ΕΘΝΙΚΗ ΣΧΟΛΗ ΔΗΜΟΣΙΑΣ ΥΓΕΙΑΣ
ΥΓΕΙΟΝΟΜΙΚΗ ΣΧΟΛΗ ΑΘΗΝΩΝ 1929-1994

Οικονομική Κρίση και Χρόνια Νοσήματα

Κατερίνα Μυλωνά, LLM
Τομέας Οικονομικών της Υγείας
Εθνική Σχολή Δημόσιας Υγείας

Η επίδραση της κρίσης στην υγεία

- Ανισομερής κατανομή στην κοινωνική κλιμάκωση
- Ομάδες πληθυσμού με **μεγαλύτερο κίνδυνο πρόωρου θανάτου και αυξημένης νοσηρότητας,** ευάλωτες στην εκδήλωση μείζονος κατάθλιψης

Χρόνιοι Πάσχοντες

Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M. “The public health effect of economic crisis and alternative policy responses in Europe: An empirical analysis”. Lancet, 2009;374:315−323
Bartley M, Blane D, Montgomery S. “Health and the life course: Why safety nets matter”. *Br Med J*, 1997; 314:1194−1196

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European Journal of Public Health, 1–5

doi:10.1093/eurpub/cks143

Impact of economic crisis and other demographic and socio-economic factors on self-rated health in Greece

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Background: Financial crisis and worsened socio-economic conditions are associated with greater morbidity, less utilization of health services and deteriorated population's health status. The aim of the present study was to investigate the determinants of self-rated health in Greece. **Methods:** Two national cross-sectional surveys conducted in 2006 and 2011 were combined, and their data were pooled giving information for 10572 individuals. The sample in both studies was random and stratified by gender, age, degree of urbanization and geographic region. Logistic regression analysis was used to determine the impact of several factors on self-rated health. **Results:** Poor self-rated health was most common in older people, unemployed, pensioners, housewives and those suffering from chronic disease. Men, individuals with higher education and those with higher income have higher probability to report better self-rated health. Furthermore, the probability of reporting poor self-rated health is higher at times of economic crisis. **Conclusion:** Our findings confirm the association of self-rated health with economic crisis and certain demographic and socio-economic factors. Given that the economic recession in Greece deepens, immediate and effective actions targeting health inequalities and improvements in health status are deemed necessary.

Παράγοντες επίδρασης στην αυτοεκτίμηση του επιπέδου υγείας

Γενικός Πληθυσμός

$n = 8486$
$LR\chi^2 = 2247.32$
P (LR) < 0.001

Variable	OR (95% CI)	SE	P
Income	1.18 (1.13–1.24)	0.03	<0.001
Education	1.48 (1.35–1.62)	0.07	<0.001
Employment status[a]			
Unemployed	0.79 (0.63–0.99)	0.09	0.050
Pensioners	0.83 (0.70–0.99)	0.07	0.045
Housewives	0.78 (0.66–0.94)	0.07	0.008
Students–soldiers	1.54 (1.02–2.34)	0.33	0.039
Other	0.95 (0.46–1.93)	0.35	0.890
Age	0.87 (0.82–0.93)	0.03	<0.001
Existence of chronic disease[b]	0.18 (0.15–0.20)	0.01	<0.001
Gender[c]	1.31 (1.17–1.47)	0.08	<0.001
Survey year[d]	0.88 (0.78–0.99)	0.05	0.042

Πηγή Εθνική Σχολή Δημόσιας Υγείας, 2011

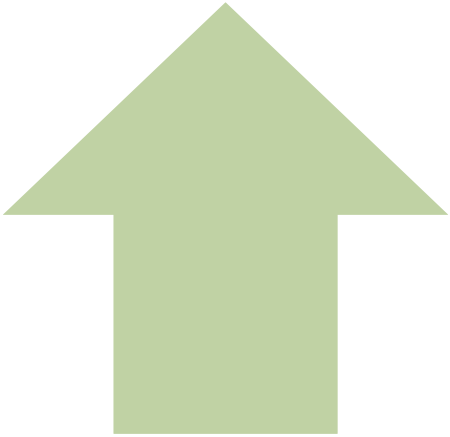
Μνημόνιο – Μέτρα (ενδεικτικά)

- **Αναθεώρηση συμμετοχών**
- **Περιορισμός της εισόδου μη γενοσήμων φαρμάκων στη θετική λίστα**
- **Αύξηση των μη συνταγογραφούμενων φαρμάκων.**
- **Αναθεώρηση του πακέτου παροχών που παρέχεται από τον ΕΟΠΥΥ**
- **Υποχρεωτική συνταγογράφηση βάσει δραστικής**
- **Προώθηση γενοσήμων, αντικατάσταση στο φαρμακείο**

