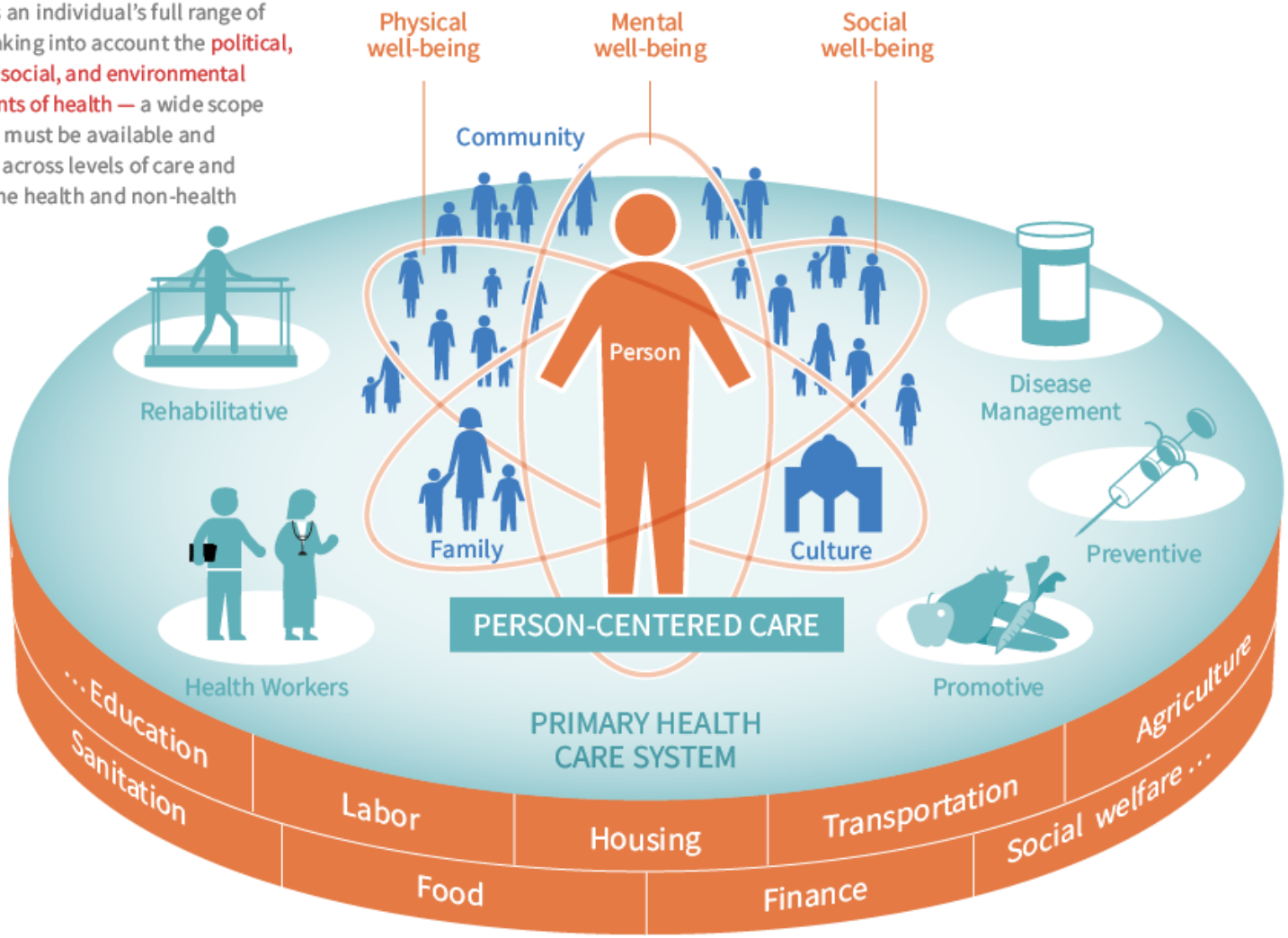
To be empowered users of the health system, patients must be educated and supported to make **informed decisions** and actively participate in their own care.

HIGH-QUALITY PRIMARY HEALTH CARE IS

Comprehensive

High-quality primary health care treats the "whole" person within their family, cultural, and community context — delivering a wide range of preventive, promotive, curative, and rehabilitative services

To address an individual's full range of needs — taking into account the political, economic, social, and environmental determinants of health — a wide scope of services must be available and integrated across levels of care and between the health and non-health sectors.

