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L. PUCETTI

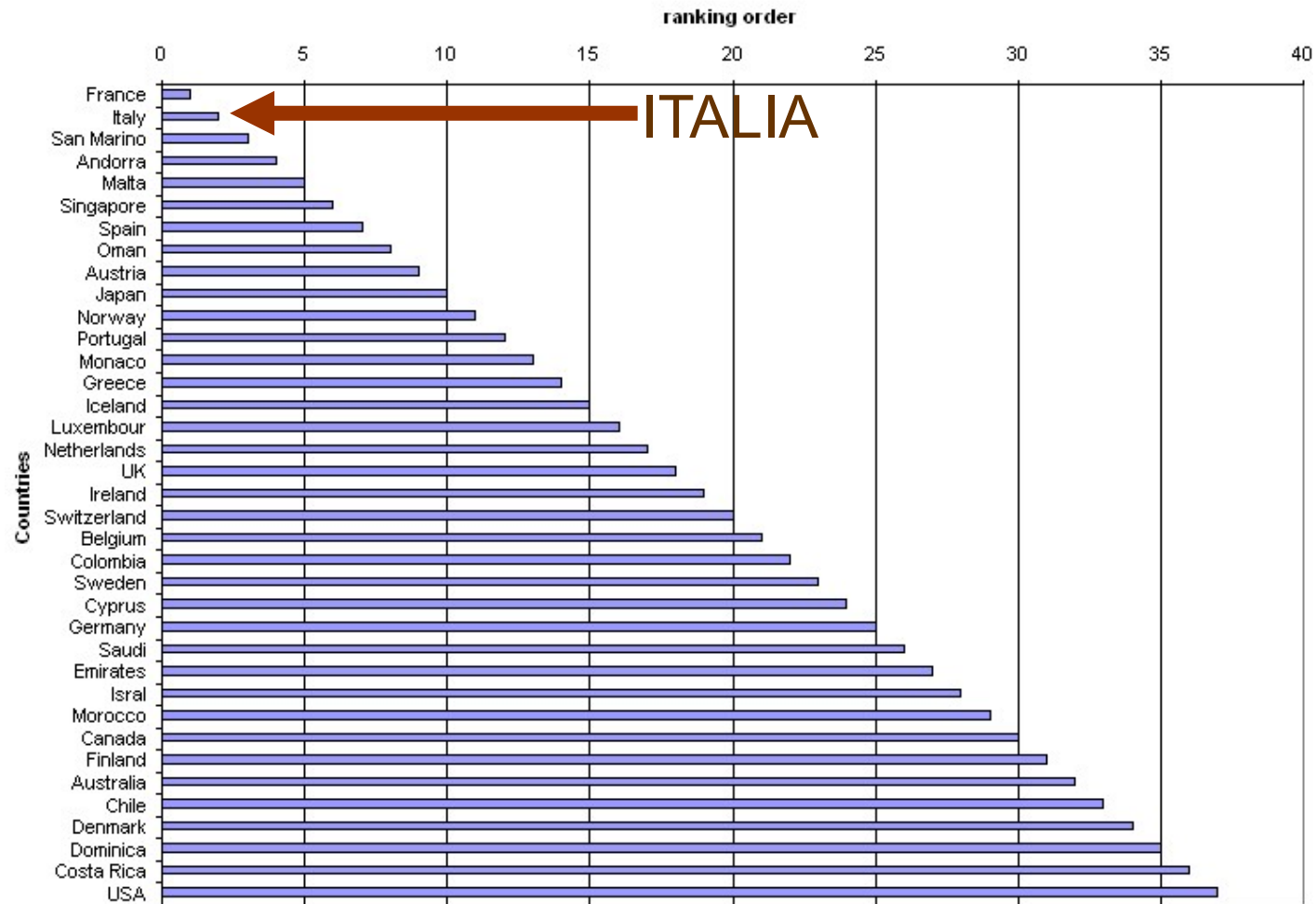
INNOVAZIONE E

CAMBIAMENTO IN SANITÀ

SOCIETA' MEDICA INTERDISCIPLINARE

RANKING HEALTH 2000

RANKING HEALTH 2000 WHO

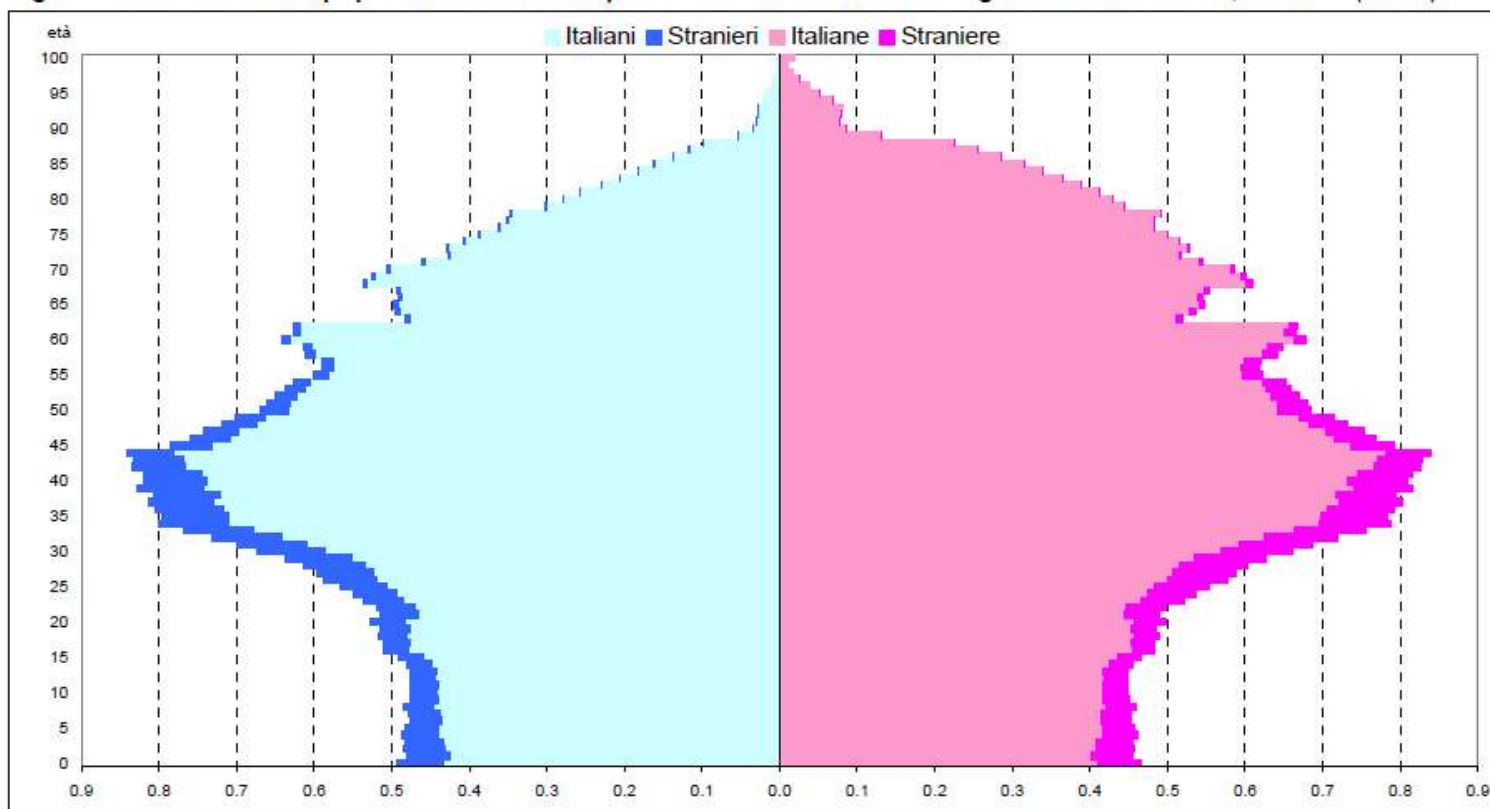


SCENARIO

- INVECCHIAMENTO E DENATALITA'
- CRONICIZZAZIONE (FOLLOW-UP)
- DISGREGAZIONE SOCIALE E FAMILIARE
- CRISI ECONOMICA
- RIDUZIONE POSTI LETTO
- BANALIZZAZIONE PREVENZIONE
- ANTICIPAZIONE DIAGNOSTICA
- CONSUMISMO SANITARIO
- BUROCRAZIA

Bomba demografica

Figura 4 – Piramide della popolazione residente per sesso e cittadinanza al 1° gennaio 2009 – Italia, valori % (stima)