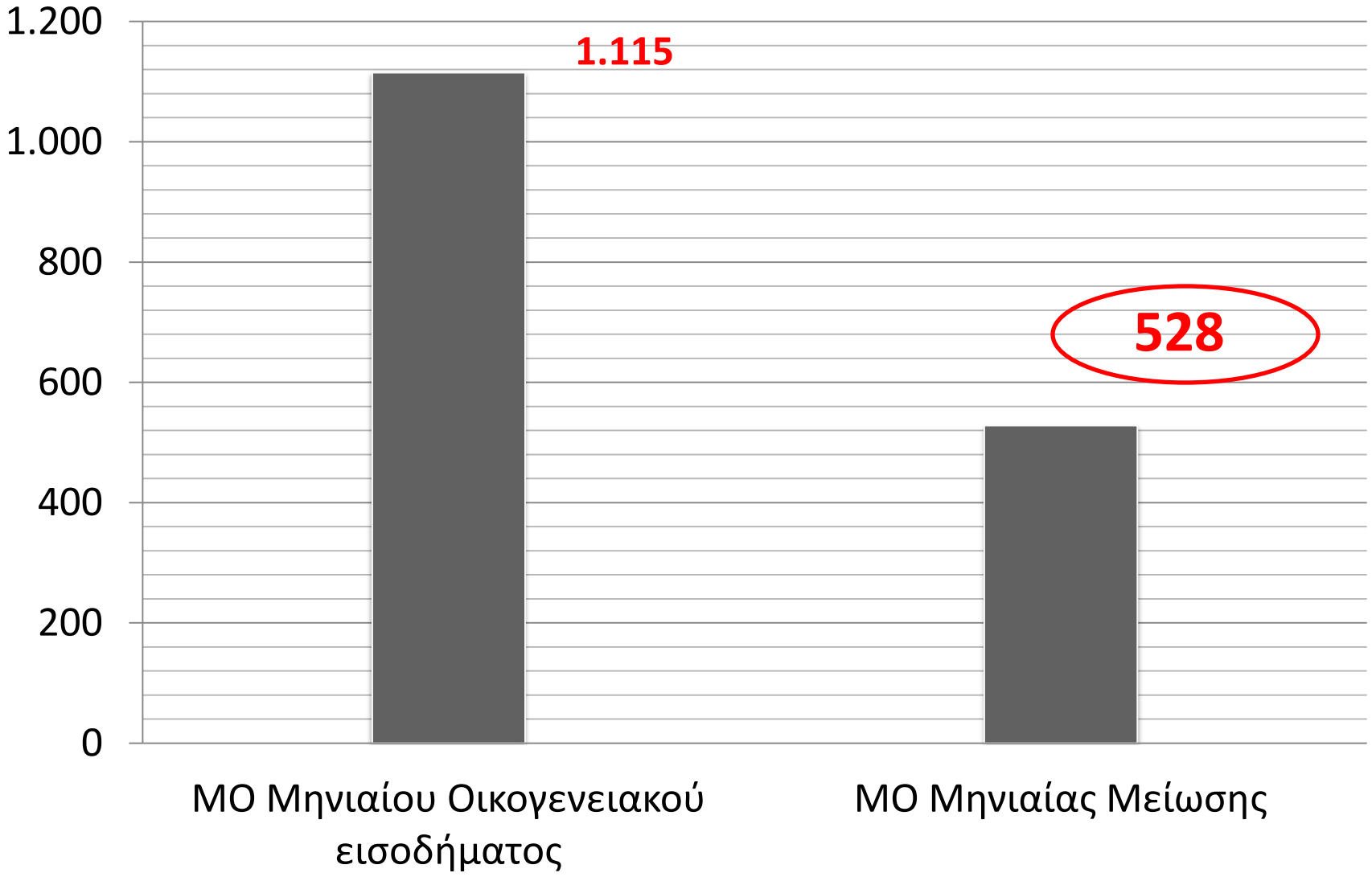
2012 / €2,88 δις

2013 / €2,44 δις

2014 / €2,0 δις



Μείωση εισοδήματος



Πηγή: Εθνική Σχολή Δημόσιας Υγείας, 2013

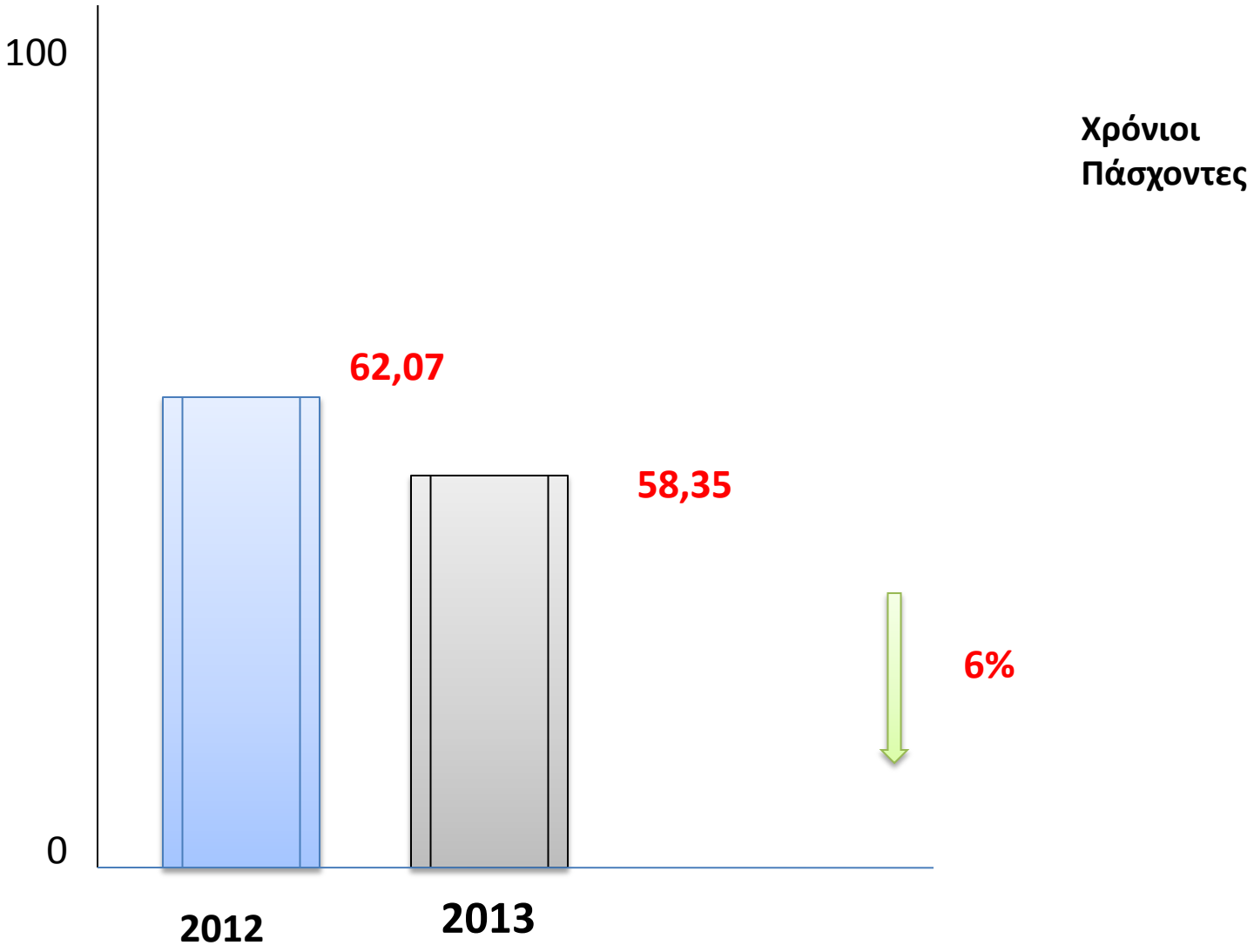
Συνέπειες

Διαχείριση Χρόνιου Νοσήματος

- ✓ Επίπεδο Υγείας
- ✓ Χρήση
- ✓ Πρόσβαση

- ✓ Επιλογή
- ✓ Απόφαση

Αυτοεκτίμηση του επιπέδου υγείας



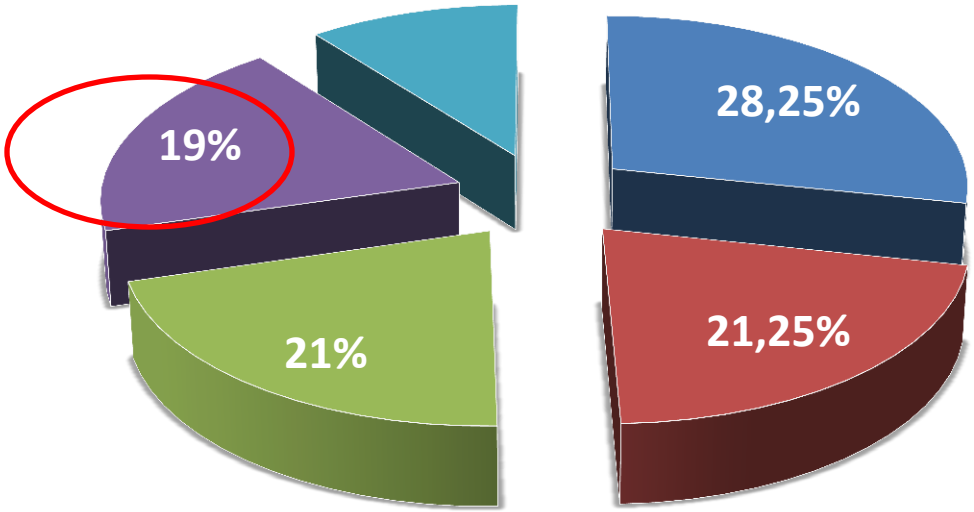
Πηγή: Εθνική Σχολή Δημόσιας Υγείας, 2013