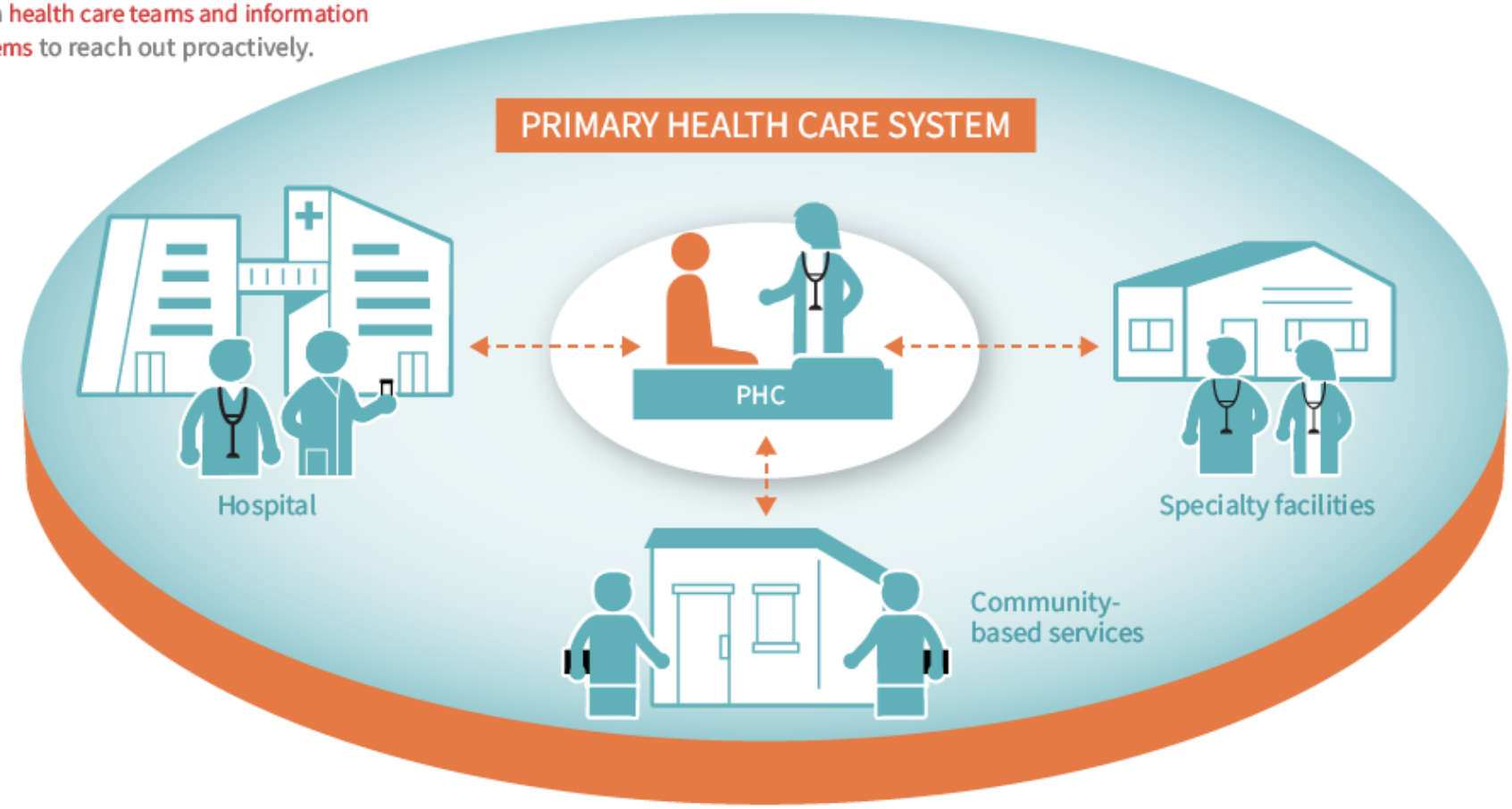


HIGH-QUALITY PRIMARY HEALTH CARE IS

Coordinated

High-quality primary health care is coordinated around a person's needs and preferences throughout treatment and across various care sites. Coordination ensures appropriate follow-up treatment, minimizes the risk of error, and prevents complications.

Coordination of care often requires both health care teams and information systems to reach out proactively.



Coordination

- **Link:** patients with community resources to facilitate referrals and respond to social service needs
- **Integrate:** behavioral health and specialty care into care delivery through co-location or referral arrangements
- **Track and support:** patients when they obtain services outside the practice
- **Follow-up:** with patients within a few days of an emergency room visit or hospital discharge
- **Communicate:** test results and care plans to patients and families
- **Provide:** care management services for high-risk patients

Team-Based Care Organization

Strong team-based care makes PHC offerings more comprehensive and contributes to better coordination of care

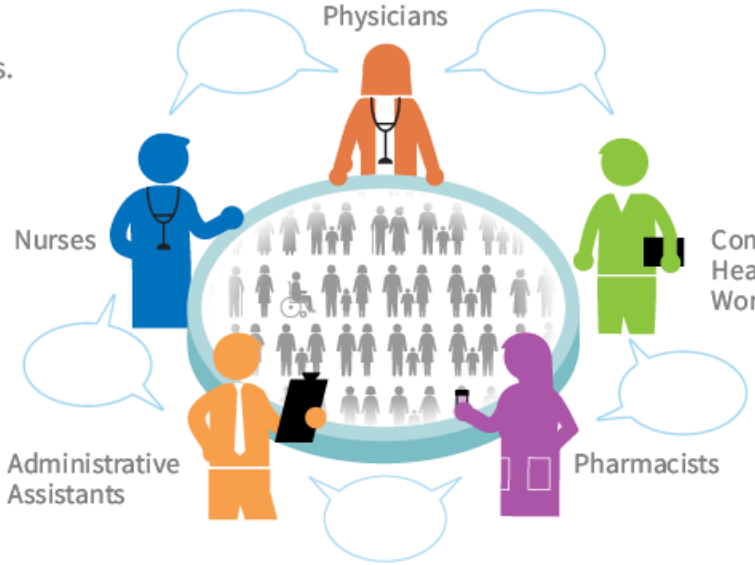
STRUCTURE OF THE TEAM

There is no ideal team size or composition. These depend on the **needs and size of the patient group**, as well as the competencies of the health workforce.

TEAM CULTURE

Team members should work to build a strong team culture to support patients. It is important that team members:

Communicate about delegation of responsibilities



Build respect and trust within the team

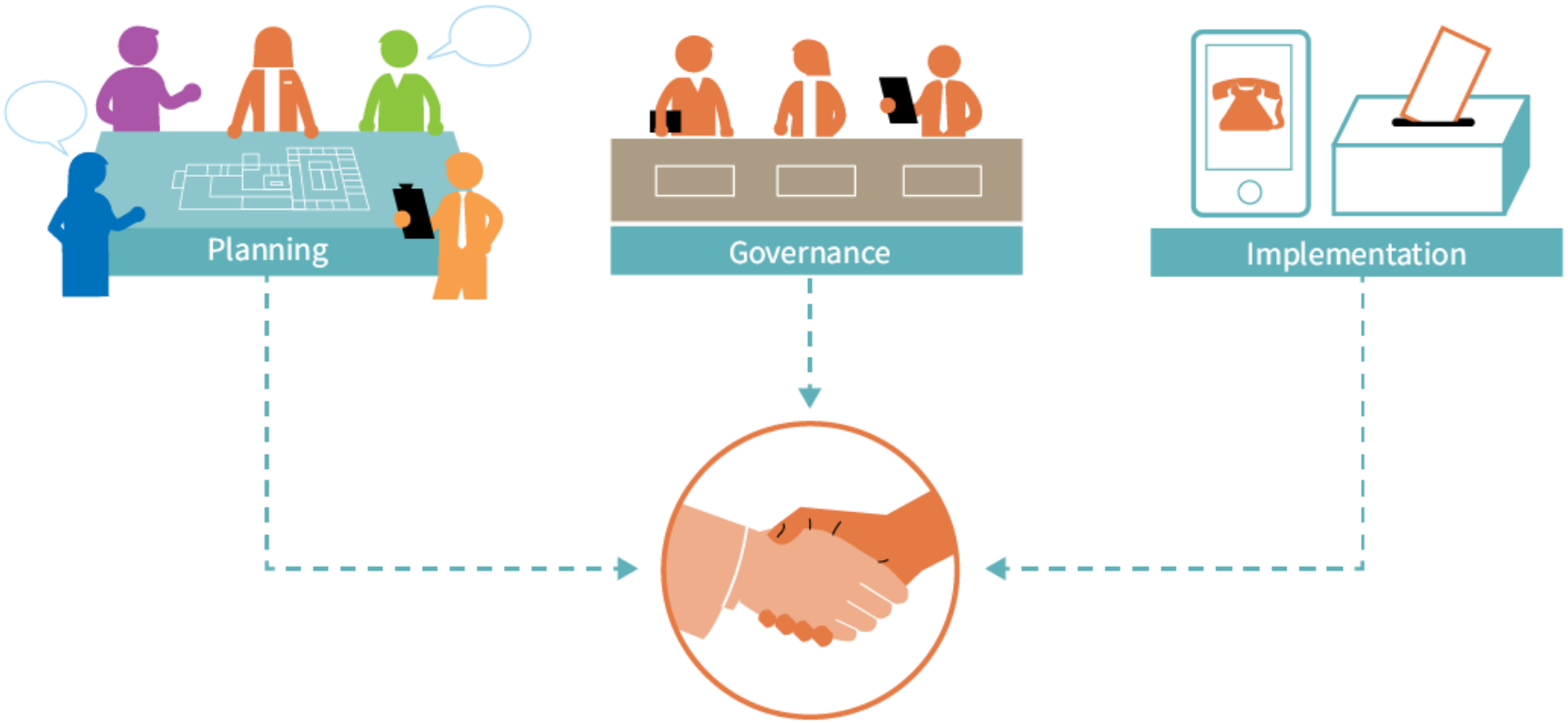
Share a sense of collective responsibility for the health of their patients.

Community Engagement:

The active and continual solicitation and incorporation of community input in the planning, governance, and implementation of primary health care

A RANGE OF ENGAGEMENT OPTIONS

Create resources and communication channels to invite community feedback and ensure transparency



Availability of Effective PHC

The level to which providers are available, competent, and motivated to sufficiently address patients' PHC needs

Can a patient see a provider when needed?

PROVIDER AVAILABILITY

Three components determine availability:

Suitable Workforce

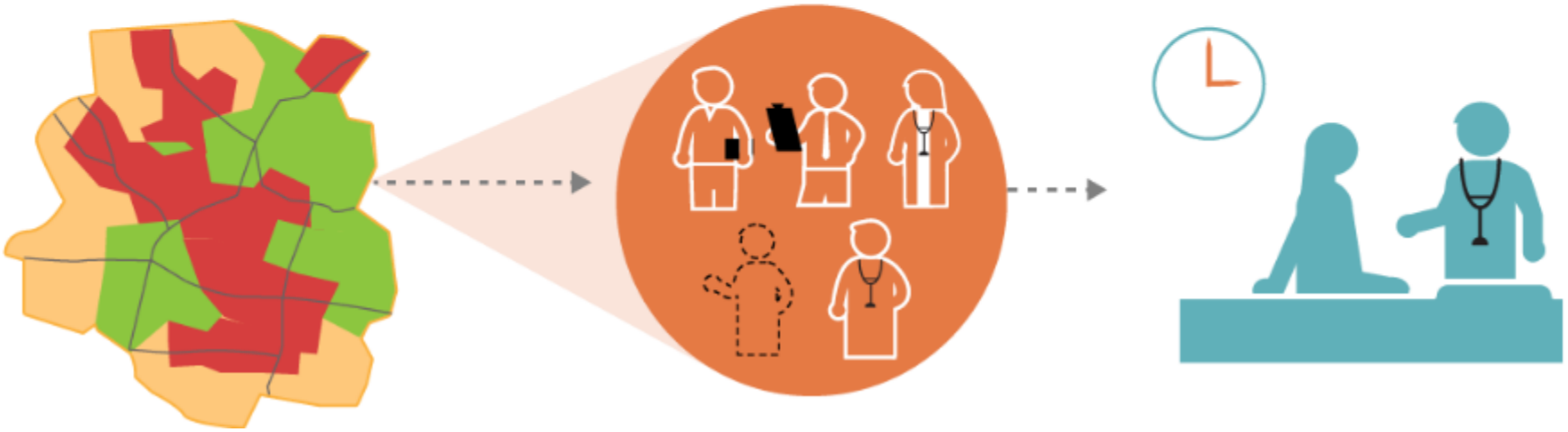
An adequately sized workforce with appropriate skill mix and equitable distribution

