Interreg
Greece-Bulgaria
EQUAL2HEALTH
European Regional Development Fund

EUROPEAN UNION

Medical Staff Guide

The project is co-funded by the European Regional Development Fund (ERDF) and by national funds of the countries participating in the Interreg V-A "Greece-Bulgaria 2014-2020" Cooperation Programme.

Contents

1. Vulnerable groups in Greece

1.1 Definition of vulnerable groups according to Law 4430/2016

"Social and Solidarity Economy and development of its bodies and other provisions"

The Law 4430/2016 on “Social and Solidarity Economy and development of its bodies and other provisions” (Government Gazette A '205 / 31-10-2016), aims to create the legislative framework for the Social and Solidarity Economy, as form of alternative organization of economic activities and aims at: a. In the diffusion of the Social and Solidarity Economy in all possible sectors of economic activity. b. To support and strengthen productive self-management projects and collective social entrepreneurship.

According to this law, those groups are defined as "vulnerable" population whose integration into social and economic life due to physical and mental causes or due to delinquent behavior. These include:

a) persons with disabilities of any form (physical, mental, intellectual, sensory),

b) people with substance abuse problems or addicts;

c) juveniles with delinquent behavior, prisoners and detainees.

‘Special’ are defined as those groups of the population which are disadvantaged in terms of their smooth integration into the labor market economic, social and cultural reasons. These include:
a) victims of domestic violence;

b) victims of trafficking in human beings;

c) the homeless,

d) persons living in poverty;

e) economic migrants,

f) refugees and asylum seekers pending examination application for asylum,

g) heads of single-parent families;

h) people with cultural peculiarities,

i) the long-term unemployed up to twenty-five years and over fifty years.

The European Commission states that 'vulnerability is dynamic and individuals are vulnerable when exposed to multiple exclusion procedures'. Furthermore, the risk of finding any vulnerable person depends on the interaction that exists between certain factors, such as personal (innate or acquired), social and environmental.

It then links vulnerability to 9 target groups:

- Elderly people
- Children and families from disadvantaged backgrounds
- Residents of rural / isolated areas
- People with physical, mental and learning disabilities or poor mental health
- Long term unemployed
- Financially inactive
- The "poor workers"
- Victims of domestic violence and violence by a close partner
- People with unstable housing conditions (the homeless)
- Prisoners

In addition, regarding these rights, according to article 12 of the revised European Social Charter of the Council of Europe (NOMOS NO. these members of their family have a right to social security "and 13

"Every person who does not have sufficient resources has the right to social and medical perception."

Then, according to the World Health Organization (WHO), there are certain groups of people in society who are at a disadvantage and have fewer resources. These groups, often referred to as "vulnerable", include:

- Women and especially those who have experienced or are experiencing some kind of abuse,
- People living in absolute poverty (eg residents of very poor areas - 'slums')
- People with psycho-traumatic experiences due to conflicts and wars,
- Immigrants, especially refugees and those displaced from their homelands,
- Children and adolescents who grow up without care and
- Indigenous peoples in different parts of the world

1.2 Situation of the uninsured in the Greek reality

The Greek state has launched some comprehensive efforts aimed at free access to all public health structures to provide nursing and medical care to the uninsured and vulnerable social groups:

- Law 4368/2016 (article 33 - Health coverage of uninsured and vulnerable social groups),

- the interpretative circulars KYA A3 (γ) /ΓΠ/οικ.25132/4-4-2016 (Arrangements for ensuring the access of the uninsured to the Public Health System) and

- Α3γ / Γ.Π.οικ.39364 / 31.05.2016 (Clarifications on ensuring the access of the uninsured and socially vulnerable groups to the public health system).

The most fundamental change introduced by the above institutional framework in relation to all previous efforts is:

- the equalization of the right of the insured, uninsured and former holders of an Individual Book of the Financially Weak or Uninsured in terms of access to the public health system.

- The health coverage that is guaranteed is complete and includes the nursing, diagnostic and pharmaceutical coverage.

The rights of the uninsured are in a nutshell:

- Exactly what the insured from the public health care structures are entitled to (Free and free access to primary and secondary public health structures, administration of medication, etc.).

The total number of uninsured citizens is estimated at about 2.5 million citizens and those who:

- due to the financial crisis they have lost their insurance capacity even if they have debts to insurance companies,

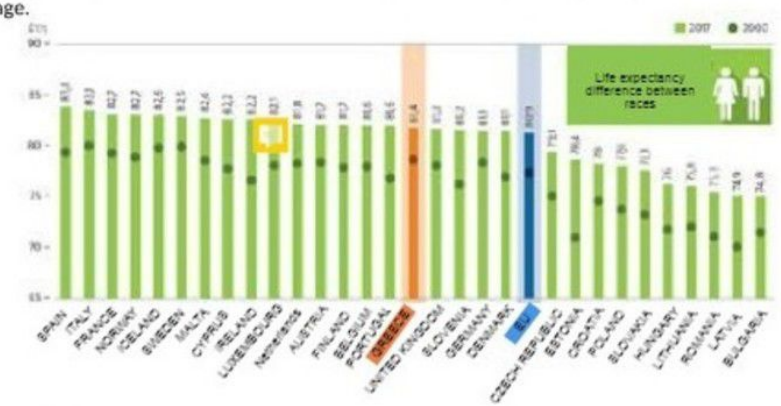
- reside legally in the country

- do not have legal residence documents, but need immediate health care as members of vulnerable social groups (e.g. minors, pregnant women, people with disabilities, dependents, homeless people, etc.).