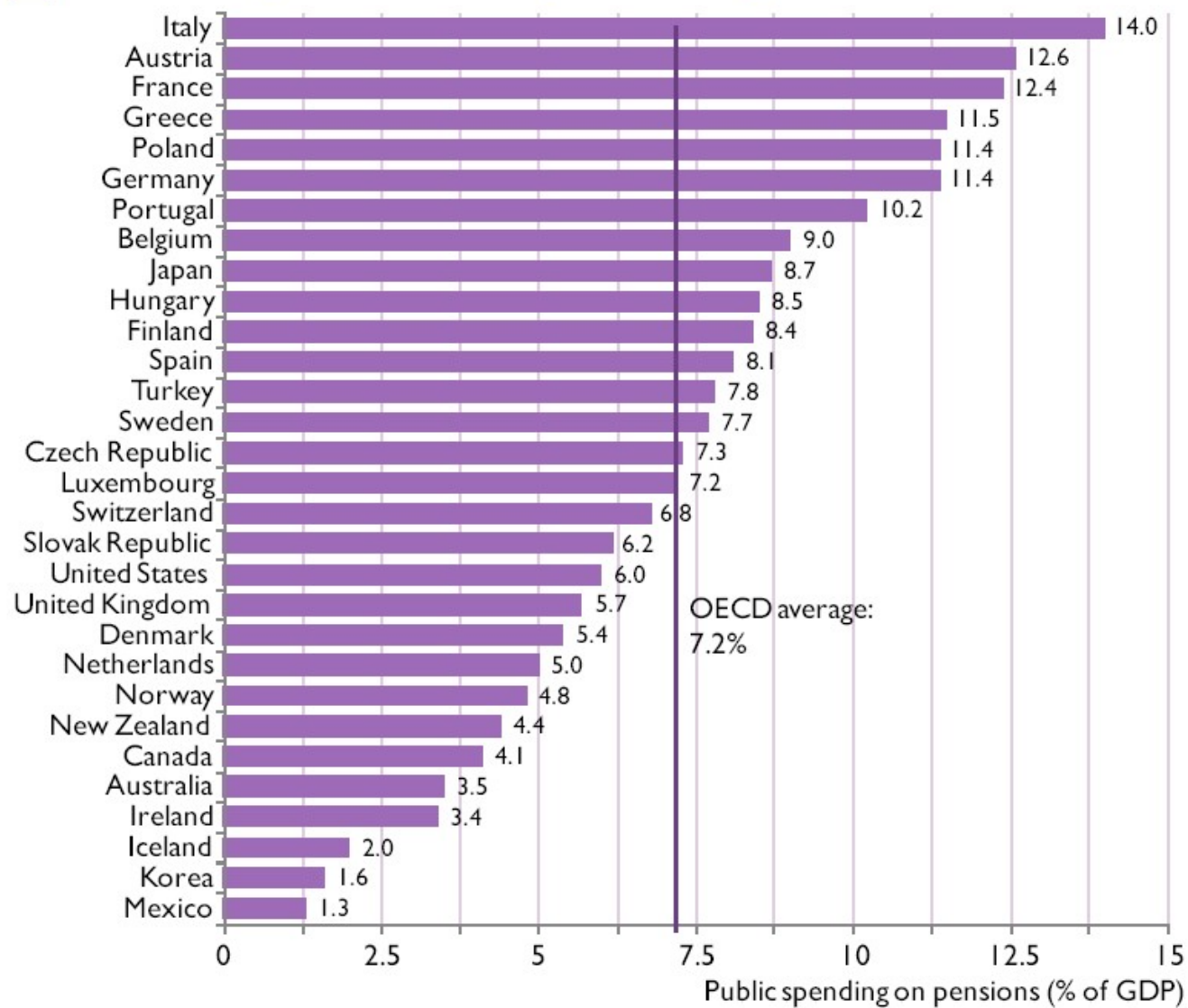


Bomba dipendenza

Anni	Numero medio di figli per donna	Speranza di vita alla nascita (in anni)		Struttura per età della popolazione (valori percentuali)			Indici di struttura (valori percentuali)			Età media (valori in anni)
		Maschi	Femmine	0-14	15-64	65+	Vecchiaia	Dipendenza	Dipendenza strutturale	anziani
2002	1,27	77,1	83,0	14,2	66,8	19,0	133,8	49,8	28,5	42,2
2003	1,29	77,2	82,8	14,2	66,6	19,2	135,9	50,1	28,9	42,3
2004	1,33	77,7	83,7	14,1	66,4	19,5	137,8	50,6	29,3	42,5
2005	1,32	77,6	83,2	14,1	66,1	19,8	140,4	51,2	29,9	42,7
2030	1,48	81,0	83,6	12,2	60,8	27,0	222,1	64,0	44,0	47,0
2050	1,60	86,6	88,8	12,7	53,7	33,6	264,1	86,0	63,0	49,1