Χρόνιοι πάσχοντες & Ψυχικά Νοσήματα

Disease	Prevalence			
	Depression	Anxiety	Effect of time	Age and sex
Heart disease	After myocardial infarction or coronary artery disease: 20%;[7] 1.6%–50%;[8] 15%–20%;[9] 20%–28%.[10] Before myocardial infarction: 33%–50%.[11] Heart failure: 25%–30%;[10] 14%–26%.[12]	Panic disorder in patients with coronary artery disease and cardiology outpatients: 10%–50%.[24]	Depression at time of follow-up after myocardial infarction: 60%–70%.[7]	Women with heart disease report more symptoms of anxiety and depression than men.[25]
Stroke	Post-stroke: 5%–44%;[13] 6%–34%;[14] 30%–36%.[15]	Increased incidence of generalised anxiety disorder.[14]	Rates of post-stroke depression persist > 6 months.[13,14]	No age or sex associations for post-stroke depression.[15]
Diabetes mellitus	Type 2: 8%–52%.[16] Type 1: 12%.[17]	Generalised anxiety disorder in 14% of patients with diabetes; higher in those with type 2.[26]	No systematic reviews found.	Prevalence rates of both depression and anxiety consistently higher in women than men.[26,27]
Asthma	No systematic reviews found. Survey data show major depression in 14.4% (compared with 5.7% in patients without asthma).[28]	No systematic reviews found.	No systematic reviews found.	No systematic reviews found.
Cancer	At diagnosis: 50%[19] (this is a global measure of distress). Ongoing: 20%–35%.[19] Cancers with poorer prognosis: 20%–50%;[18,19] 7%–50%.[29]	Generally: 15%–23%.[18,19] Colorectal cancer: 15%–23%.[29] With disease progression: up to 69%.[30]	Post-traumatic stress disorder in survivors of childhood cancers: point prevalence, 4.7%–21%;[20] lifetime prevalence, 20.5%–35%.[20]	No systematic reviews found.
Arthritis and osteoporosis	Rheumatoid arthritis: 13%–17%;[21,22] up to 80%.[31] High levels of psychological adjustment problems noted in children and adolescents.[32] Osteoporosis: strong and consistent association with depression.[23]	No systematic reviews found. Some single studies found a relationship between arthritis and anxiety.[33,34]	No systematic reviews found.	No systematic reviews found. Younger patients with arthritis more likely to have depression, anxiety and social withdrawal.[35]

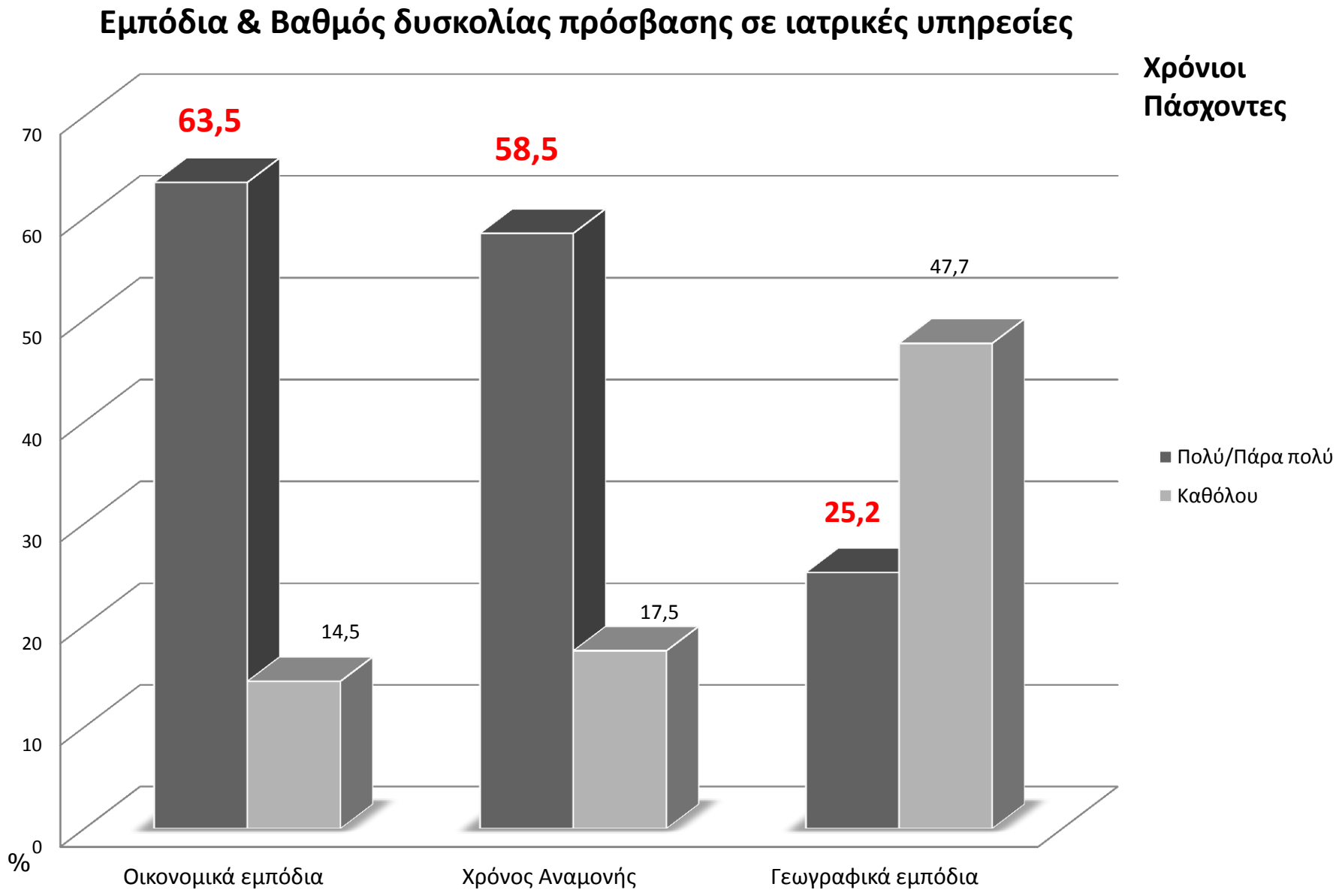
Πηγή: Clarke MD, Currie KC, Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence, MJA 2009; 190: S54–S60

Χρήση Δομών ΠΦΥ (Σεπτ.2012-Φεβρ.2013)



- Γιατρός που πλήρωσε εξ ολοκλήρου η ασφάλισή σας
- Μονάδα υγείας του ΕΟΠΥΥ
- Γιατρός που πληρώσατε μερικώς εσείς και η ασφάλισή σας
- Γιατρός που πληρώσατε εξ ολοκλήρου εσείς ή οι συγγενείς σας
- Άλλο (ΚΥ, ΠΙ)