2. Relevant statistics according with the “State of Health in the EU-Greece. Health profile 2019”

Regarding health in Greece:

• Life expectancy at birth in Greece reached 81.4 years in 2017, half a year higher than the EU average.



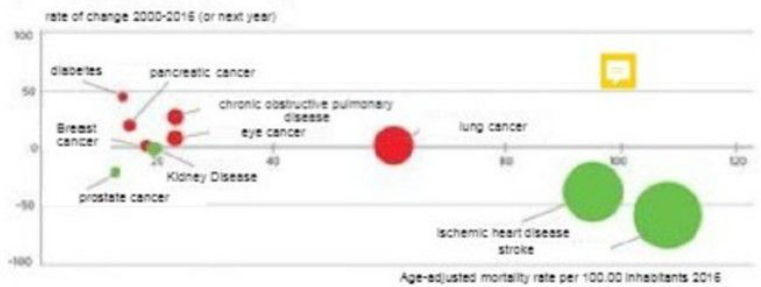
SOURCE EUROSTAT'S DATABASE

• Life expectancy has risen slightly faster for men, while it has remained stagnant for women in recent years, with a gender gap similar to that of the EU.

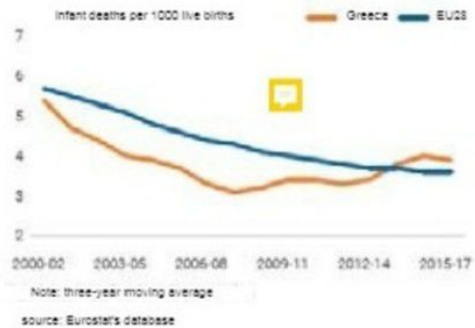
•Life expectancy at age 30 among those with the lowest level of education and those with higher education was 6 years for men and 2.4 years for women, below the EU average (7.6 and 4.1 for men and women, respectively).

- The main causes of death: stroke and ischemic heart disease from 2000 onwards.
- Lung cancer: most common cause of death from cancer.
-
- Increase in mortality from pancreatic cancer and colorectal cancer from 2000 onwards.

- Growing problem in the last 2 decades: deaths from diabetes and chronic diseases of the respiratory system. It should be noted here that the rate is lower than the EU average. However, this increase may indicate a weakness in the treatment of chronic diseases.



- Increase in suicide rate by 30% - average 4.3 per 100 000 inhabitants since 2010 (compared to 3.3 in the previous decade) while the EU average: 10.3 per 100 000 inhabitants in 2016.
- • Increase in the prevalence of symptoms of major depression in the general population, from 3.3% in 2008 to 12.3% in 2013.
- • Stable reduction in infant mortality: 3.5 (just below the EU average) in 2017.



Regarding the vulnerable group of refugees in Greece:

- In 2015 the number of passers-by reached 1 million.
- Since 2016, refugees have the right to access the same level of services as Greek citizens.
- Asylum seekers who suffer from specific diseases, have a disability or are accommodated in social welfare units, have access to the services regardless of their legal status.

• Living conditions make the health of these vulnerable groups difficult.

• The most common health problems observed in refugees and immigrants in Greece:

• - Gastrointestinal disorders.

• - Respiratory disorders.

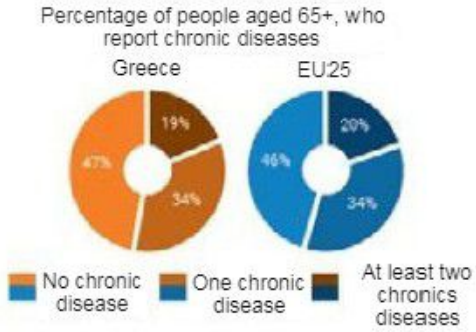
• - Chronic diseases, e.g. diabetes and hypertension, pregnancy and childbirth complications,

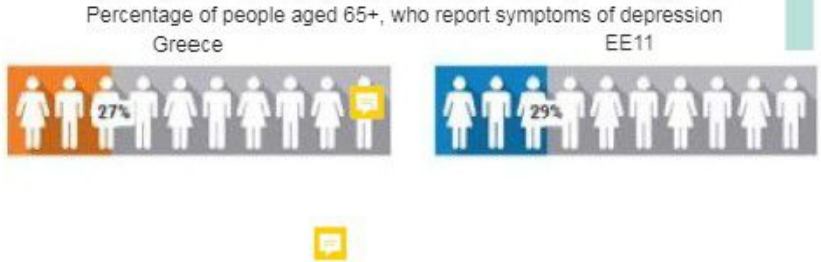
• - physical and psychological trauma.