DIPENDENZA

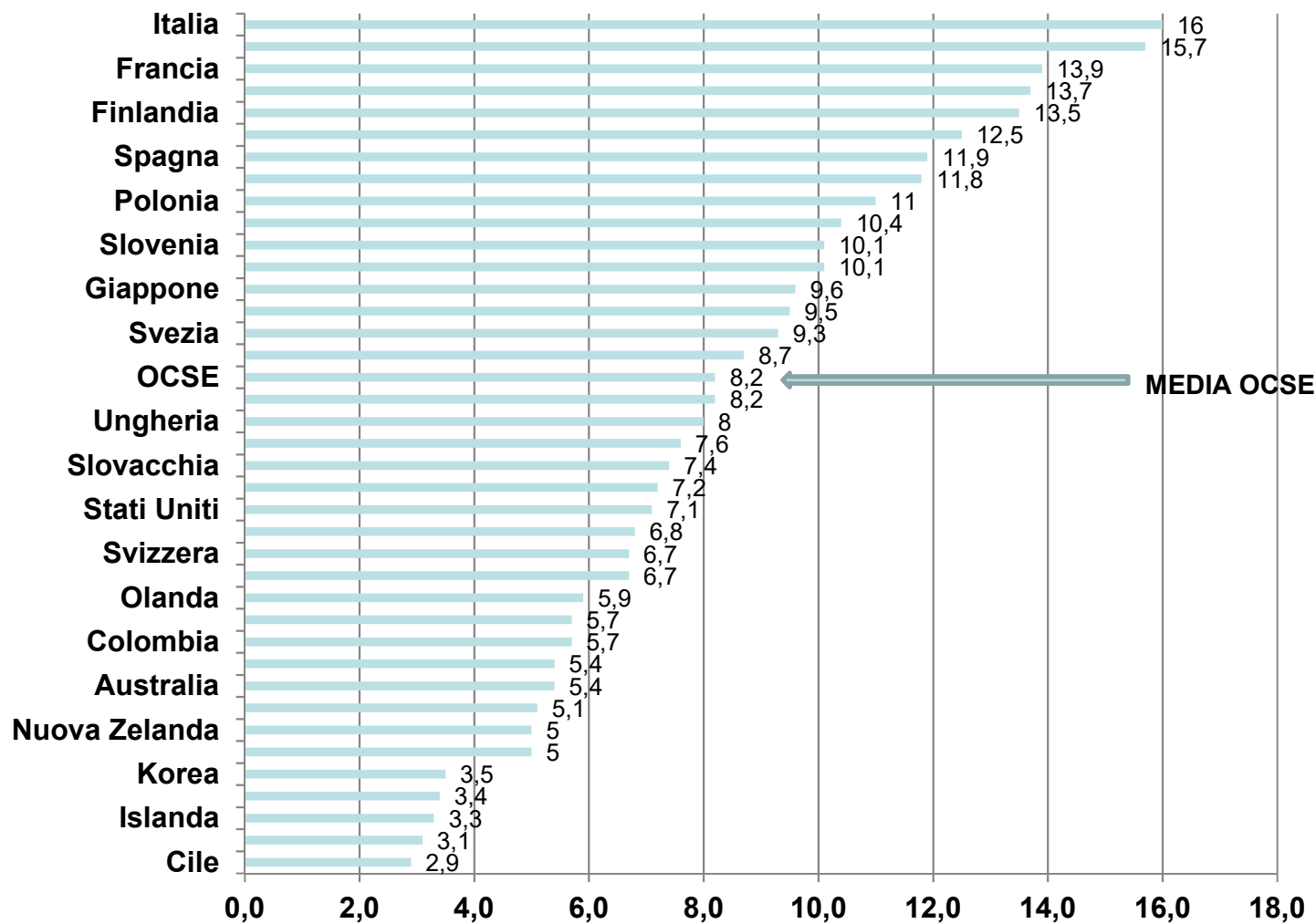
4 Public pension spending 2005



Source: OECD *Pensions at a Glance 2009*

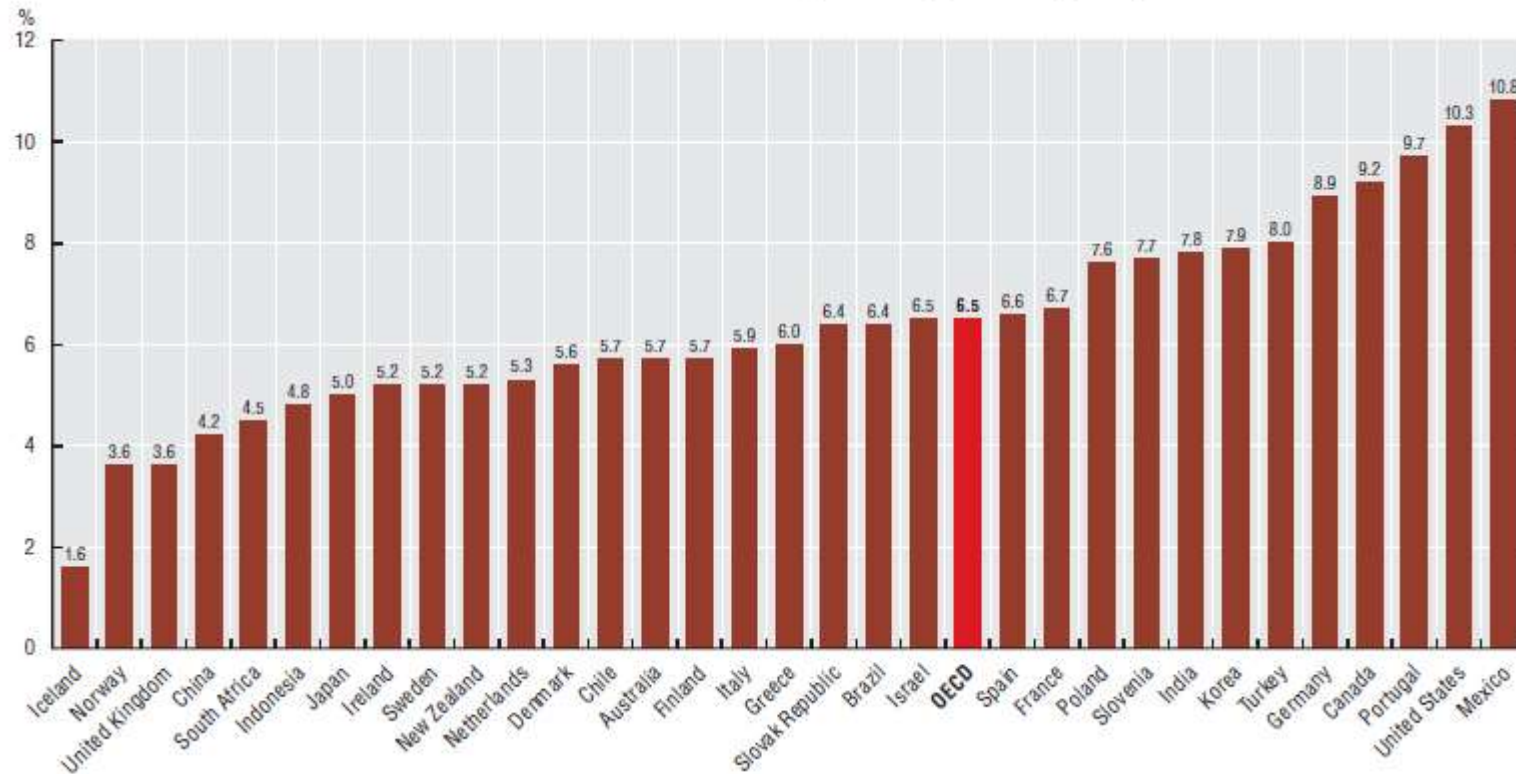
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Spesa pensioni su PIL 2019)