Οικονομική κρίση και Χρήση Υπηρεσιών Υγείας



Πηγή: Εθνική Σχολή Δημόσιας Υγείας, 2013

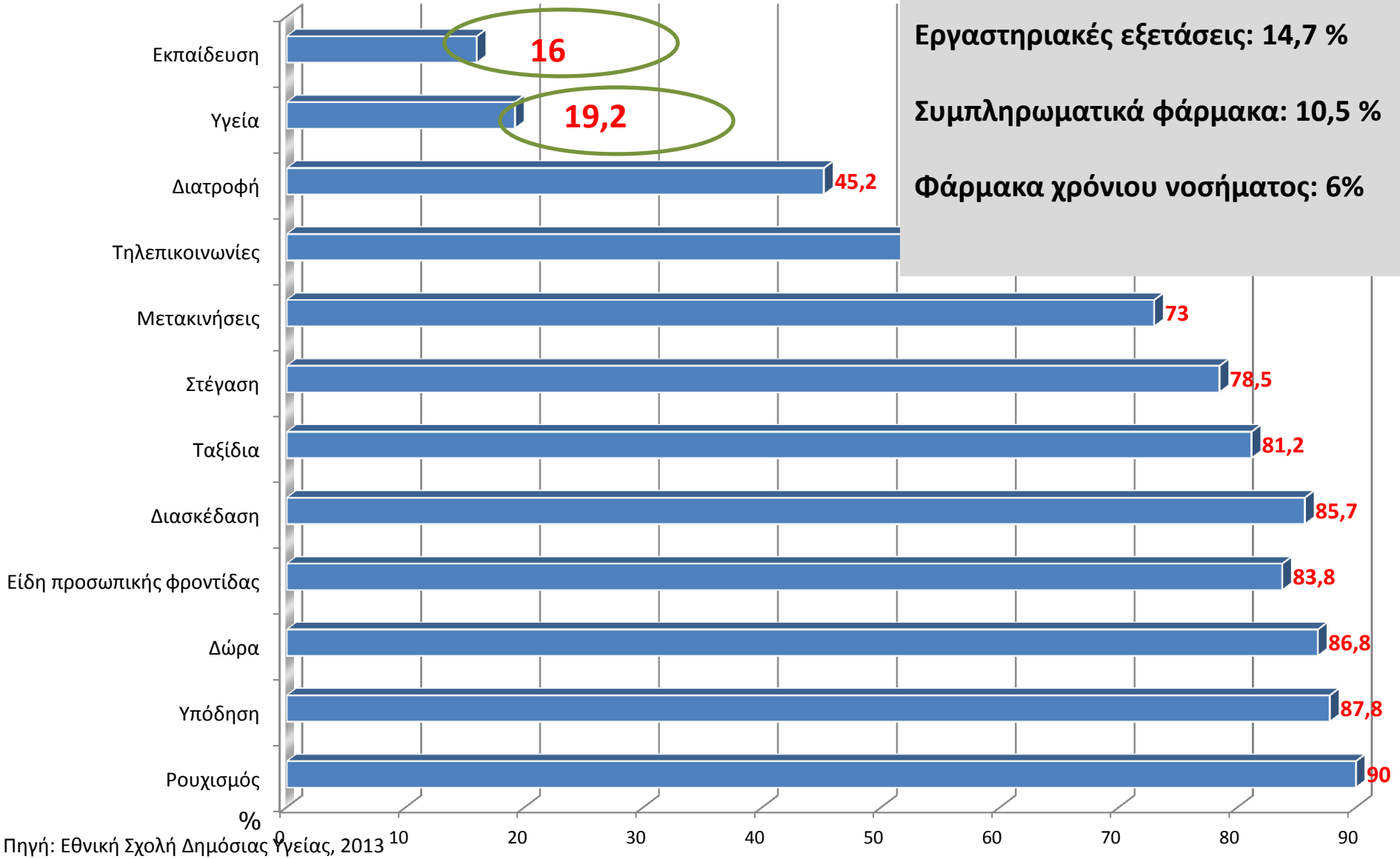
Προκλήσεις … πιθανά νέα εμπόδια;

Νέο Οικονομικό Περιβάλλον

- ✓ Μείωση Εισοδήματος
- ✓ ΥποχρεωτικήΣυνταγογράφηση INN
- ✓ Χορήγηση από το φαρμακοποιό του φθηνότερου γενοσήμου της συγκεκριμένης δραστικής ουσίας

% Μείωση Δαπάνης ανά Κατηγορία

Χρόνιοι Πάσχοντες



Επισκέψεις σε γιατρούς: 16,7 %

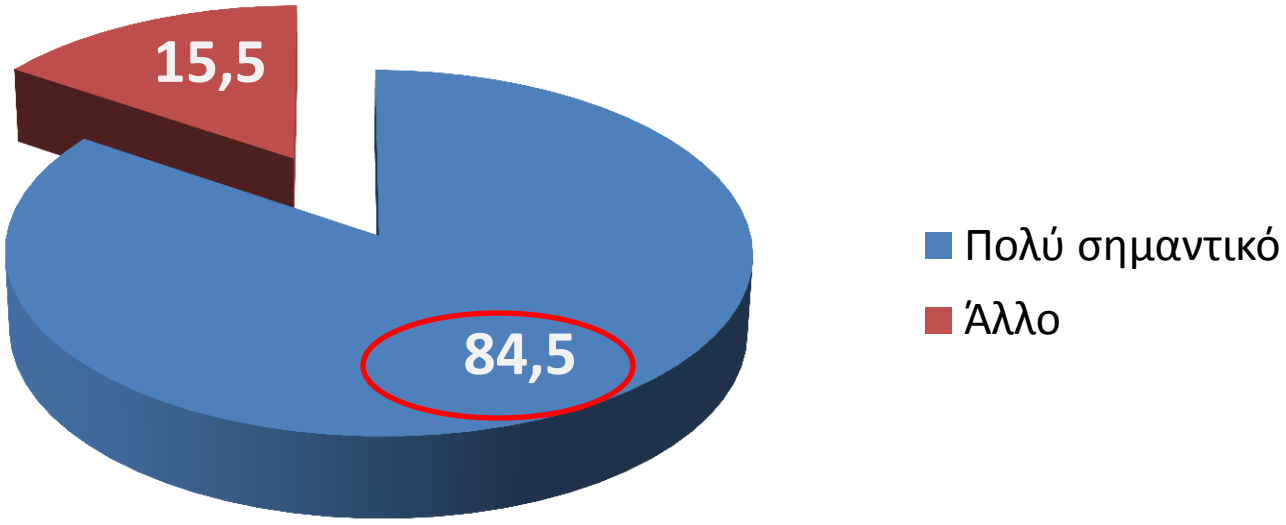
Εργαστηριακές εξετάσεις: 14,7 %

Συμπληρωματικά φάρμακα: 10,5 %

Φάρμακα χρόνιου νοσήματος: 6%

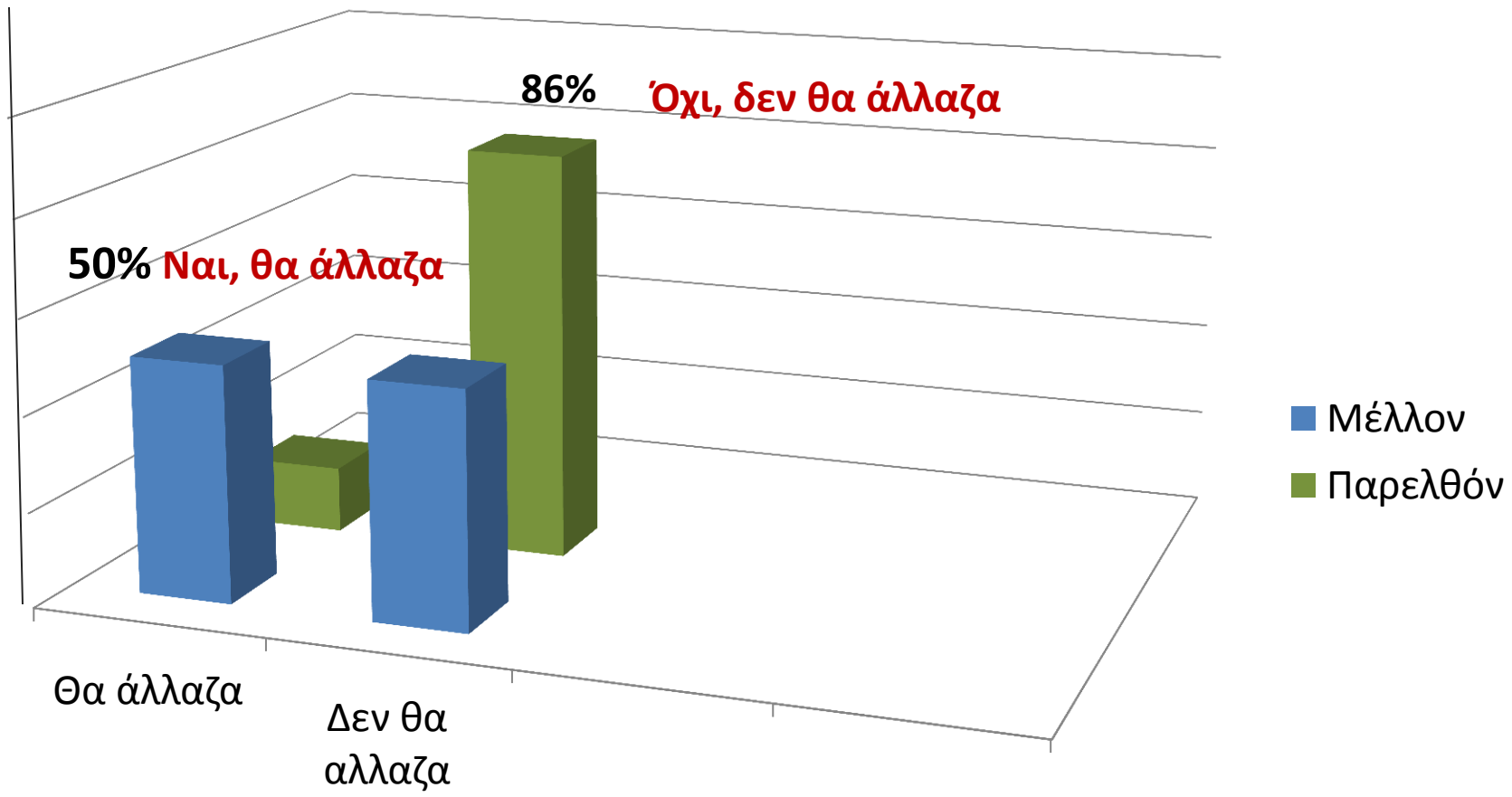
Πηγή: Εθνική Σχολή Δημόσιας Υγείας, 2013