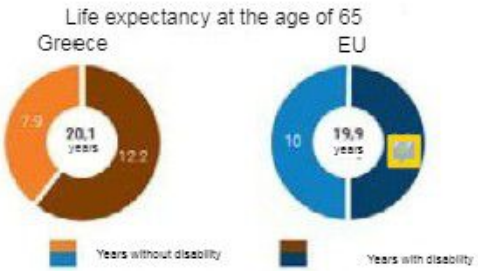
• Immigrants and refugees in Greece are gastrointestinal and respiratory disorders, chronic diseases such as diabetes and hypertension, pregnancy and childbirth complications, as well as physical and psychological trauma.

• Subsequently:

• • 1/5 (22%) people in Greece are aged 65 and over.







• In 2017, life expectancy at the age of 65 was 20.1 years, slightly higher than in all EU countries.

• Greeks are expected to live only about 40% of these years without disability, while in the rest of the EU almost 50%.

• The percentage of Greeks who state that they do not suffer from chronic disease is 47% while in the EU 46%.

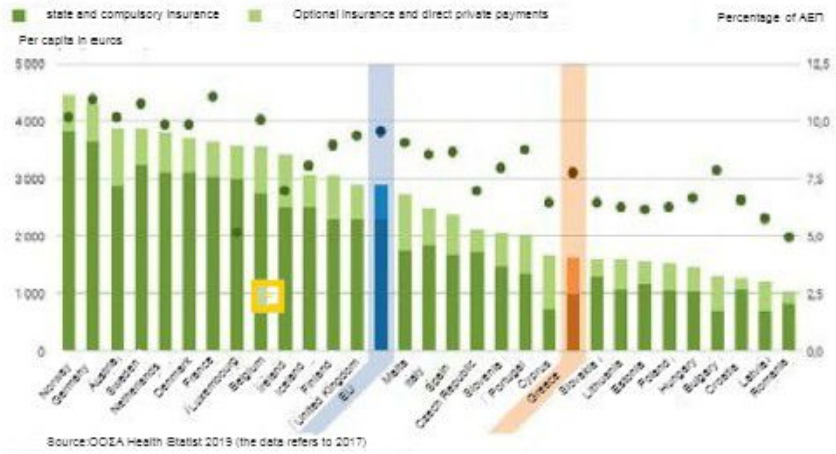
• It should be noted here that chronic diseases include heart attack, stroke, diabetes, Parkinson's disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis).

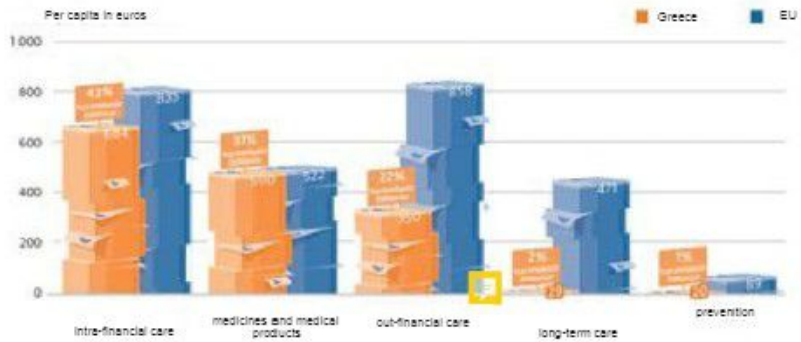
Then, regarding the health system:

• In 2017, Greece allocated 8% of GDP to health.

• € 1,623 per person - well below the EU average (€ 2,884).

• In 2017, most of the expenditures (42%) were allocated for inpatient care, followed by medicines (31%) and outpatient care (22%).





• Greece spends comparatively minimal resources for preventive care, just 20 EURO per person (compared to 89 EURO which is the EU average) or 1.3%.

• In Greece only 61% of healthcare expenditures come from public sources while 35% are financed directly by households (the 4th highest percentage in the EU).

• Informal payments represent more than 1/4 of direct private payments. This raises serious concerns about equality and barriers to accessing healthcare.

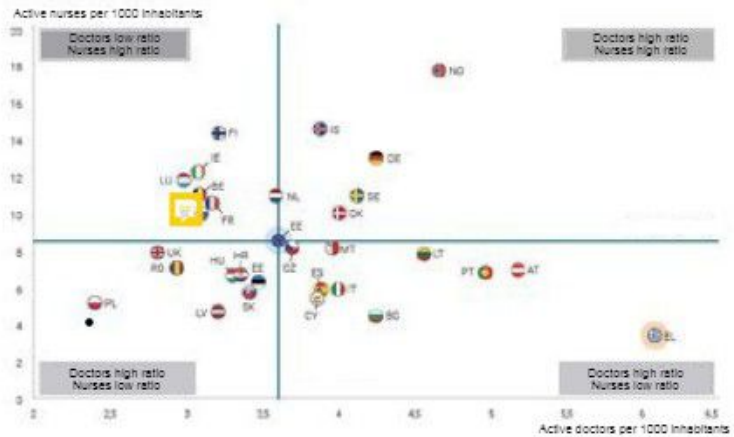
• Greece now offers universal healthcare coverage.