Minimal Absenteeism

That workforce is predictably onsite and availble to serve patients

Sufficient Time

Each provider has enough time to devote to each patient's needs



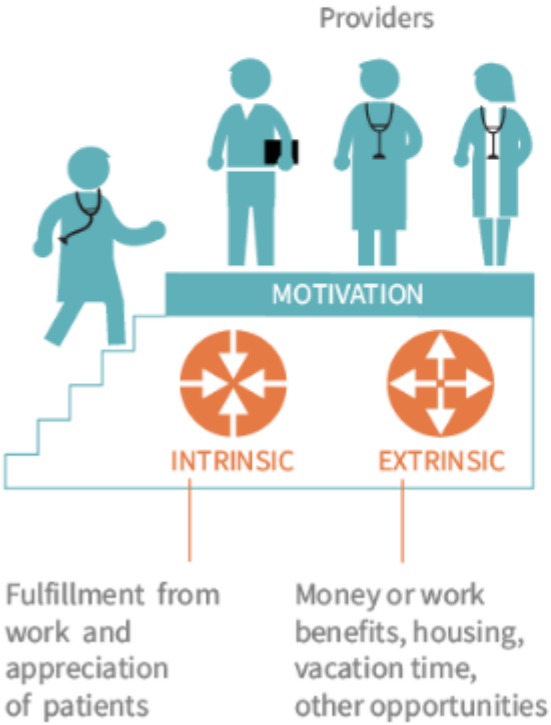
Availability of Effective PHC

The level to which providers are available, competent, and motivated to sufficiently address patients' PHC needs

During interactions with providers, do the patients receive appropriate care?

PROVIDER MOTIVATION

May be intrinsically or extrinsically driven, and is affected by both availability and competence



PROVIDER COMPETENCE

Should be pursued during pre-service training , in-service training, and during standard supervision. Training should be specific to the skills and tasks providers are expected to provide

RESPECTFUL AND TRUSTING RELATIONSHIPS

Patients and providers should have mutually trusting and respectful relationships that are strengthened over time

Financial Access

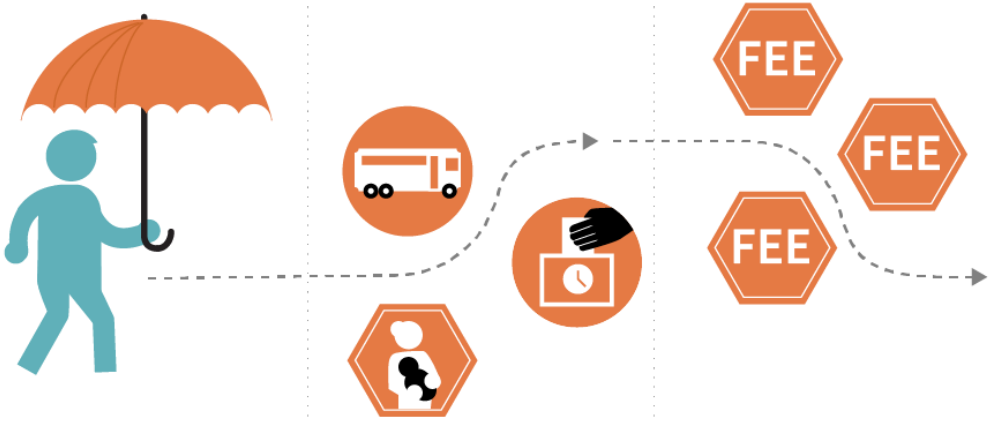
The absence of financial barriers to care such as excessive costs at the point of care and associated costs.

TO OVERCOME FINANCIAL BARRIERS TO HEALTH CARE, PATIENTS SHOULD HAVE:

Cost Protection
Do I have health insurance that protects me from catastrophic health expenditure?

Reasonable associated cost
Do I have indirect costs associated with accessing care, such as those for childcare, lost wages due to missed work, or transportation?"

Reasonable fees
When I am at a facility, do I pay burdensomeout-of-pocket payments for care?



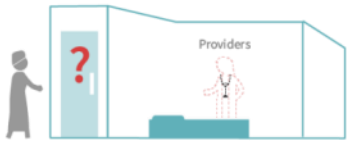
For financial access to care

Geographic Access

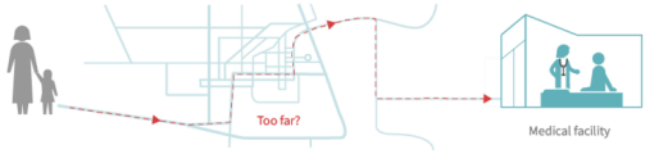
The absence of barriers to accessing care when needed, including excessive distance, inadequate transportation, and other physical challenges

BARRIERS TO GEOGRAPHIC ACCESS

Human Resources
Is there a provider present in my facility or community?



Facility Distribution
Is there a physical facility nearby?



Inadequate Transportation or Difficult Terrain
Am I able to get to the facility?

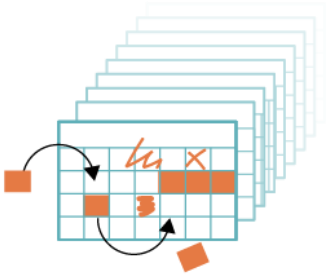
Timeliness

Patients must be able to access primary care services with acceptable and reasonable waiting times, and at days and times that are convenient to them

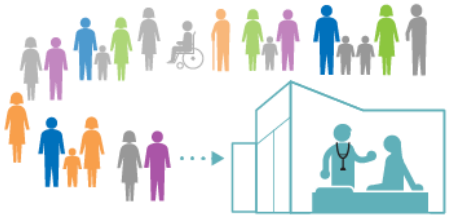
BARRIERS TO ACCESS

Common issues include:

Inconvenient operational hours



Inefficient or non-existent appointment systems

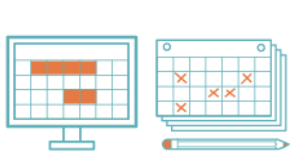


Medical facilities

Long waiting times/short consultation times once patients are at the facility

IMPROVED ACCESS STRATEGIES

Facilities can improve timeliness by using some of the following strategies:



Appointment systems

Remote consultations

Integrated, comprehensive services in the same visit

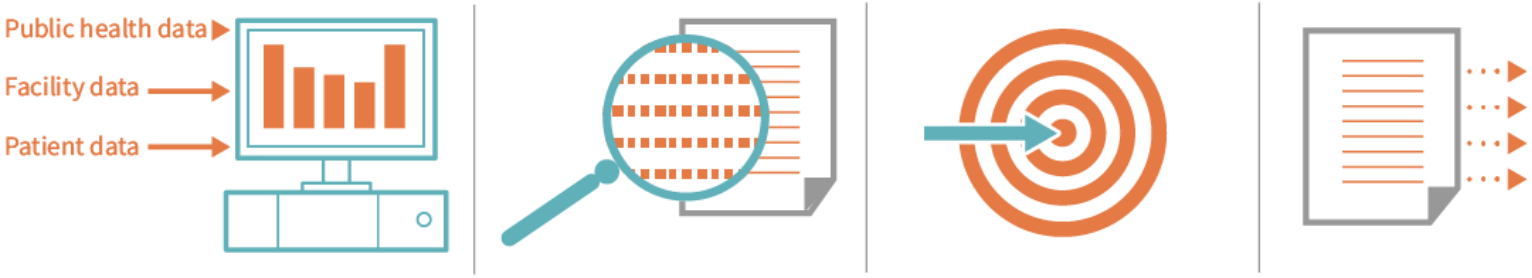
Group visits for general health education

Staggered shifts to extend facility operating hours

Information Systems Use

Includes the collection, reporting and use of data across all levels of the PHC system

EFFECTIVE USE OF INFORMATION SYSTEMS INCLUDES...



Routine collection of data

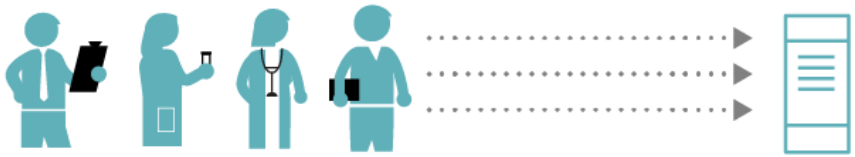
Interpretation of data

Use of data for priority setting and performance monitoring

Reporting data to stakeholders

.... AND REQUIRES ...

Sufficient staff capacity...



...to capture, report, and review data using existing Information system infrastructure

CENTRAL CONSIDERATIONS ARE:

1. **Technical** – What kind of technology is used for information systems and how do these fit within existing data collection systems.

2. **Behavioral** – How can staff be trained to use the technical information systems and how will it fit into their workflow.

3. **Sustainability** – How will these programs or interventions be designed with sustainability in mind.

Performance Measurement and Management

Performance measurement and management is the process of establishing targets, monitoring performance against those targets, and implementing and adapting improvement efforts

MEASUREMENT SEQUENCE:

1 Establish Targets

Targets should be set in collaboration with diverse stakeholders

2 Collect & Track Data

Facilities should measure progress toward targets, using systems that easily integrate into their already existing environment and that don't place a burden on providers

3 Adapt & Improve

Once facility performance data is received, health system stakeholders must have processes in place to interpret data and use results to drive adaptation and improvement efforts. A number of quality improvement frameworks are available to support this step.

THE IMPORTANCE OF SUPPORTIVE SUPERVISION

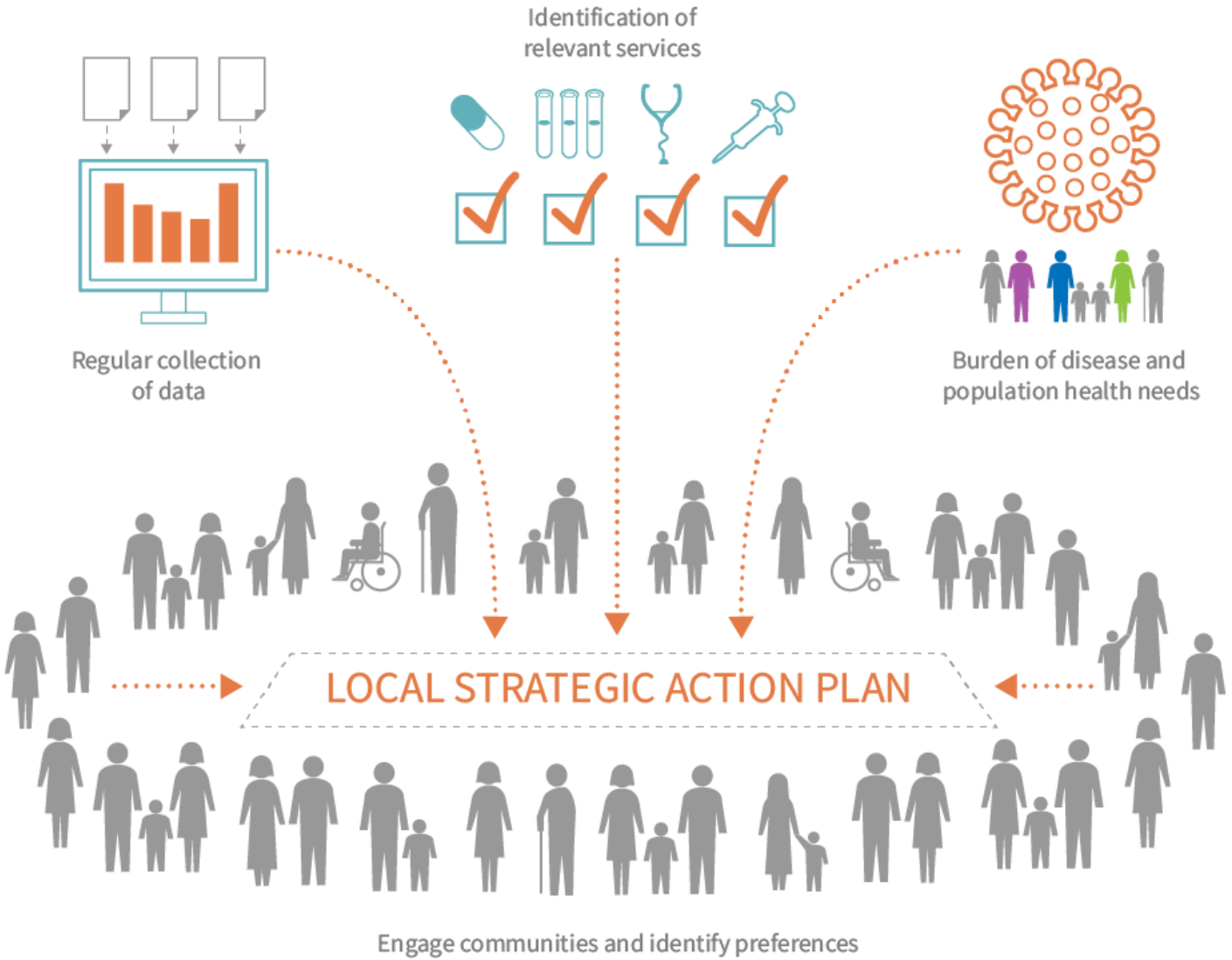
Supportive supervision of individual providers is a key component of performance measurement and management.