Ρόλος Φαρμάκου

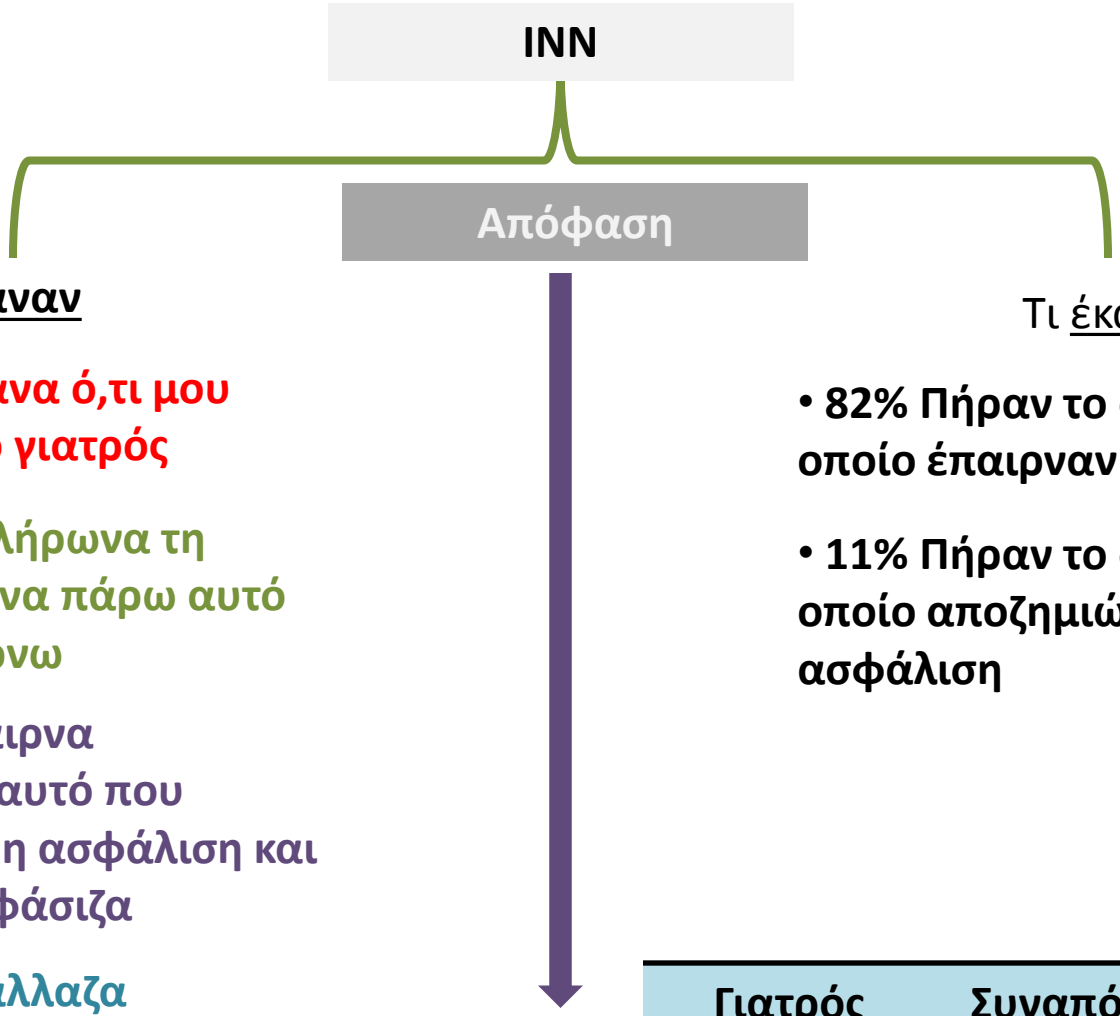


Οικονομική επιβάρυνση ασθενών

(Αλλαγή φαρμάκου για οικονομικούς λόγους)