• Services are largely concentrated in large cities, while in rural areas there are shortages both at the level of qualified staffand at the level of facilities.

• In 2017 there were 4.2 hospital beds per 1000 inhabitants, less than the EU average (5.0).

Greece has the highest number of doctors and at the same time the lowest number of nurses per 1,000 inhabitants in the EU.

• The proportion of general practitioners is only 1/16 doctors in Greece, compared to 1/4 on average in the EU.



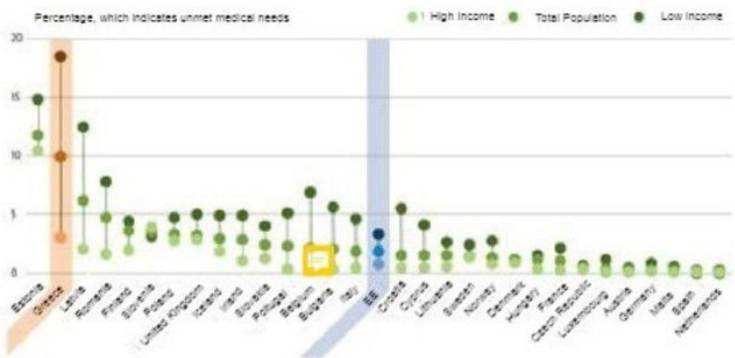
Regarding accessibility to medical care:

• In 2017, Greece had the 2nd highest level of self-reported unmet medical care needs in the EU.

• 1/10 of households reported that they did not have access to health services when they needed them.

• Unmet needs were reported by almost 1/5 households in the poorest quintile, but only by 3% of richer households. This is the biggest gap in income inequality in Europe.

- 2017 was the first year in which the overall level of unmet needs fell, after a continuous increase for six consecutive years.
- Out of 10% of households with unmet needs, 4/5 report costs as the main barrier to accessing care.
- Greece has very high rates of direct private payments amounting to 35% of health expenditures, twice the EU average, which is attributed to the challenged demand.
- Payments for medicines constitute the largest share of expenditures in direct private payments (13%).
- The 2nd largest share of expenditures concerns payments for in-hospital services (11%).



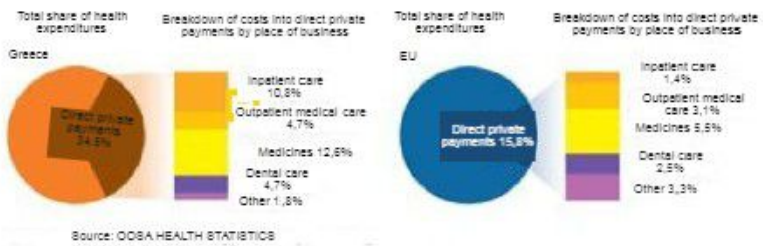
- Cost is the main barrier to accessing services.

- The rate of inpatient spending is high, 12% for the poorest income group.
- It is unlikely that the poorest households will turn to private hospital care due to their limited financial resources. > This percentage indicates that payments are also made in the context of public inpatient care.
- The average share of pharmaceutical expenditure increased from 13% in 2012 to 18% in 2013.
- The average patient charge per prescription increased by 2/3 during the period from 2011 to 2014.
- In 2014, a fixed charge of 1 EURO per prescription was imposed, unless patients belong to a group excluded from the measure.
- Patients must pay the difference between the retail price and the amount of compensation up to a maximum of 20 EURO per package, as the case may be.

• Exemptions from cost-sharing for medicines include those suffering from life-threatening illnesses, very low-income individuals / families (less than € 2,400 / € 3,600 per year) and people with chronic illnesses whose income is less than EUR 6,000 per year).

• In 2017, Greece had one of the highest levels of spending on direct private payments as a percentage of the household budget in the EU (4.2% compared to 2.2% which was the EU average). This significant reliance on direct private payments as a source of health funding can lead to inequalities in access.

• Among those who actually have access to health services in Greece, the rate of catastrophic spending increased from 7% in 2010 to 10% in 2016, the fourth highest in the EU.



Source: OOSA HEALTH STATISTICS

• Almost 80% of all catastrophic expenditures in Greece are concentrated in the poorest 40% of households.

• It should be noted that these figures precede the extension of coverage that took place at the end of 2016 and highlight the need to establish strong mechanisms to protect vulnerable groups and patients with increased health care needs, especially in times of financial crisis.

• Informal payments are a problem in Greece: they account for about 1/4 of all direct private payments and pose a serious risk to access, financial protection and equality.

• The main volume of informal payments comes from:

- patients who want better or faster care
requirements by physicians, and
- Inadequate knowledge of relevant rights, especially among the poorest people and those living in rural areas.

