

Estonia case study: Experiences in measuring care integration and how this information feeds into payment system reforms

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Estonia in brief

Population 1.3 million

High-income country

- GDP per capita 19 854USD* (2016)

Health expenditures (2016)

- 6.7% of GDP
- Per person 1 340 USD
- Public expenditure 75.7%

Social health insurance (single payer) since 1992

- Coverage with health insurance 94-96% of population

Family doctor first contact of care, providers act under private law



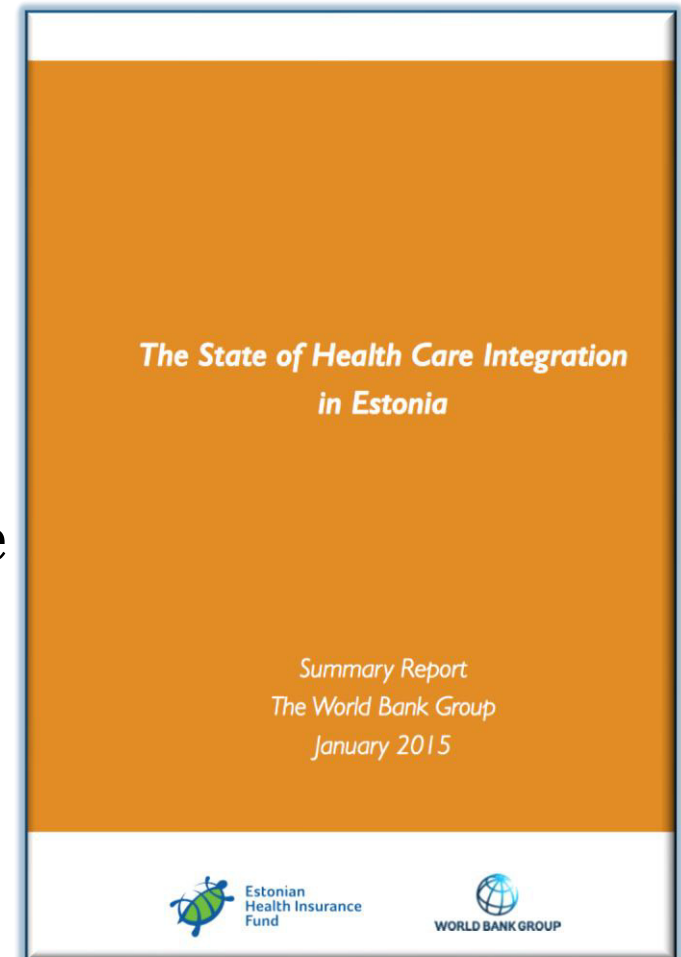
Is Estonian health care system well integrated to be prepared for NCD?

World Bank study (2015)

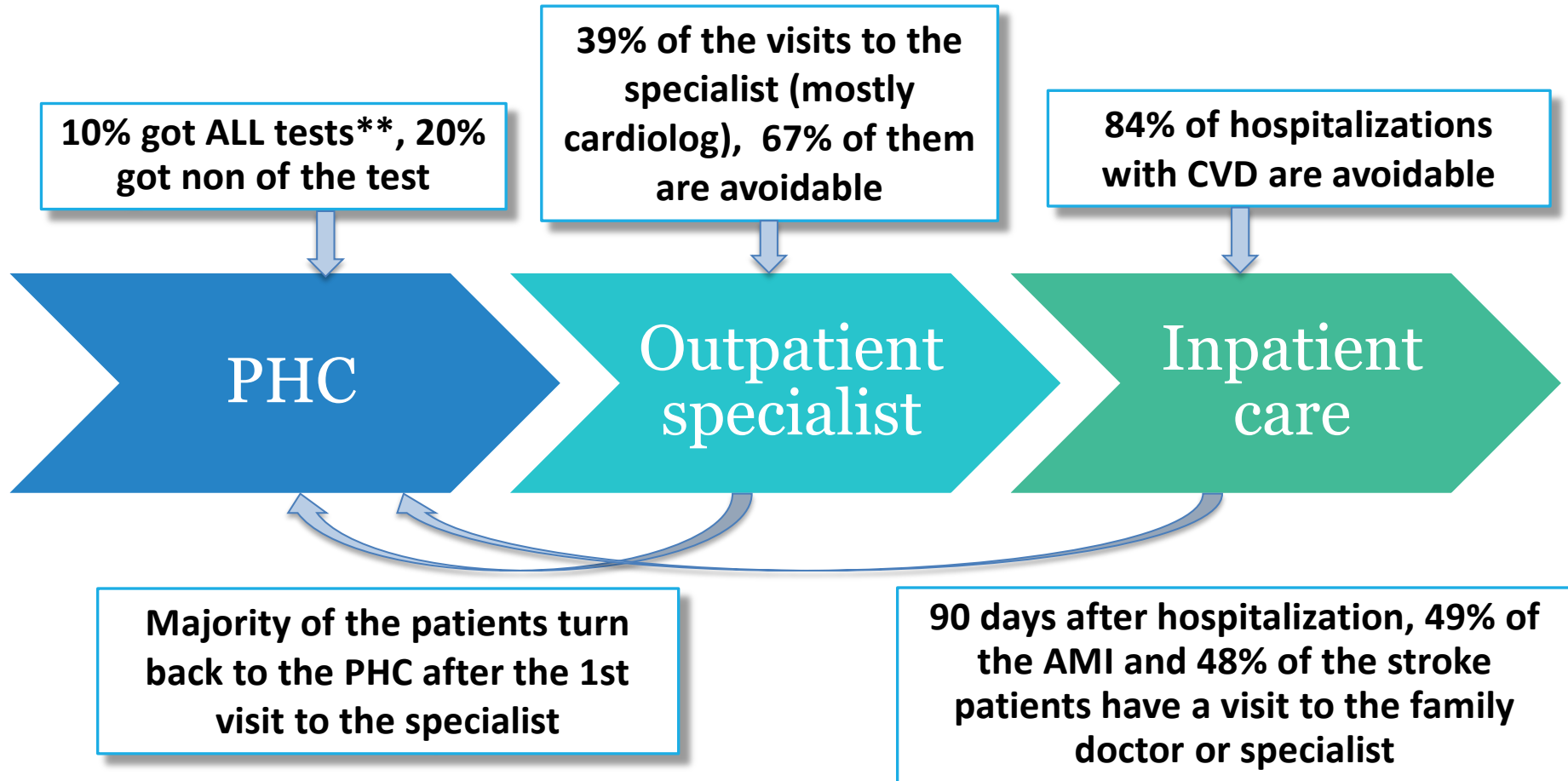
- Focus groups and key informant interviews
- Document review
- Data analysis (Estonian Health Insurance Fund's claims data, Census)