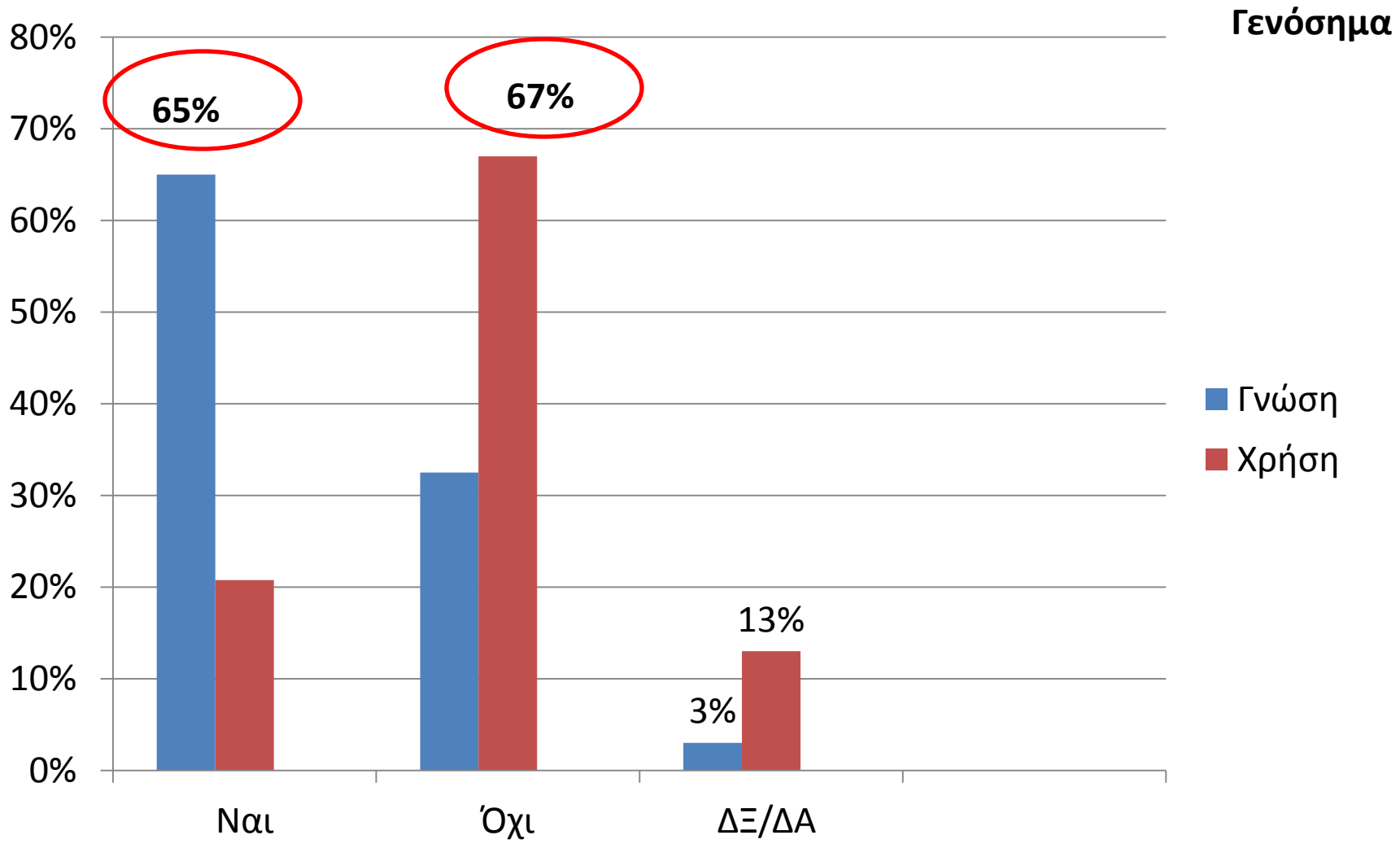


Νέο Περιβάλλον… Αποφάσεις



Γιατρός	Συναπόφαση	Ασθενής
24,8%	58,3%	17%

Νέο Περιβάλλον… Αποφάσεις… Στόχοι



	Στατιστικά Σημαντικές Ανεξάρτητες Μεταβλητές					
	Εισόδημα	**Αντίληψη ασθενών για μείωση του εισοδήματος**	**Φύλο**	**Εκπαίδευση (+)**	**Αυτοεκτίμηση Επιπέδου Υγείας (+)**	**Επάγγελμα**
Εξαρτημένες Μεταβλητές	**Οικονομικοί /εισοδηματικοί περιορισμοί**	**Οικονομικοί /εισοδηματικοί περιορισμοί**	**Χρονικοί περιορισμοί**	**Ασφάλεια γενοσήμων**	**Χρονικοί περιορισμοί**	**Γεωγραφικοί περιορισμοί**
	Γεωγραφικοί περιορισμοί	**Χρονικοί περιορισμοί**	**Αποτελεσματικότητα γενοσήμων**	**Willingness to Pay (Αποτελεσματικότερο Φάρμακο- Ναι/Όχι)**	**Ποιότητα γενοσήμων**	
	Αποτελεσματικότητα γενοσήμων	**WTP (συνολικά)**	**Ασφάλεια γενοσήμων**	**WTP (Αποτελεσματικότερο Φάρμακο- Ναι/Όχι)**	**Δαπάνη για Διαχείριση Νόσου**	
	Ποιότητα γενοσήμων					
	Ασφάλεια γενοσήμων					
	WTP (συνολικά)					
	WTP (Αποτελεσματικότερο Φάρμακο- Ναι/Όχι)					

Τυχαίες Σκέψεις

✓ **Στόχος της περιστολής της δημόσιας φαρμακευτικής δαπάνης**

Αμφίβολος

Τάσεις υποκατάστασης σε νεότερες/ακριβότερες δραστικές για τις ίδιες ενδείξεις

✓ **Στόχος της περιστολής της δημόσιας φαρμακευτικής δαπάνης**

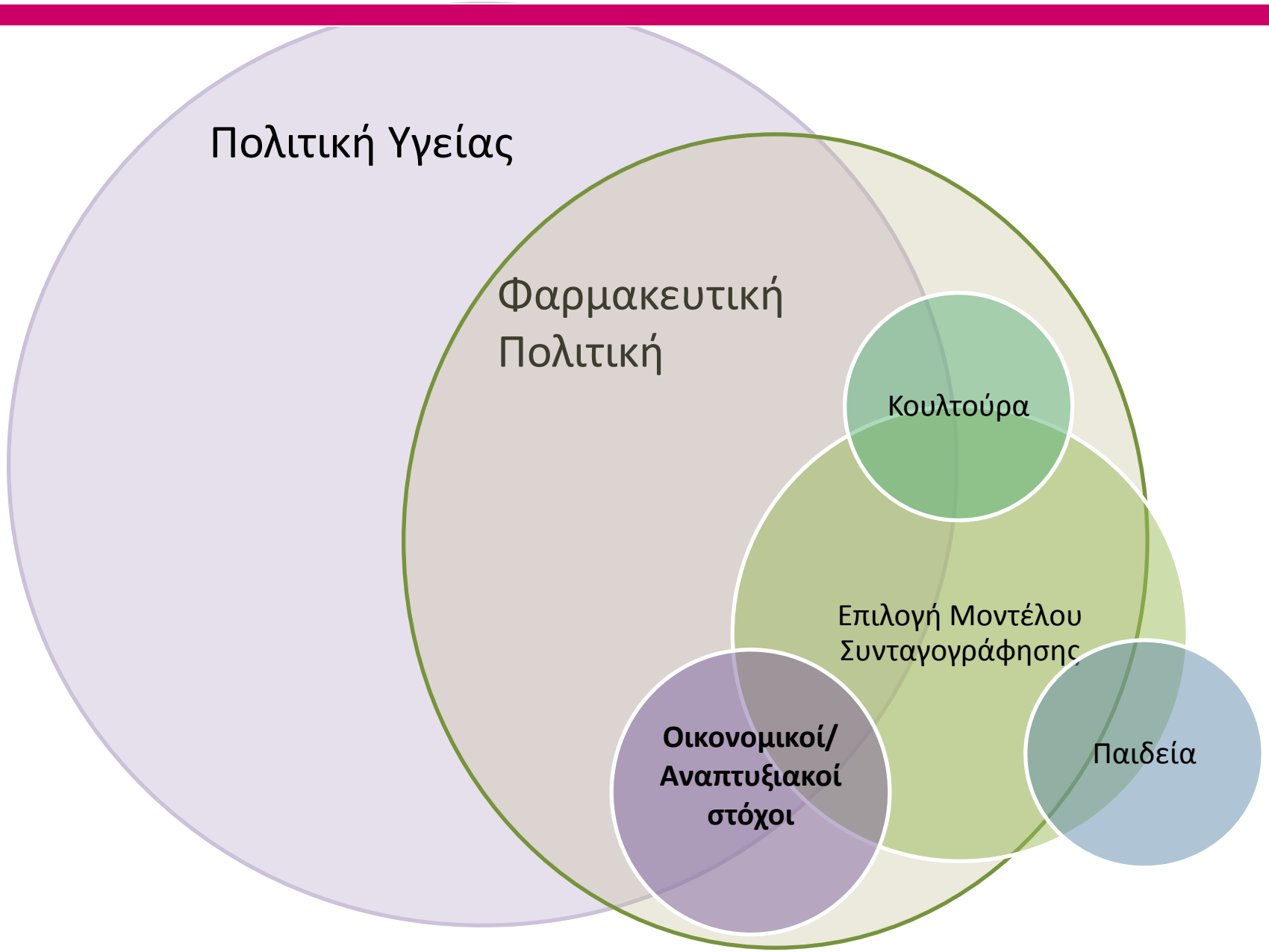
Βέβαιος

Μέσω της λογιστικής μεταφοράς της διαφοράς στις ιδιωτικές δαπάνες

Κόστος απορρύθμισης

Π.χ. Διαβήτης 50% υψηλότερο κόστος θεραπείας για τους μη ρυθμισμένους ασθενείς

Τυχαίες Σκέψεις



Πρόληψη

Contents lists available at SciVerse ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Recommending organized screening programs for adults in Greece: A Delphi consensus study