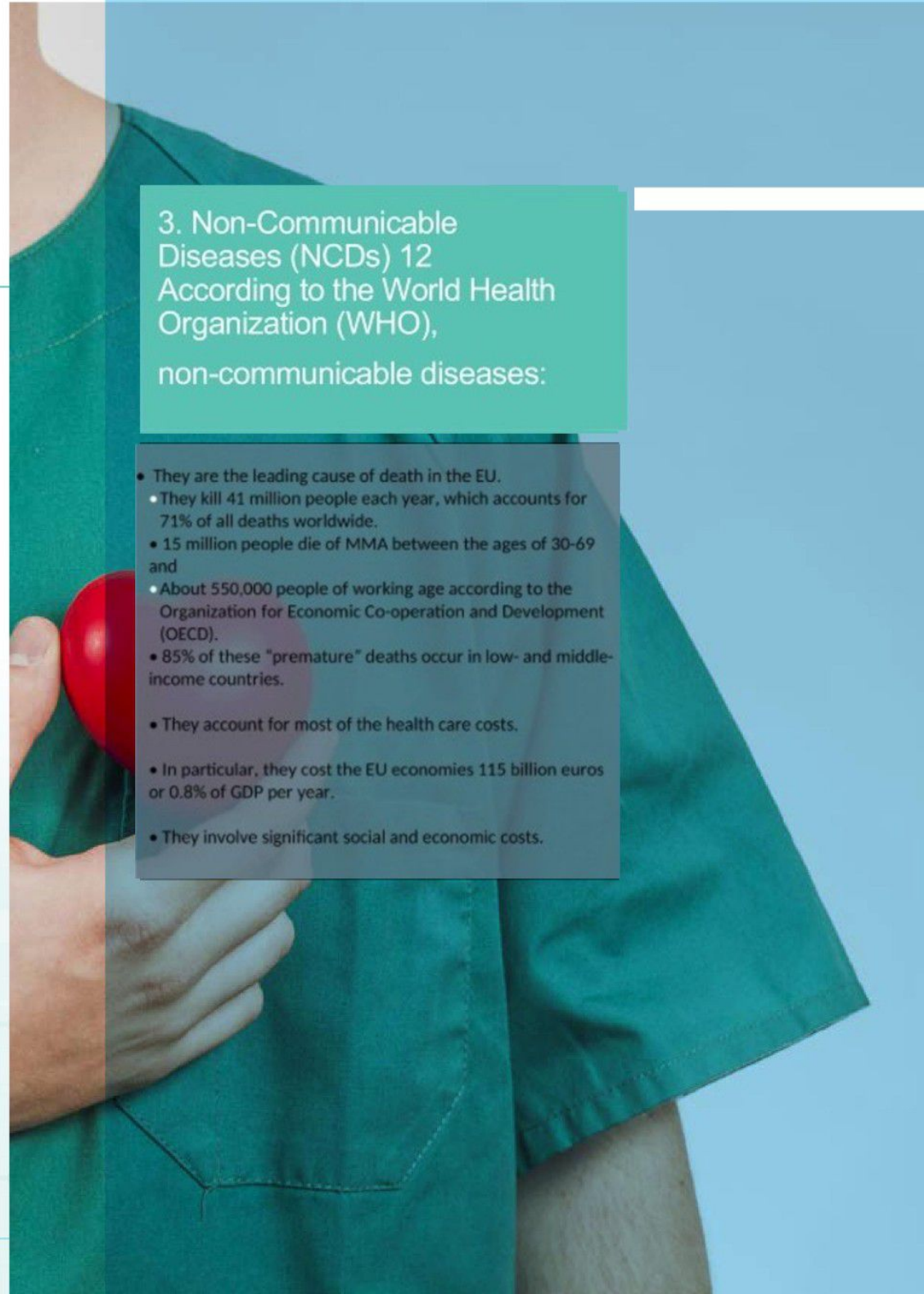
When the numerous health insurance funds merged under the EOPYY in 2011:

• Services have been streamlined and standardized to provide a comprehensive and fairly wide range of services.

• Coverage has become fairer.

• Some services that were previously covered (including some with limited therapeutic value) have been abolished or reduced.

- Restrictions were imposed on the number of EO-PYY-funded visits per doctor.
- These restrictions reduced the scope for overtreatment.
- At the same time, some patients have either delayed seeking care or turned to a private institution.
- Some services included in the package may not be available in practice, e.g. Dental care is almost entirely funded by direct payments from patients.



3. Non-Communicable Diseases (NCDs) 12 According to the World Health Organization (WHO),

non-communicable diseases:

- They are the leading cause of death in the EU.
- They kill 41 million people each year, which accounts for 71% of all deaths worldwide.
- 15 million people die of MMA between the ages of 30-69 and
- About 550,000 people of working age according to the Organization for Economic Co-operation and Development (OECD).
- 85% of these "premature" deaths occur in low- and middle-income countries.
- They account for most of the health care costs.
- In particular, they cost the EU economies 115 billion euros or 0.8% of GDP per year.
- They involve significant social and economic costs.