Supervision should not be punitive, but instead focused on collective problem solving and identifying gaps and opportunities to fill them.

Local Priority Setting

Strategic action plans that correspond to the local burden of disease and needs and preferences of the population

EFFECTIVE PLANNING INCLUDES:

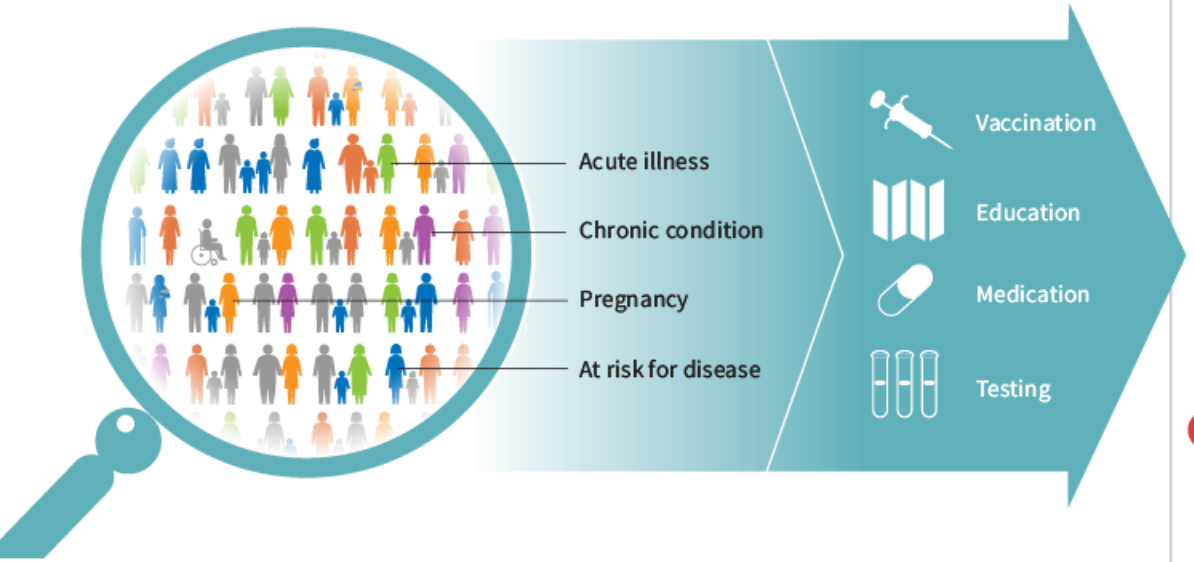


Proactive Population Outreach

Caring for people in communities and homes

1 SEGMENTATION

Ideally, all individuals receive community-based care, but health systems may need to prioritize community-based care only for **specific segments** of their panel.



2 COMMUNITY PROVIDERS

Health workers with **specific training** deliver services within communities.

3 FOLLOW-UP

Community providers are linked to higher-level facilities such as health centers, hospitals, and other specialists who can address more complicated cases with **clear, bi-directional communication systems**

Safety

Patient safety is ensured or compromised by factors related to provider competence, diagnosis accuracy, medicines, supplies, communication, and more