Anastasios Skroumpelos*, Dimitris Zavras, Elpida Pavi, John Kyriopoulos

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Keywords:
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Secondary prevention
Delphi technique
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ABSTRACT

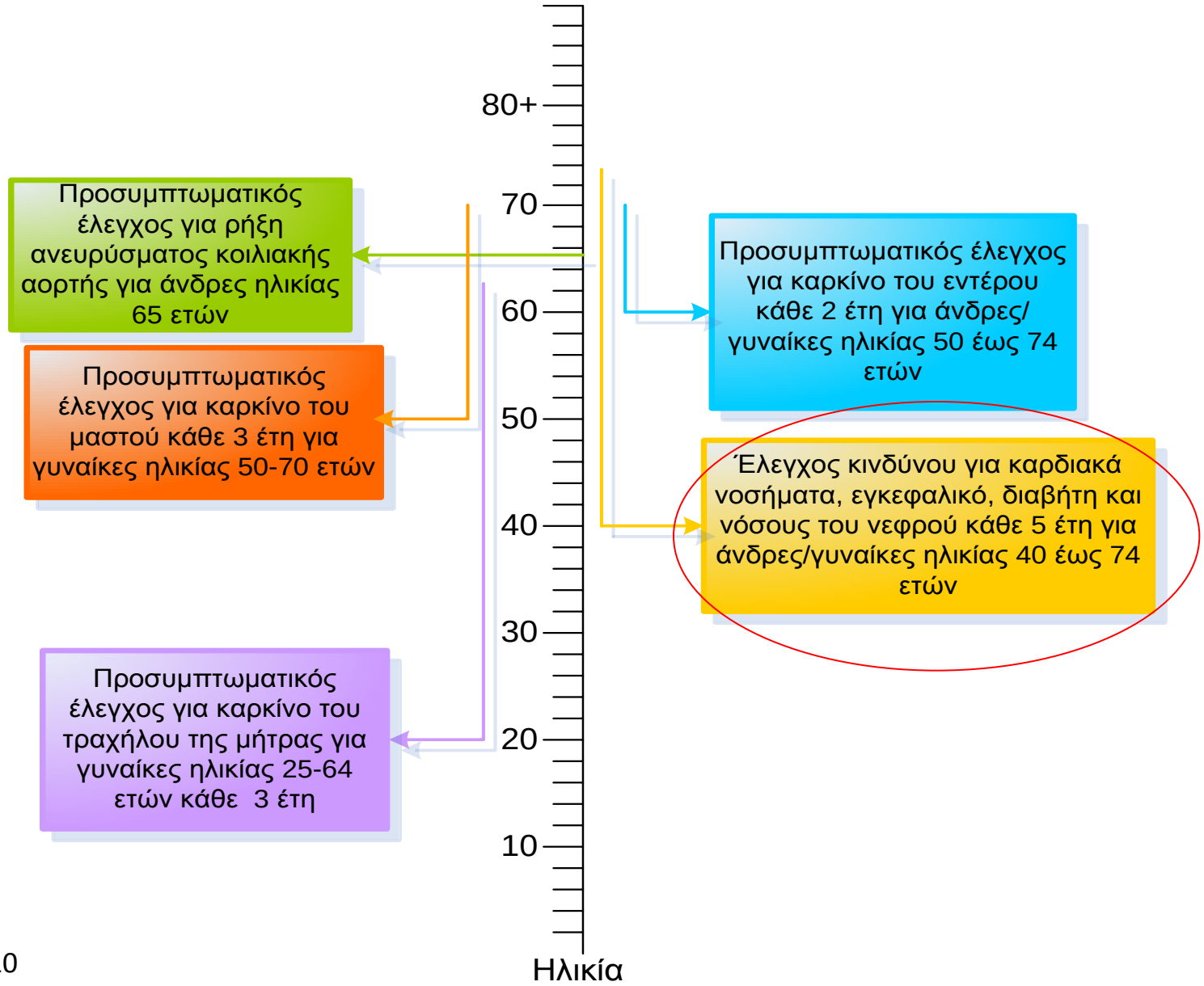
Objective: In the absence of organized screening programs in Greece, the aim of this study is to propose a set of programs, which exhibit potential to improve health system's performance.

Methods: A literature review was conducted to identify those programs fulfilling certain screening evaluation criteria. Using Delphi method programs identified were evaluated by a multi-professional expert panel who were asked to provide their consent and recommendations for the implementation, target-group, rescreening interval, primary screening method and social insurance reimbursement level. Kuder–Richardson 20 and Cronbach's α were used for assessing internal consistency and number of rounds.

Results: The majority of experts supported the introduction of organized screening programs for breast cancer, cervical cancer, colorectal cancer, abdominal aortic aneurysm and vascular risk assessment. Major disagreements arose on the target-group of the colorectal cancer and abdominal aortic aneurysm program concerning age-limits. Experts argued that only those fulfilling programs' eligibility criteria or those referred should be reimbursed by social insurance.

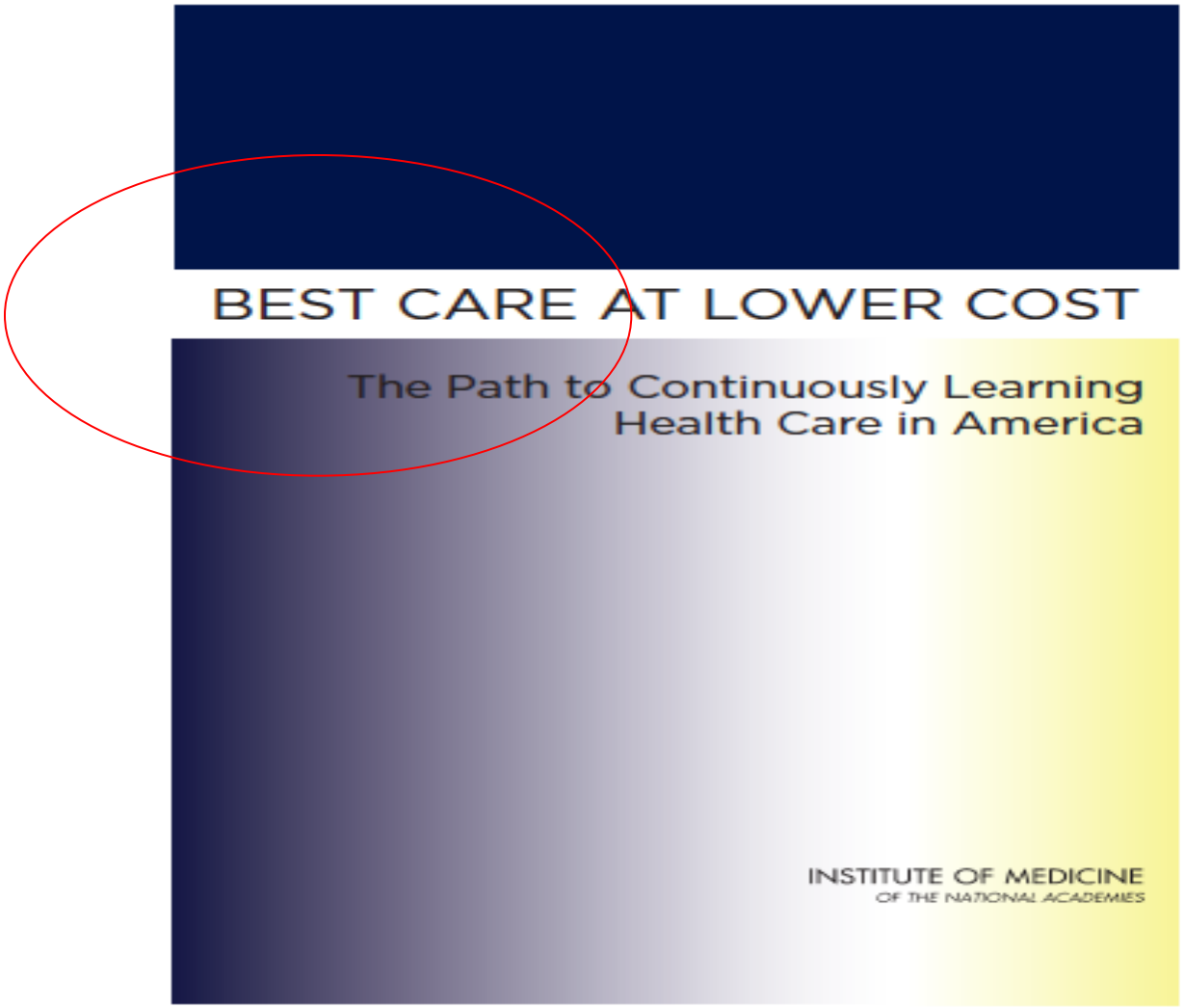
Conclusion: Recommended screening programs provide for the first time a comprehensive and consensus based proposal for the secondary prevention policy of the country. They are expected to contribute to the reduction of the disease burden from important health problems and to the optimum allocation of resources invested in health.