Also important are:
• Disability.
• Poor health.
• Retirement for health reasons.
More specifically, the following 4 groups of diseases are the main types of MMA and represent over 80% of all MMA premature deaths:
• Cardiovascular diseases (eg heart attacks and strokes), which are responsible for the largest percentage of MMA deaths with 17.9 million people per year.
• Cancer, which is the cause of death of 9 million people / year.
• Chronic respiratory diseases (eg chronic obstructive pulmonary disease and asthma) with 3.9 million deaths per year.
• Diabetes, which is considered a cause of death for 1.6 million / year.
Also, a possible increased risk of death due to MMA can be caused by:
• Tobacco use (Greece: 22% and EU: 17%).
• Unhealthy diet / Nutritional risks (Greece: 19% and EU: 18%).
• Harmful alcohol consumption (Greece: 4% and EU: 6%).
• Low physical activity (Greece: 3% and EU: 3%).

•• 42% of all deaths in Greece can be attributed to the above behavioral risk factors (compared to 39% in the EU).
•
• 1/5 of all deaths in 2017 were due to smoking (active and passive smoking).

• Nutritional risks (including low intake of whole grains, fruits and vegetables and high salt intake) in combination with low physical activity are responsible for about 21% of deaths.

•• 4% is attributed to alcohol consumption.

4. Roma: Historical, Population and Social information about their community.

- The following are some population and social data for the Roma community:
  - The Roma are the largest ethnic group and at the same time the most vulnerable minority in Europe.
- They do not have a 'historic homeland', yet their population is estimated at between 10-12 million, of which the vast majority are 70% from Central and Eastern Europe as well as the former Soviet Union.
  - It is estimated that they make up 6-11% of the populations of Bulgaria, Romania, Slovakia and Northern Macedonia.
- According to various historical records, even though their roots are controversial, Roma migrated in waves from northern India to Europe between the 9th and 14th centuries.
  - Roma are known for their special and peculiar cultural elements and are divided into many subgroups, which differ due to their linguistic, historical and professional characteristics.

4.1. The Roma community and the health systems in Greece and the European Union

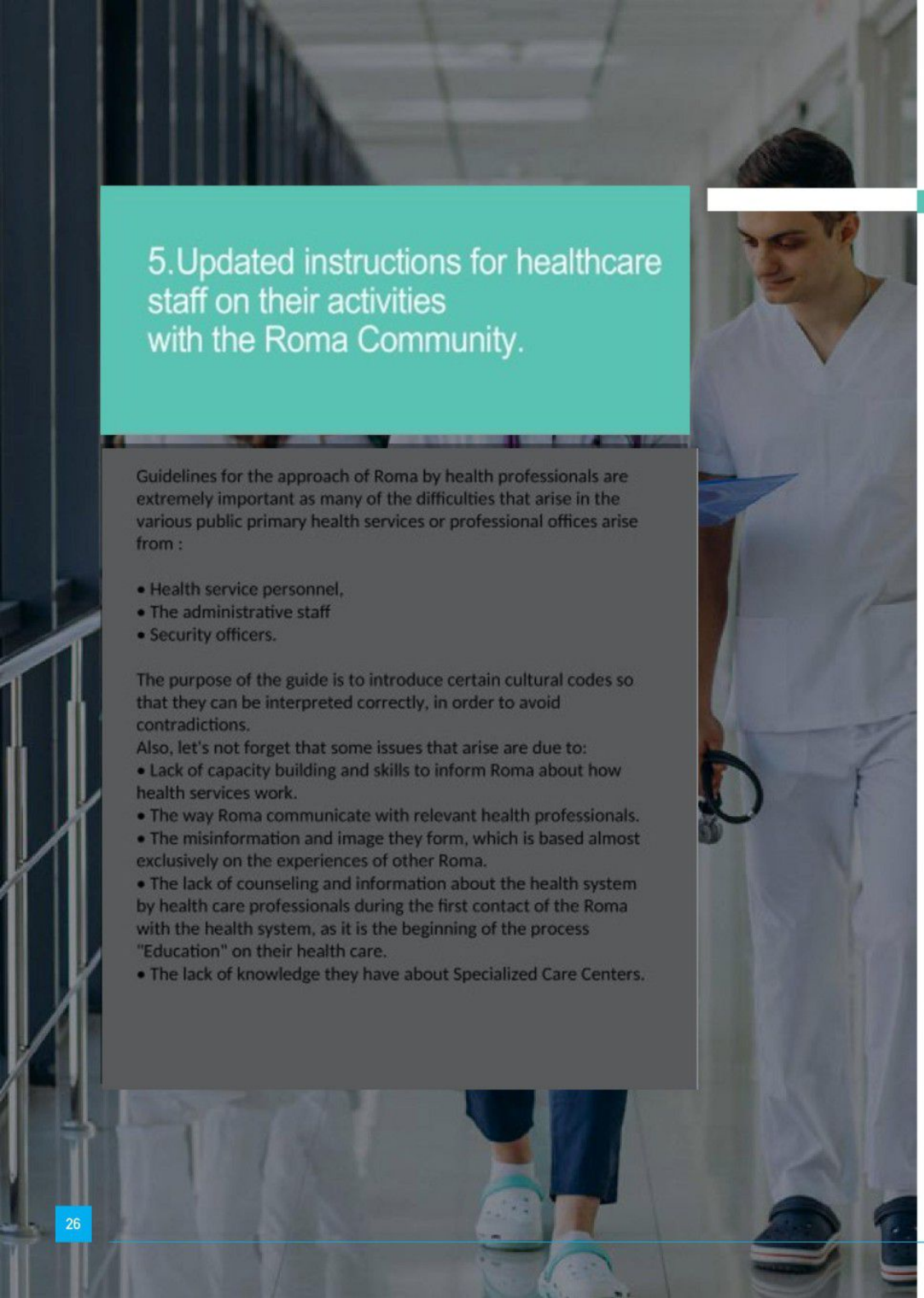
Several efforts have been made by various European Union bodies, for example through the creation of a strong anti-discrimination legal framework and related minorities, for example Roma, equal access to health, employment, education and housing.