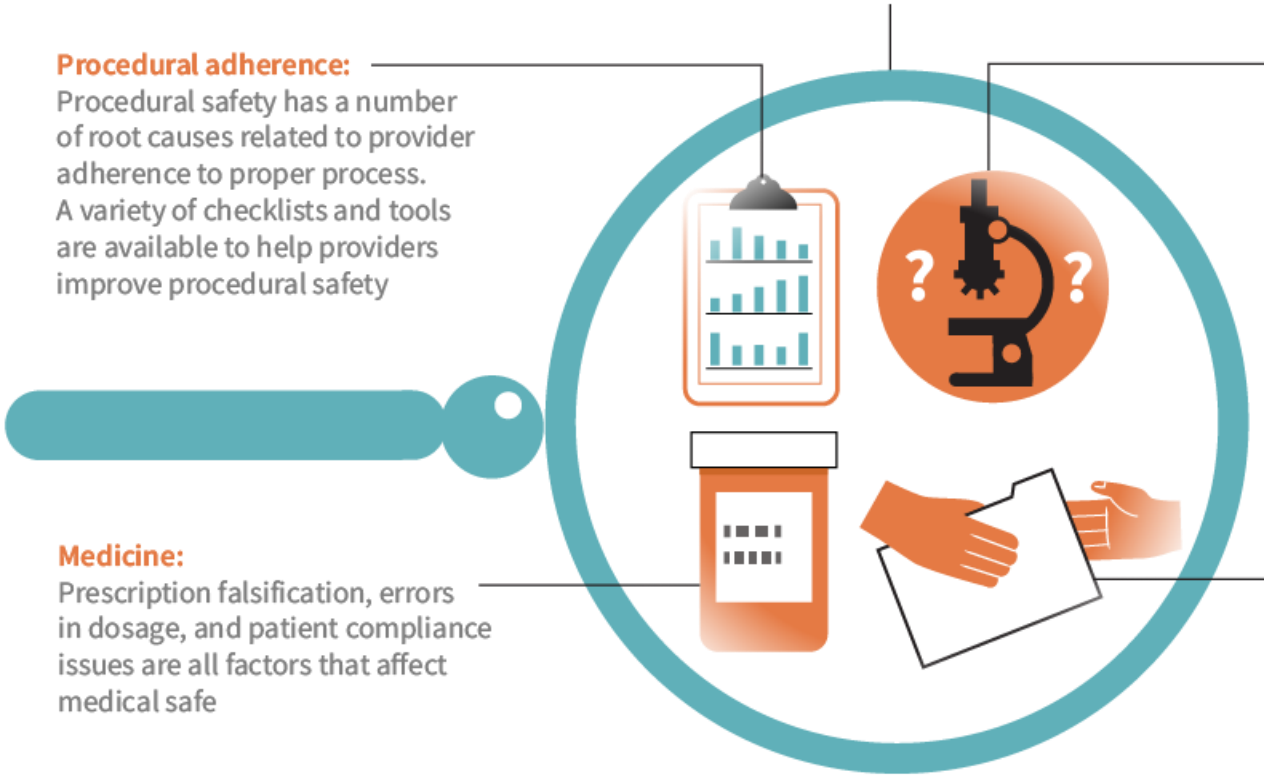
FIVE COMPONENTS OF SAFETY:

SAFETY SYSTEMS:

Facility leaders should ensure that systems are in place to identify errors, understand root causes, and adapt accordingly. Leaders must create a culture where providers can raise concerns without fear of punitive action, and where everyone is valued as a key participant in improving safety

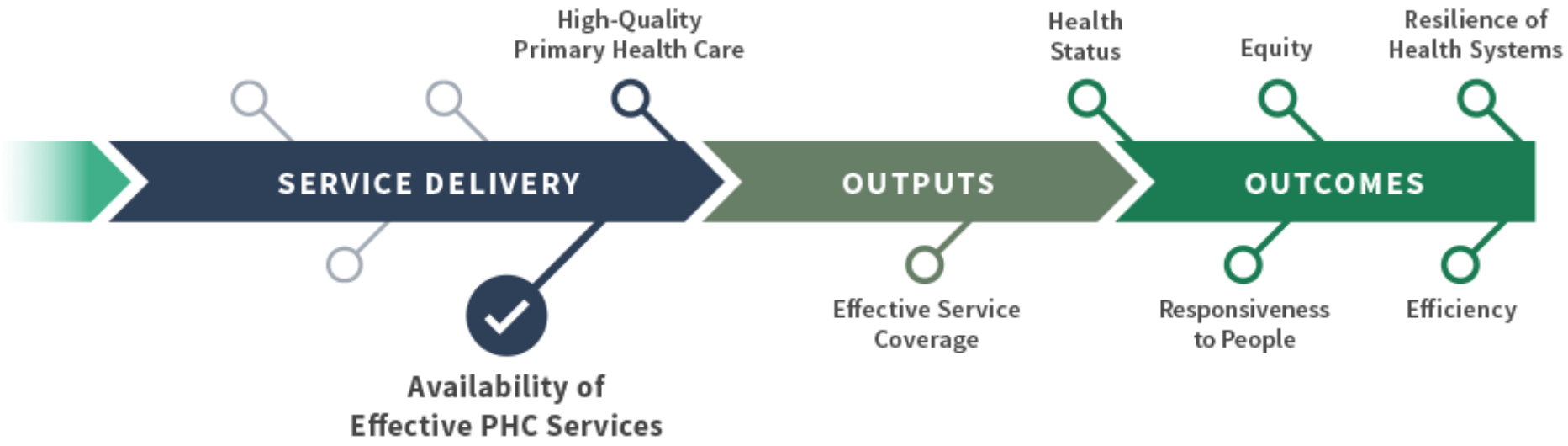
Procedural adherence:
Procedural safety has a number of root causes related to provider adherence to proper process. A variety of checklists and tools are available to help providers improve procedural safety

Diagnosis:
Mis-diagnosis and other diagnosis errors may occur for a variety of reasons, but are generally related to uncertainty, system level failures, or faulty thinking or reasoning



Medicine:
Prescription falsification, errors in dosage, and patient compliance issues are all factors that affect medical safe

Transitions:
Transitions between care providers as part of patient hand-offs or shift changes are moments where miscommunication can cause errors to occur


High-Quality
Primary Health Care
Health
Status
Equity
Resilience of
Health Systems
SERVICE DELIVERY
OUTPUTS
OUTCOMES
Effective Service
Coverage
Responsiveness
to People
Efficiency
Availability of
Effective PHC Services

ΠΦΥ στην Ελλάδα…

Γεφύρι της Άρτας…

Οποιαδήποτε ομοιότητα με πρόσωπα ή καταστάσεις είναι εντελώς συμπτωματική και ουδεμία σχέση έχει με την πραγματικότητα

Σύστημα παραπομπής-
Cost effective path of care

"**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

1. Υποχρεωτική δήλωση οικογενειακού γιατρού από όλους τους πολίτες

- **ο πολίτης** θα κληθεί να **δηλώσει τον οικογενειακό γιατρό που ίδιος επιθυμεί** και που στην τελική αποτελεί τον γιατρό στον οποίο προστρέχει για τις ανάγκες υγείας του.