Diabetes explosion

1.10.1 Prevalence estimates of diabetes, adults aged 20-79 years, 2010



Obesity explosion

Figure 1. Obesity rates

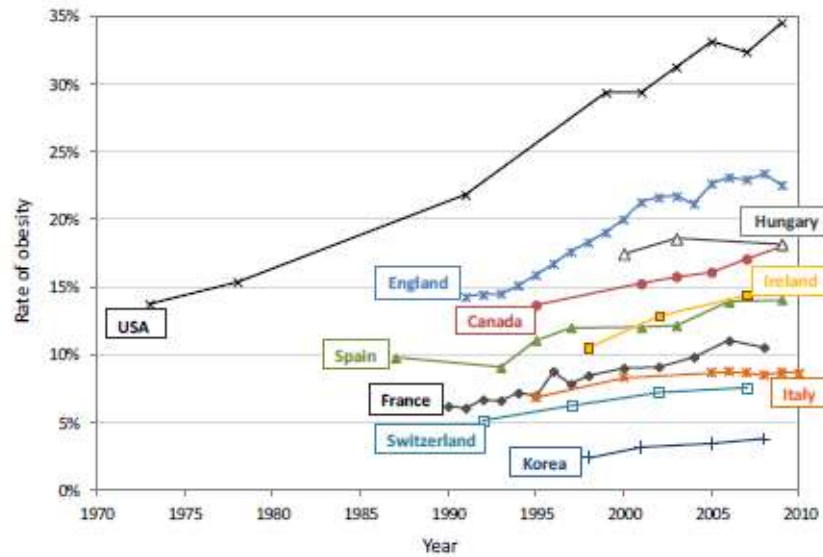
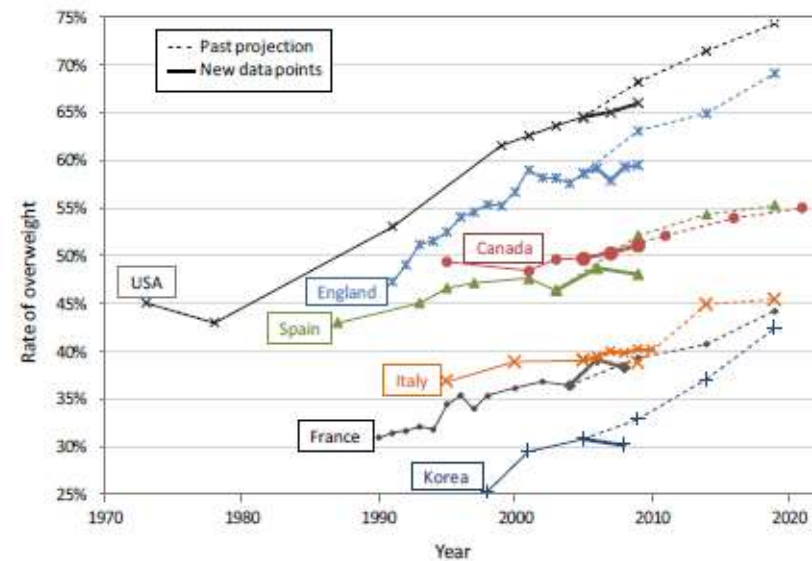
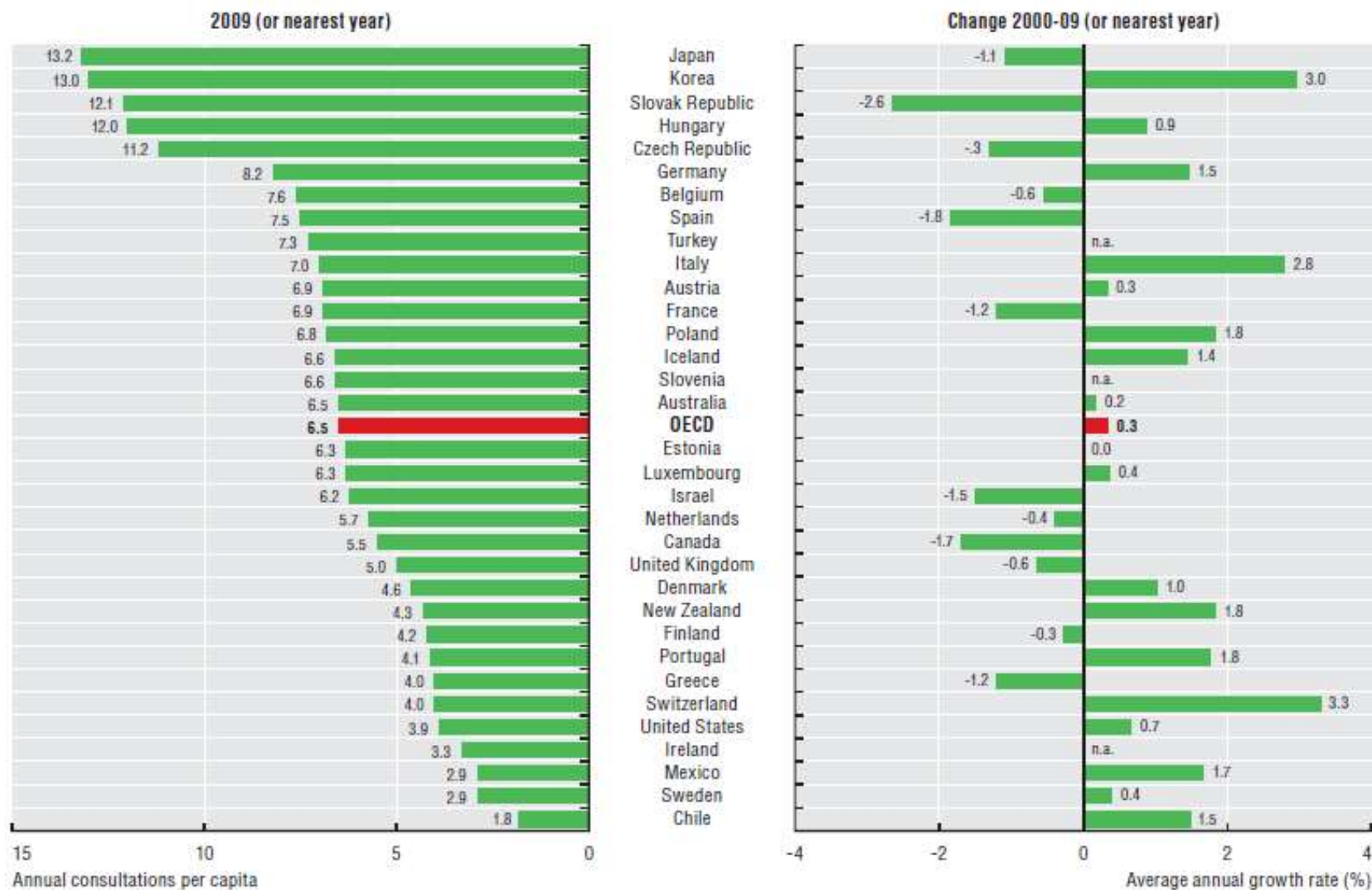