Furthermore, the establishment of European frameworks, policies and strategies that are exclusively aimed at improving the life of the Roma, their integration, raising funds to be allocated to actions for them, etc. continues.

However, inequality in access to public health continues to be strong and their health status is proving to be severely burdened in general. In addition, the need for their survival forces them to often leave to chance the health problems that occur, without giving basis to the necessary prevention, vaccinations, etc. A serious obstacle is also the lack of education and health education, illiteracy, which makes it difficult to communicate with the staff or to understand the written information from them.

It is interesting to note that Roma perceive their health differently than other people tend to do. The point of view of their family plays an almost decisive role, even though as a minority community they have the greatest health needs. More specifically, there is a higher prevalence of communicable and non-communicable diseases within the community and a significantly lower life expectancy than national averages. Furthermore, research has shown that residents of Roma communities have the highest incidence of major chronic diseases compared to the general population and continue to suffer from limited access and racist treatment of those who are 'at an advantage' in health care.

Finally, insufficient vaccination coverage has been observed in Roma children residing in Greece with a significant difference compared to the child population of non-minorities. This is related to the lower living conditions, gender, as in girls the vaccination coverage is even lower, school participation, as the children who go have a higher percentage of vaccination coverage, etc. It has also been observed that when vaccination is provided by medical centers near their place of residence, most parents show interest in it, although due to the financial crisis there was an insufficient supply of vaccines and staff.



5.Updated instructions for healthcare staff on their activities with the Roma Community.

Guidelines for the approach of Roma by health professionals are extremely important as many of the difficulties that arise in the various public primary health services or professional offices arise from :

- Health service personnel,
- The administrative staff
- Security officers.

The purpose of the guide is to introduce certain cultural codes so that they can be interpreted correctly, in order to avoid contradictions.
Also, let's not forget that some issues that arise are due to:
- Lack of capacity building and skills to inform Roma about how health services work.
- The way Roma communicate with relevant health professionals.
- The misinformation and image they form, which is based almost exclusively on the experiences of other Roma.
- The lack of counseling and information about the health system by health care professionals during the first contact of the Roma with the health system, as it is the beginning of the process "Education" on their health care.
- The lack of knowledge they have about Specialized Care Centers.

Therefore, some actions are proposed for the staff of the health services that aim at the effective and smooth communication and cooperation with them, such as:
- Information on the cultural characteristics of the Roma community, especially those that are crucial for health, negative impact and are useful for its improvement.
- Training and capacity building of health professionals regarding their services to vulnerable groups.
- Avoiding generalizations and rebukes and combating prejudices and stereotypes about behaviors committed by members of a Roma group or family.
- Acceptance of diversity and heterogeneity that is formed based on their economic and social status, level of education, manners and customs, etc.
- Special training of health personnel oriented to the development of skills for resolving conflict situations.
- Utilization of discussion skills in parallel with the pursuit of unanimity.
- Use of patient-centered interview techniques.
- Use simple, clear and everyday vocabulary.
- Explanation of technical terms.
- Pay attention to the patient's gestures and body language in order to gather valuable information about his or her emotional state.
- Prefer oral communication over written communication, as they usually do not have the same value for Roma.
- Repeat the diagnosis, treatment and the necessary procedure regarding the arrangement of appointments until you are sure that you have been noticed.
- Use of words that belong to their own vocabulary in order to bridge the social gap.
- Separation of the identical meaning they have with the words 'doctor-death / disease'.
- Explain the benefits and benefits of prevention and health care for everyone through health education activities.
- Clarification of health services, for example with the help of mediators, as there is usually too much or too little use.
- Information on the access and operation of the various specialized centers. Therefore, some actions are proposed for the staff of the health services that aim at the effective and smooth communication and cooperation with them, such as:
- Information on the cultural characteristics of the Roma community, especially those that are crucial for health, negative impact and are useful for its improvement.
- Training and capacity building of health professionals regarding their services to vulnerable groups.
- Avoiding generalizations and rebukes and combating prejudices and stereotypes about behaviors committed by members of a Roma group or family.
- Acceptance of diversity and heterogeneity that is formed based on their economic and social status, level of education, manners and customs, etc.
- Special training of health personnel oriented to the development of skills for resolving conflict situations.
- Utilization of discussion skills in parallel with the pursuit of unanimity.
- Use of patient-centered interview techniques.
- Use simple, clear and everyday vocabulary.
- Explanation of technical terms.
- Pay attention to the patient's gestures and body language in order to gather valuable information about his or her emotional state.
- Prefer oral communication over written communication, as they usually do not have the same value for Roma.
- Repeat the diagnosis, treatment and the necessary procedure regarding the arrangement of appointments until you are sure that you have been noticed.
- Creating a relationship of trust between the professional and the patient. Expression of empathy, careful monitoring of discussions, two-way communication, etc. Flexibility and adaptation of the behavior of the health professional depending on the person in front of him, his needs and capabilities.