Προτεινόμενα ΕΠΠΕ για Ενηλίκους



Πηγή:ΕΣΔΥ,2010

Ζητούμενα



ΕΠΙΛΟΓΕΣ στον ασθενή

Ζητούμενα

THE COMMONWEALTH FUND

November 2011

Issues in International Health Policy

Disease-Management Programs Can Improve Quality of Care for the Chronically Ill, Even in a Weak Primary Care System: A Case Study from Germany

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

Stephanie Stock, Dagmar Starke, Lutz Altenhofen, and Leonhard Hansen

Abstract: Enhancing the coordination and quality of care for chronically ill patients is a challenge across health care systems. In Germany, following a 2002 reform, physician-based and patient-centered disease-management programs (DMPs) were implemented in a nationwide rollout. These programs are characterized by information technology support, the central role of a designated doctor in ambulatory care, a patient-centered approach that encourages patient self-management, quality assurance (including reminders and benchmarking), and financial incentives for physicians, patients, and sickness funds. Results of a four-year follow-up show that despite the programs' implementation in a weak primary care system, quality of care and

Διαχείριση χρόνιου νοσήματος

Επαγγελματική Ιατρική Φροντίδα	2 ώρες ετησίως
Αυτοφροντίδα	8.758 ώρες ετησίως

Ζητούμενα

Engineering the System of Healthcare Delivery. Edited by W.B. Rouse and D.A. Cortese.
IOS Press, 2010
doi:10.3233/978-1-60750-533-4-159

Chapter 10

Transforming healthcare through patient empowerment

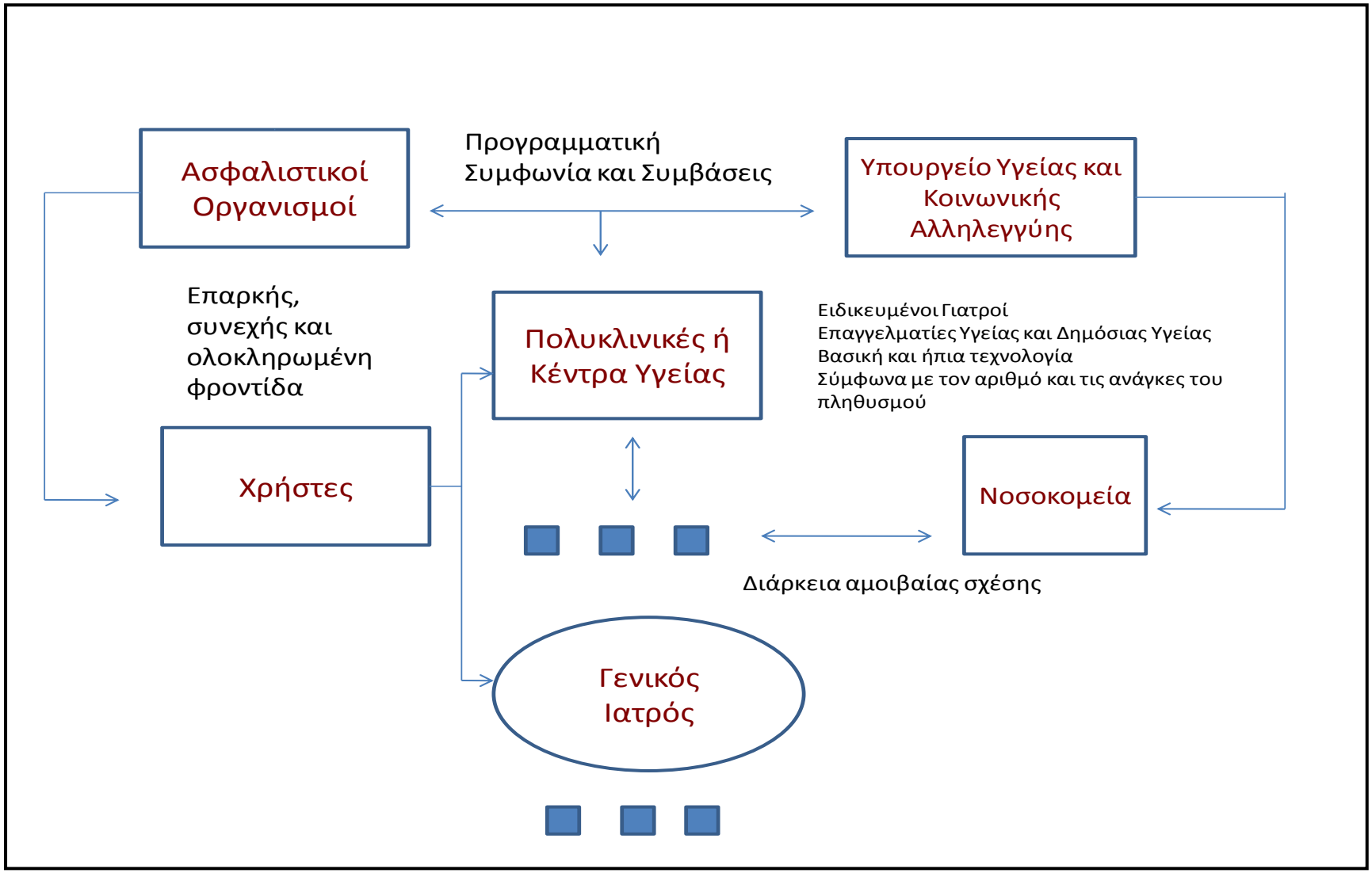
Leslie Lenert
E-mail: leslie.lenert@gmail.com

I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. Hippocrates

Abstract: The United States faces tremendous challenges with its healthcare system. By any standard, it is expensive and performs poorly in most measures of health and thus, is in great need of reform. But how do we reform things without making the situation worse? Some of the more fundamental problems arise from the combination of a fee-for-service payment system for physicians with insurance-based financing care. This combination results in conflicts among the interests of patients, physicians and payers. This paper examines this issue from a decision analytic perspective, starting with a definition of the patient-centered view, and an assessment of the practicality of controlling costs by making healthcare more patient-centric. It then illustrates how fee-for-service models corrupt decision-making and other solutions designed to reign in the abuses of the fee-for-service model and also negatively impacts the quality of decision making for individual patients. Whatever the strategies for health reform, the degree of patient-centeredness of care is a benchmark that allows policy makers to understand how far they have had to deviate from optimal to achieve the desired ends of cost control.

Πιθανές απαντήσεις σε συνθήκες κρίσης χρόνια νοσήματα

Δίκτυα ολοκληρωμένης φροντίδας υγείας



Πηγή : Kyriopoulos (2000)

Ευχαριστώ για την προσοχή σας!