Figure 2. Overweight rates



Ancipazione diagnostica, cronicizzazione, consumismo, medicina difensiva

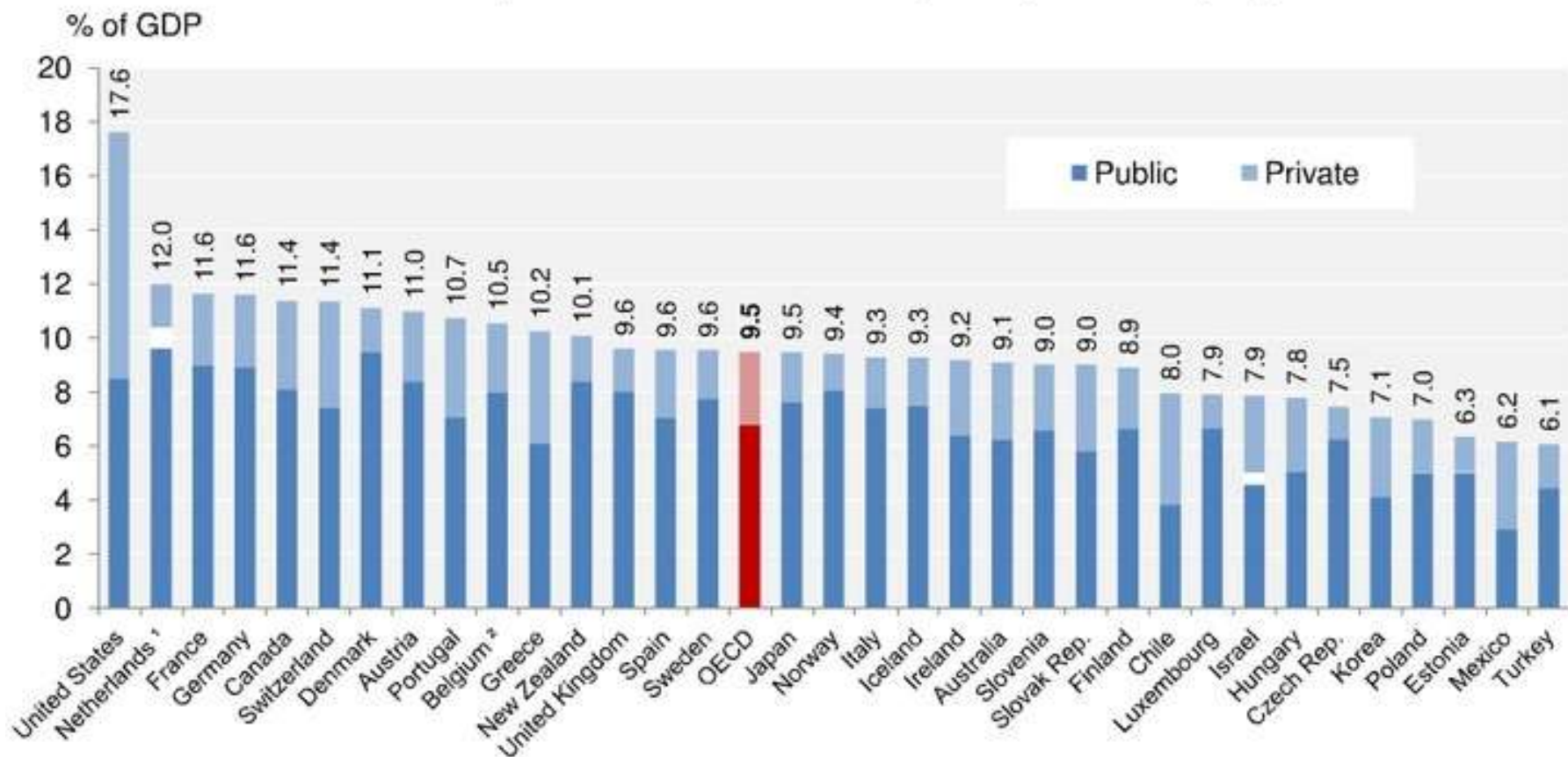
4.1.1 Doctors consultations per capita, 2009 and change between 2000 and 2009



Source: OECD Health Data 2011.

Health expenditure as % of GDP

Total health expenditure as a share of GDP, 2010 (or nearest year)



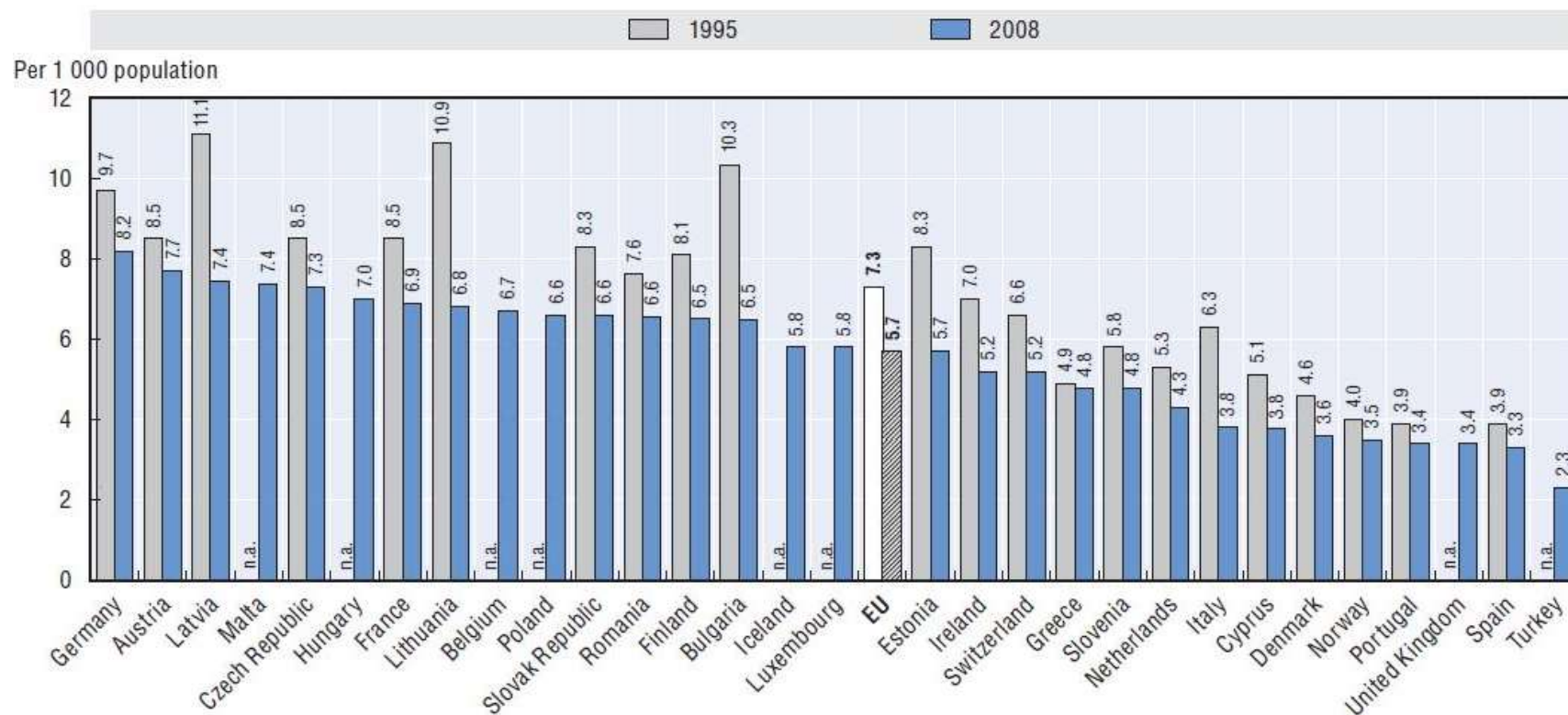
1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