- Ο οικογενειακός γιατρός θα μπορεί να είναι **γενικός/ οικογενειακός ιατρός,** είτε **παιδίατρος για παιδιά,** είτε **παθολόγος για ενήλικες.**

- Ο οικογενειακός γιατρός θα μπορεί να είναι **γιατρός δημόσιων δομών, ιδιώτης συμβεβλημένος, αμιγώς ιδιώτης.**

- **Η υποχρεωτική δήλωση θα μπορεί να συνδεθεί με την διατήρηση του δικαιώματος να απολαμβάνει παροχές από τον ΕΟΠΥΥ- φάρμακα, εξετάσεις, κλπ**

2. Εισαγωγή συστήματος αναφοράς από την ΠΦΥ → εξειδικευμένη, *εξωνοσοκομειακή και νοσοκομειακή*, φροντίδα

- Τόσο λόγω της κατανομής ιατρών στις ειδικότητες στη χώρα μας, όσο και της κουλτούρας που έχει αναπτύξει ο Έλληνας ασθενής, σύστημα παραπομπής **αυστηρό-*gatekeeping*, είναι πολύ δύσκολο να εφαρμοστεί** και θα φέρει μεγάλες αντιδράσεις.

- Πολύ κοντύτερα στην ελληνική πραγματικότητα είναι το σύστημα αναφοράς που εφαρμόζεται στη Γαλλία. **Οικονομικά κίνητρα στους ασθενείς να χρησιμοποιήσουν τον οικογενειακό τους γιατρό σαν σημείο πρώτης επαφής,** που θα φέρει και τη ζητούμενη αλλαγή κουλτούρας σταδιακά.

Προτεινόμενο υπόδειγμα εφαρμογής

Αύξηση αποζημίωσης γιατρού εξειδίκευσης ανά επίσκεψη στα 20 € *(από10).*

- ***αν ο ασθενής έχει παραπομπή από τον ΟΙ του:***
  - ***κάλυψη του κόστους των 20 € της επίσκεψης από τον ΕΟΠΥΥ.***
  - ***Τυχόν παρακλινικές εξετάσεις που θα συστήσει ο ιατρός εξειδίκευσης αποζημιώνονται κατά 85% από τον ΕΟΠΥΥ.***

- ***αν ο ασθενής δεν έχει παραπομπή από τον ΟΙ του:***
  - ***Τα 10€ από τα 20€ της επίσκεψης τα πληρώνει ο ασθενής.***
  - ***έχει 50% συμμετοχή στο κόστος των παρακλινικών εξετάσεων στις οποίες δυνατόν να τον παραπέμψει ο ιατρός εξειδίκευσης***

*(**σημειωτέον** πως ενδεχόμενη εφαρμογή αυτού **θα εξαφανίσει ουσιαστικά και το claw back για τους κλινικοεργαστηριακούς ιατρούς**).*

3. Αξιοπρεπής αποζημίωση του οικογενειακού γιατρού

- Η βάση της αποζημίωσης θα πρέπει είναι **per capita, σταθμισμένη για το προφίλ κινδύνου του ασθενούς**- *ηλικία, φύλο, νοσηρότητα.*

- Ικανοποιητική κρίνεται η αύξηση της **μέσης per capita αποζημίωσης στα 40€ / έτος** από την αναξιοπρεπή των 10€ /έτος που ισχύει τώρα.

- *Η αναξιοπρεπής προτεινόμενη αποζημίωση αποτέλεσε την αποκλειστική αιτία του ναυαγίου της πρότασης του ΕΟΠΥΥ για συμβάσεις με ιδιώτες οικογενειακούς ιατρούς…*

Αυτές θα είναι οι αμοιβές των γιατρών με το ΓεΣΥ

Οι συζητήσεις 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 αρμοδίων πολιτικών ή μη, οι αμοιβές των προσωπικών γιατρών κατά μέσο όρο υπολογίζονται σε €100.000 ετήσιο εισόδημα για τους παιδιάτρους και περίπου €120.000 μέσο ετήσιο εισόδημα για προσωπικούς ιατρούς για ενήλικες.

ηλικία	/pt/y (CY)	/pt/y (GR)
<3	**210 €**	**14,4 €**
4-7	**155 €**	**14,4 €**
8-18	**91 €**	**14,4 €**
16-50	**83 €**	6,72 €
51-70	**117 €**	11,52 €- 13,08 €
>70	**145 €**	13,08 €

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

4. Χρηματοδότηση της ΠΦΥ και της εξωνοσοκομειακής εξειδικευμένης φροντίδας

- **η επένδυση στην ΠΦΥ φέρνει μεγάλες επιστροφές** και καθιστά την παρέμβαση εν πολλοίς αυτοχρηματοδοτούμενη, μέσω του περιορισμού μη απαραίτητων, απρόσφορων ή και επικίνδυνων επισκέψεων σε γιατρούς, ΤΕΠ, νοσηλειών υπηρεσιών ή, και παρεμβάσεων.

- **Εναλλακτικοί τρόποι χρηματοδότησης του συστήματος**, τουλάχιστον στην αρχική φάση, που θα πρέπει να εξετάσει το ΥΥ για την απαραίτητη ενίσχυση της χρηματοδότησης της εξωνοσοκομειακής φροντίδας είναι:
  - **α) επιβολή φόρων αμαρτίας** σε **προϊόντα καπνού, αλκοόλ και ζάχαρη**- που αποτελούν συνάμα τους κύριους παράγοντες κινδύνου για τα χρόνια μη μεταδοτικά νοσήματα
  - **β) επιβολή συμμετοχής στους ασφαλισμένους στο κόστος για οικογενειακό γιατρό και για επισκέψεις σε ιατρούς εξειδικεύσεων**
    - ανάλογη με την οικονομική κατάσταση
    - αντιστρόφως ανάλογη με την ανάγκη υγείας

Keep the Astana Spirit alive!

Thank you