- Compromise in the changes you request from the patient that are related to his / her lifestyle and habits.
- Special thinking about the positive and negative consequences of the prescription.
- Close monitoring of patients for a long time.

6. Experiences-Conclusions

Undoubtedly, the implementation of projects aimed at providing primary care services to vulnerable and disadvantaged groups in vulnerable situations, generally contribute to: a) better access to health, b) the upgrading of the care services provided and at the same time c) significant positive steps are taken by promoting prevention, strengthening the support environment for a healthy lifestyle, encouraging health innovation.

From the point of view of the medical staff, the main findings that emerge from the implementation of the program have to do with the following:

• The administrative and medical staff employed in programs of this nature, in general, state that they are quite satisfied and satisfied both with the quality of the services provided and with the attendance - response that these programs have to the beneficiaries.

• They claim that the cooperation with this population group is positive as they behave politely and do not create problems with their behavior.

voice / 10 people) and their lack of knowledge of the Greek language

• Inconsistency and cancellation of medical visits is a common phenomenon.

• There is ignorance and lack of information on issues of care and treatment of preventive medicine. An indication of interest in their health is not appreciated, even at the urging of a doctor.

• Their attendance at primary care facilities is low and even lower in post-follow-up, especially in proportion to their total population.

• Regarding the medical staff that Roma visit, there is a tendency of preference and trust in those who already know and have visited in the past, regardless of whether there is a corresponding medical structure closest to the place where they live that provides free services.

• Even though primary care medical and administrative staff visit the camp to better serve the Roma, their attendance still appears to be declining.

Older people do not show much interest in their health and many of them never see a doctor.

• Roma women show more interest in their health than men. However, for a Roma woman to see a doctor, she will need to be accompanied by 4-5 more people.

• Their participation in cultural events and in general their manners and customs, are often set as a priority to the detriment of their health.

• Communication with this population group is difficult due to various factors, such as not having a personal telephone (about 1 phone / 10 people) and their lack of knowledge of the Greek language (comprehension, writing and reading).

• Few people will appreciate or express their gratitude for primary care programs, even if they are only for the specific population group. This is likely to happen because their needs were covered by other services such as existing HRs, Hospitals, etc.

• Finally, the conclusion that emerges after the completion of such programs is that there is excellent cooperation between the beneficiaries, the mediators and the medical / administrative staff, but the difficulty in communication and the lack of interest on their part are serious obstacles.

Suggestions

• The personalized approach and knowledge of the management of the specific population group is always effective.
• In order to have a responsibility in the field of Roma health, it is necessary for them to first understand that it is in their best interest and to be a part of their daily life, otherwise it will be sidelined.
• As a population group, Roma are characterized by slow improvement in most areas, and often avoid anything that bothers them. They need a lot of time to assimilate a change or anything new. For this reason, they need immediacy, regular encouragement and interest from third parties.
•The role of mediators is valuable for better understanding and communication with the specific population group.
• It is necessary to add other communication methods for the greater success of such programs.

Interreg
Greece-Bulgaria
EQUAL2HEALTH
European Regional Development Fund

EUROPEAN UNION

The action is part of the project entitled 'Reducing inequalities in access to primary health care'. "Reducing access inequalities in primary healthcare for socially significant diseases in CB Area's deprived communities" and the acronym "equal2health" co-financed by the European Cooperation Program CP INTERREG V-A
"Greece-Bulgaria 2014-2020" with beneficiaries from Greece and Bulgaria:

3rd Region of Health Authority of Macedonia
G.H.T. "G. PPANIKOLAOU" - P.H.T.
Unit Psychiatric Hospital of Thessaloniki

CVT Nefeli

NATIONAL HEALTH INSURANCE FUND - REGION SMOLYAN

MUNICIPAL HOSPITAL OF DEVIN

DIAGNOSTIC AND CONSULTING CENTER "ALEKSANDROVSKA"

The project is co-funded by the European Regional Development Fund (ERDF) and by national funds of the countries participating in the Interreg V-A "Greece-Bulgaria 2014-2020" Cooperation Programme.