2. Total expenditure excluding investments.

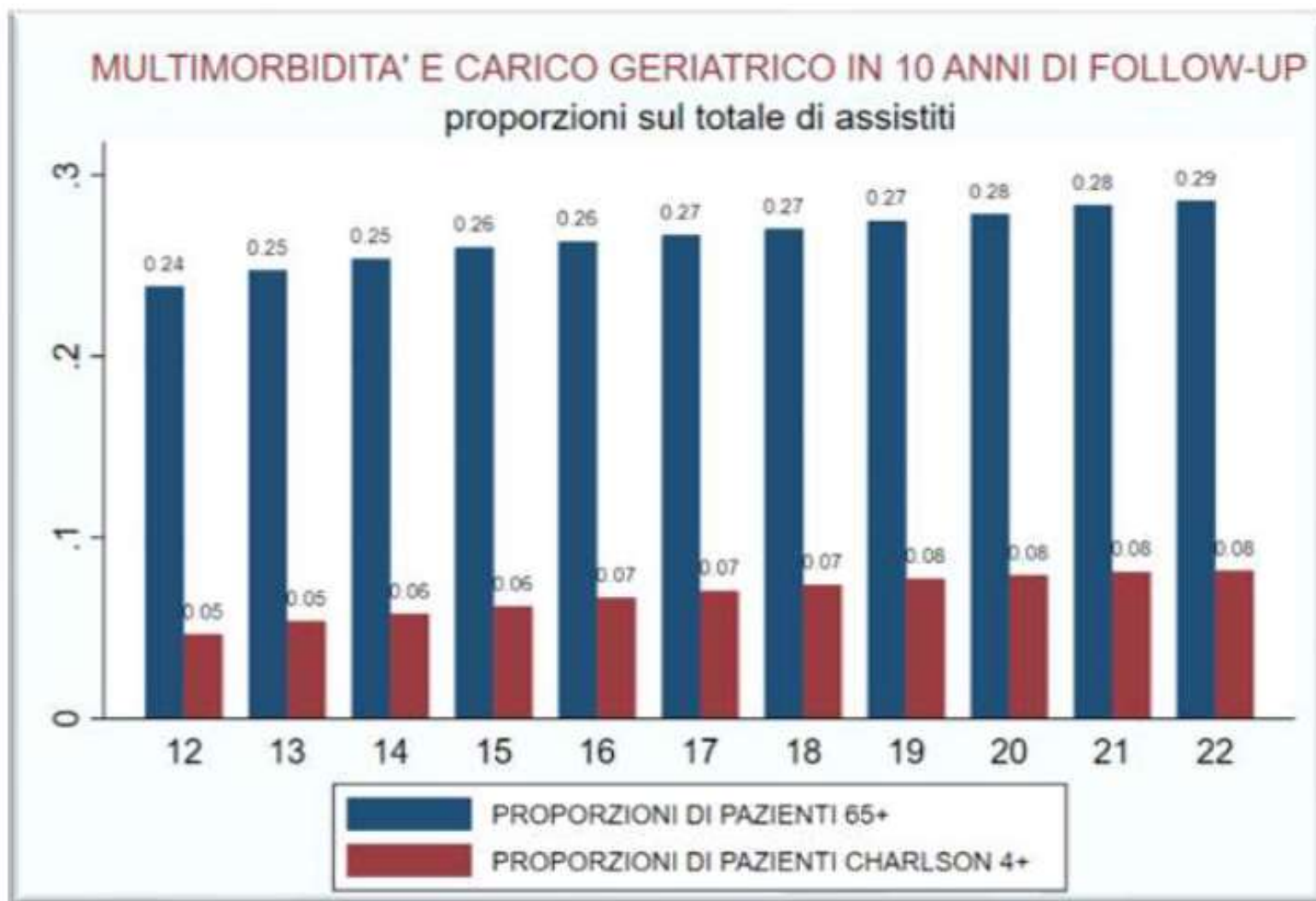
Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2012.

RIDUZIONE POSTI LETTO



Andamento multimorbilità





eHealth: verso una crisi?

Aumento della popolazione anziana

Aumento dei costi sanitari: tecnologie, pazienti informati/esigenti; malattie croniche

Le spese sanitarie crescono più velocemente rispetto alla crescita e alle risorse economiche

Ridotto numero di professionisti del settore medico

Assistenza sanitaria come Diritto Umano (Europeo)

eHealth può aiutare!

Health and
Consumers

LA SOLUZIONE ?



ALLORA...TELEMEDICINA!

SI MA...

- Sistemi spesso chiusi,
- Driver spesso non clinico (rischio inappropriatezza, consumismo)
- Progetti spot, non a regime (risorse a singhiozzo)
- Mancanza di validazione rigorosa e su ampia scala
- Chi fa cosa ...
- Chi paga e quanto?

Evidence based telemedicine

Structured telephone support o telemonitoring programmes for patients with chronic heart failure

**Inglis SC, Clark RA, McAlister FA, Ball J, Lewinter C,
Cullington D, Stewart S, Cleland JGF**

Cochrane Review published in The CochraneLibrary 2010, Issue 8

Authors' conclusions

- Structured telephone support and telemonitoring are effective:
- In reducing the risk of all-cause mortality and CHF-related hospitalizations in patients with CHF
- They improve quality of life, reduce costs, and evidence-based prescribing

Cochrane Review published in The Cochrane Library 2010, Issue 8

Implicazioni per la ricerca (1)

- Vi è ormai chiara evidenza che questi programmi migliorano gli outcomes per i pazienti con CHF.
- Alla luce delle evidenze, **non è raccomandabile eseguire ulteriori trial controllati randomizzati di confronto tra il telemonitoraggio e lo usual care.**
- Le future pubblicazioni dovranno vertere sulla **stratificazione dei benefici** di questi programmi nella popolazione dei pazienti con CHF

Cochrane Review published in The Cochrane Library 2010, Issue 8



Regione Lombardia

DECRETO N°

2886

Del

24/03/2010

Identificativo Atto n. 233

DIREZIONE GENERALE SANITA'

Oggetto DETERMINAZIONI IN MERITO AI PERCORSI E CONTINUITA' ASSISTENZIALE NEL PAZIENTE CON SCOMPENSO CARDIACO DOPO EVENTO ACUTO.

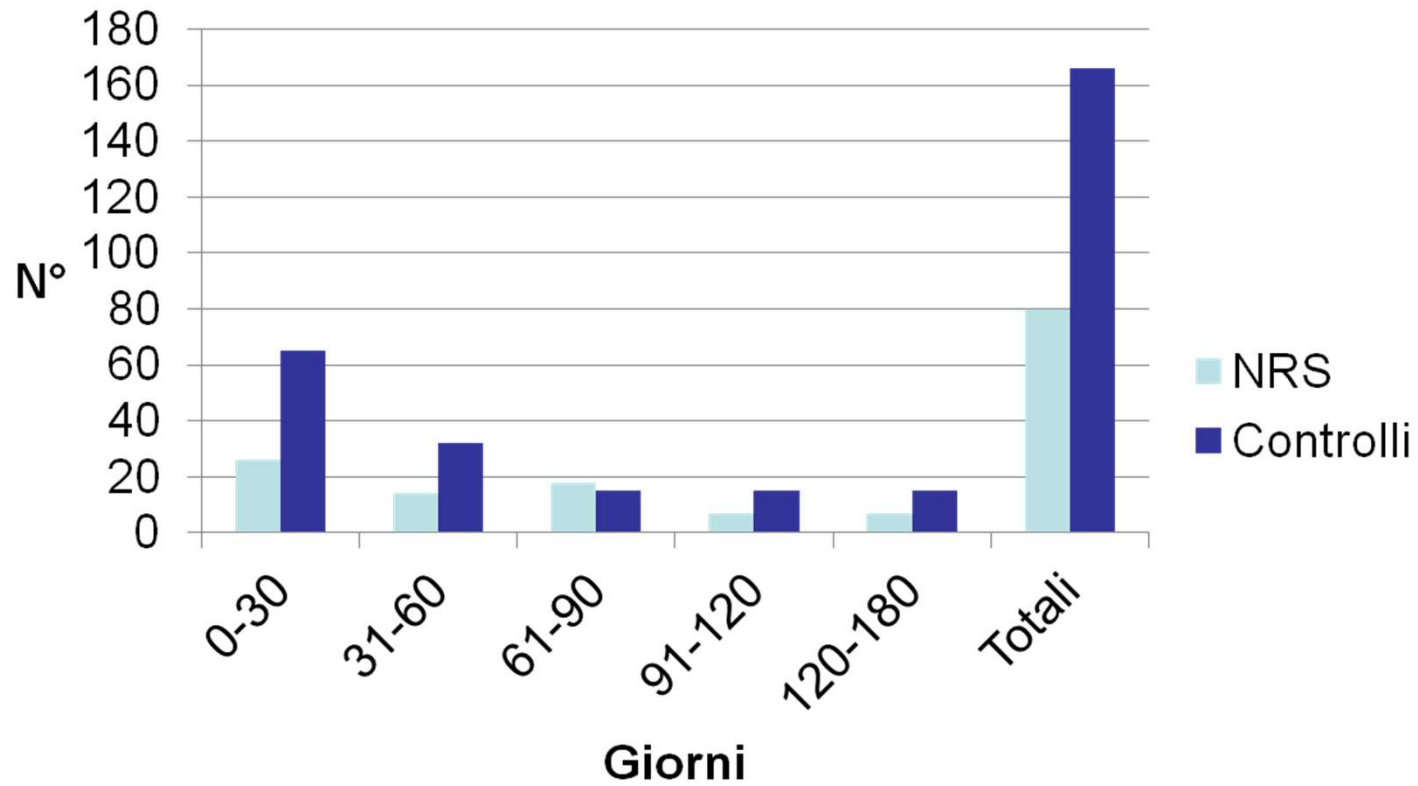
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VARIAZIONI A SEI MESI DEGLI INDICATORI DI RISULTATO

	Basale	Finale	P
Classe NYHA	2,9 ± 0,4	2,5 ± 0,4	0,0001
FEVS %	32 ± 11	36 ± 11	0,0001
MLHFQ (score) *	36 ± 23	25 ± 21	0,0001

* The Minnesota Living with Heart Failure questionnaire

Ospedalizzazioni per scompenso



Whole System Demonstrator (WSD) Project

- 2006, Department of Health, UK.
- 3 areas of England (Kent, Newham, Cornwall)
- multidisciplinary teams in health and social services for integrated care plans
- 12 months Randomized study in 1625 control patients and 1605 intervention patients with a long term condition (heart failure, chronic obstructive pulmonary disease, or diabetes from 179 general practices.
- **The aim of the WSD trial:** to evaluate whether telehealth for people with long-term conditions and telecare for people with social care needs can provide cost-effective care to improve outcomes, maintain independence, achieve significant gains in quality of life and reduce unnecessary acute hospital use and costs.

Bower et al. BMC Health Services Research 2011, 11:184

Steventon A. et al. Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial *BMJ* 2012;344:e3874

Whole System Demonstrator (WSD) trial results

Table 3| Hospital use and mortality during trial (unadjusted for clustering and covariates). Data are mean (standard deviation) unless stated otherwise

	Control group (n=1584)	Intervention group (n=1570)	Absolute difference (95% CI)	Percentage difference (95% CI)
Admission proportion (%)	48.2 (n=763)	42.9 (n=674)	-5.2 (-8.7 to -1.8)	-10.8% (-18.1% to -3.7%)
Mortality (%)	8.3 (n=131)	4.6 (n=72)	-3.7 (-5.4 to -2.0)	-44.5% (-65.3% to -23.8%)
Emergency admissions per head	0.68 (1.41)	0.54 (1.16)	-0.14 (-0.23 to -0.05)	-20.6% (-33.8% to -7.4%)
Elective admissions per head	0.49 (1.31)	0.42 (0.99)	-0.07 (-0.15 to 0.01)	-14.3% (-30.6% to 2.0%)
Outpatient attendances per head	4.68 (6.81)	4.76 (6.74)	0.08 (-0.39 to 0.55)	1.7% (-8.3% to 11.8%)
Emergency department visits per head	0.75 (1.58)	0.64 (1.26)	-0.11 (-0.21 to -0.01)	-14.7% (-28.0% to -1.3%)
Bed days per head	5.68 (15.10)	4.87 (14.35)	-0.81 (-1.84 to 0.22)	-14.3% (-32.4% to 3.9%)
Tariff costs per head (£)	2448 (4099)	2260 (4117)	188 (-474.9 to 98.8)	-7.7% (-19.4% to 4.0%)

Steventon A. et al. Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial *BMJ* 2012;344:e3874

Summary of main results

- **Lower admission proportion** within 12 month follow-up in intervention group than in control group (odds ratio 0.82, 95% confidence interval 0.70 to 0.97, $P=0.017$).
- **Mortality at 12 months** was also **lower** for intervention patients than for controls (**4.6%** v **8.3%**; *odds ratio 0.54, 0.39 to 0.75, $P<0.001$*).
- **Mean number of emergency** admissions per rates: intervention 0.54 v control 0.68.
- **Length of hospital stay** was shorter for intervention patients than for controls (mean bed days per head 4.87 v 5.68; *geometric mean difference -0.64 days, -1.14 to -0.10, $P=0.023$, which remained significant after adjustment*).

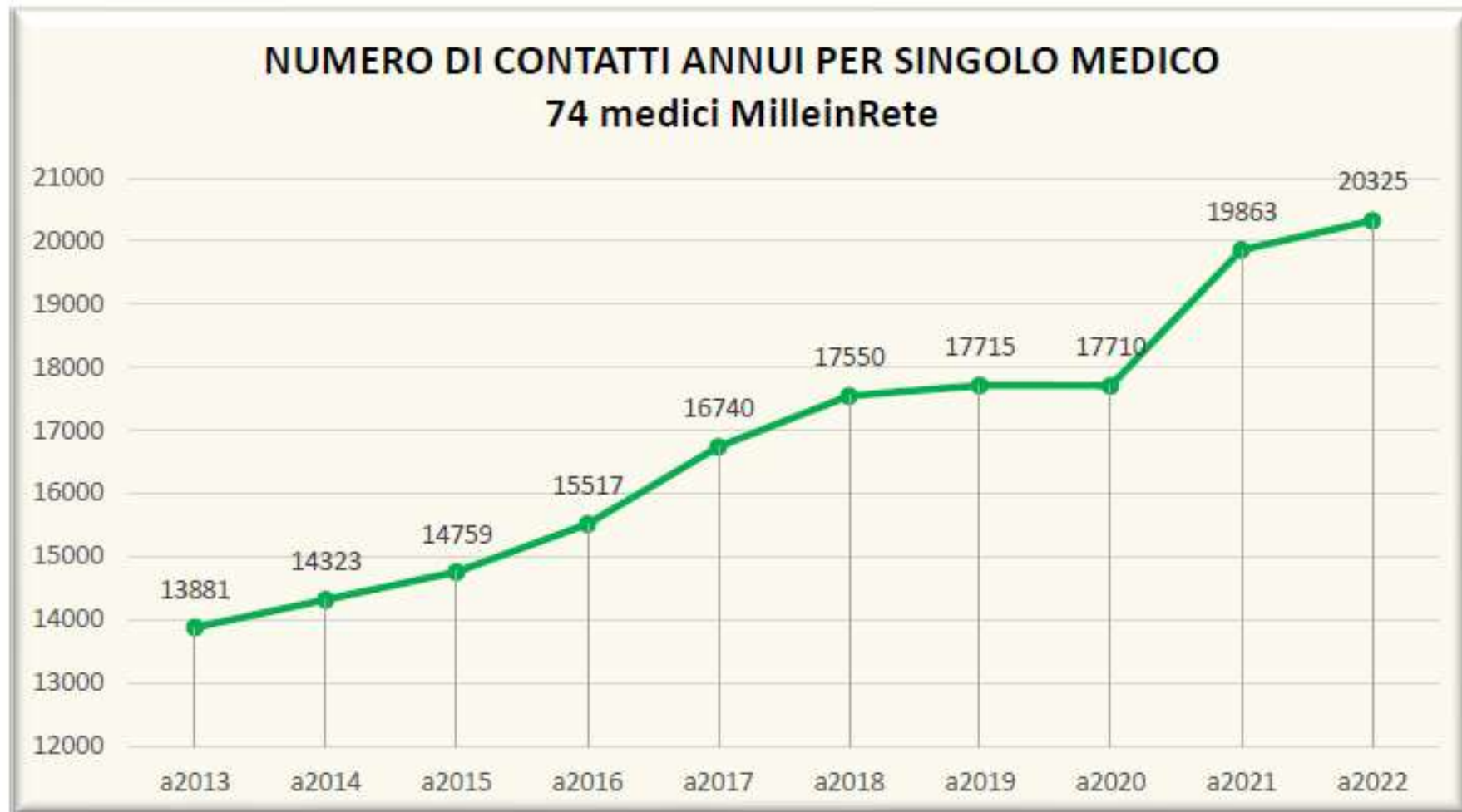
COSTS

- The QALY gain by patients using telehealth in addition to usual care was similar to that by patients receiving usual care only, and total costs associated with the telehealth intervention were higher.
- **Telehealth does not seem to be a cost effective addition to standard support and treatment.**

PROBLEMI APERTISSIMI

- Come implementare nel modello organizzativo della MG questi programmi?
- Norme, costi, incentivi, organizzazione

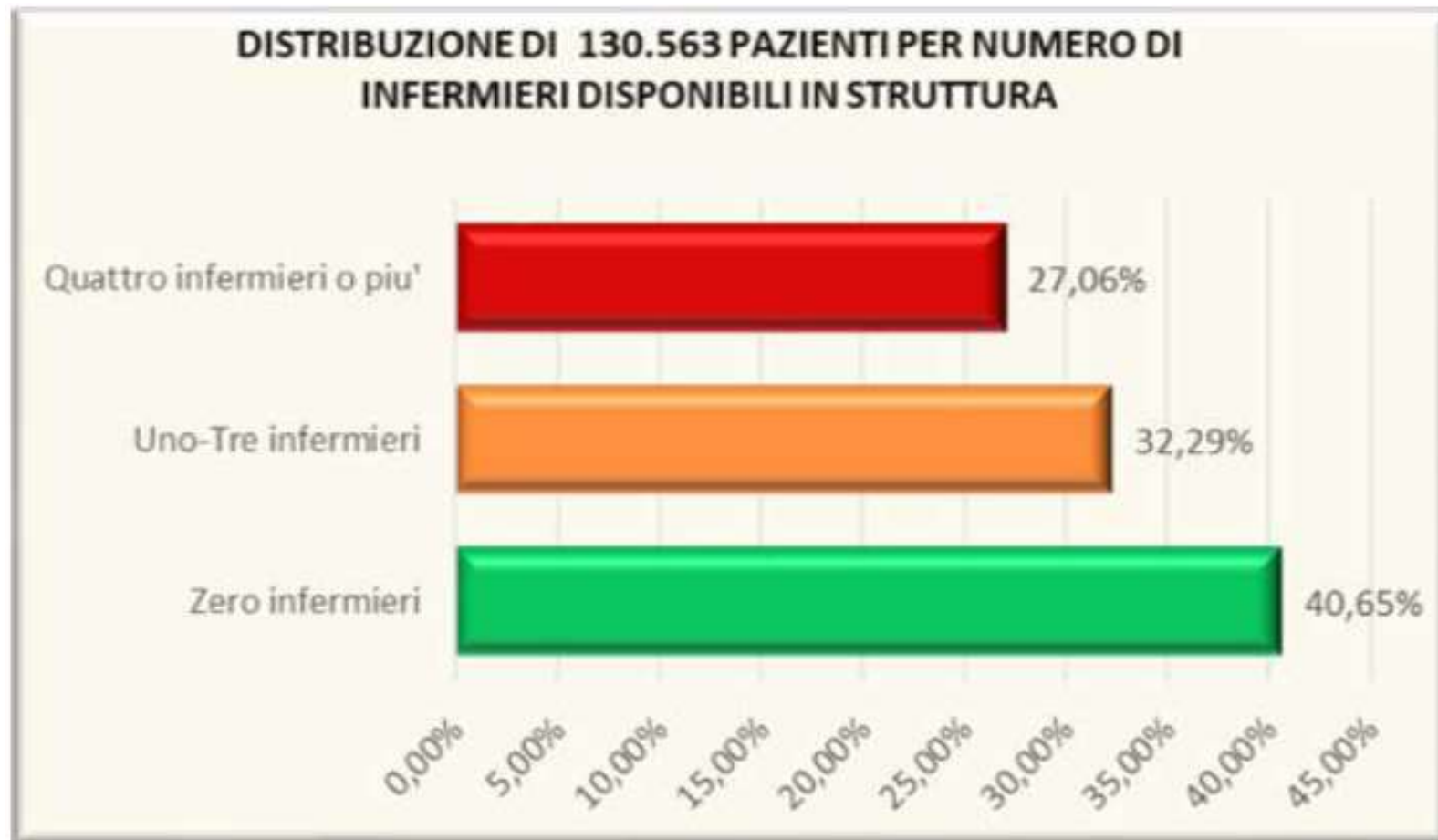
ANDAMENTO CARICO LAVORO MMG



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Percentuale presenza infermieri



Thank
you