Study based on the hypothesis that care is well integrated if:

- Services are delivered in the appropriate care setting
- Appropriate coordination and continuity of care exists



Example of study results: Pathway of the patient with high blood pressure*



*5 more visits to the doctor compared to average patient

** according to the P4P program

Summarizing study results

Care provision is still **hospital and specialist centric**

PHC organizations are rather weak, **solo practices**

Financial incentives push patients away from PHC to the specialist care

Limited focus on **care outcomes**

Refining traditional payment methods may help

- Primary care: capitation, FFS, monthly allowance, P4P
- Outpatient specialist care: FFS
- Inpatient specialist care: DRG, per diem, FFS, preparedness fee

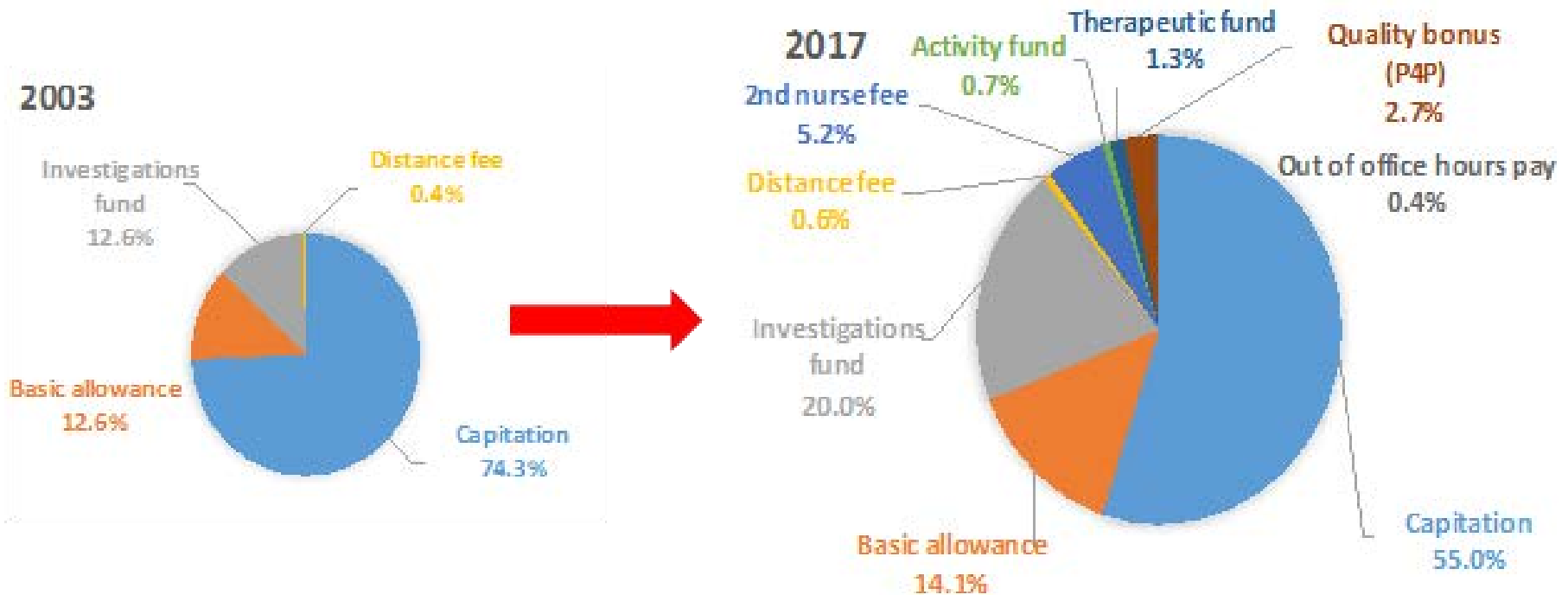


- Revision of P4P to incentivize more adherence to the guidelines
- New PHC Center payment model

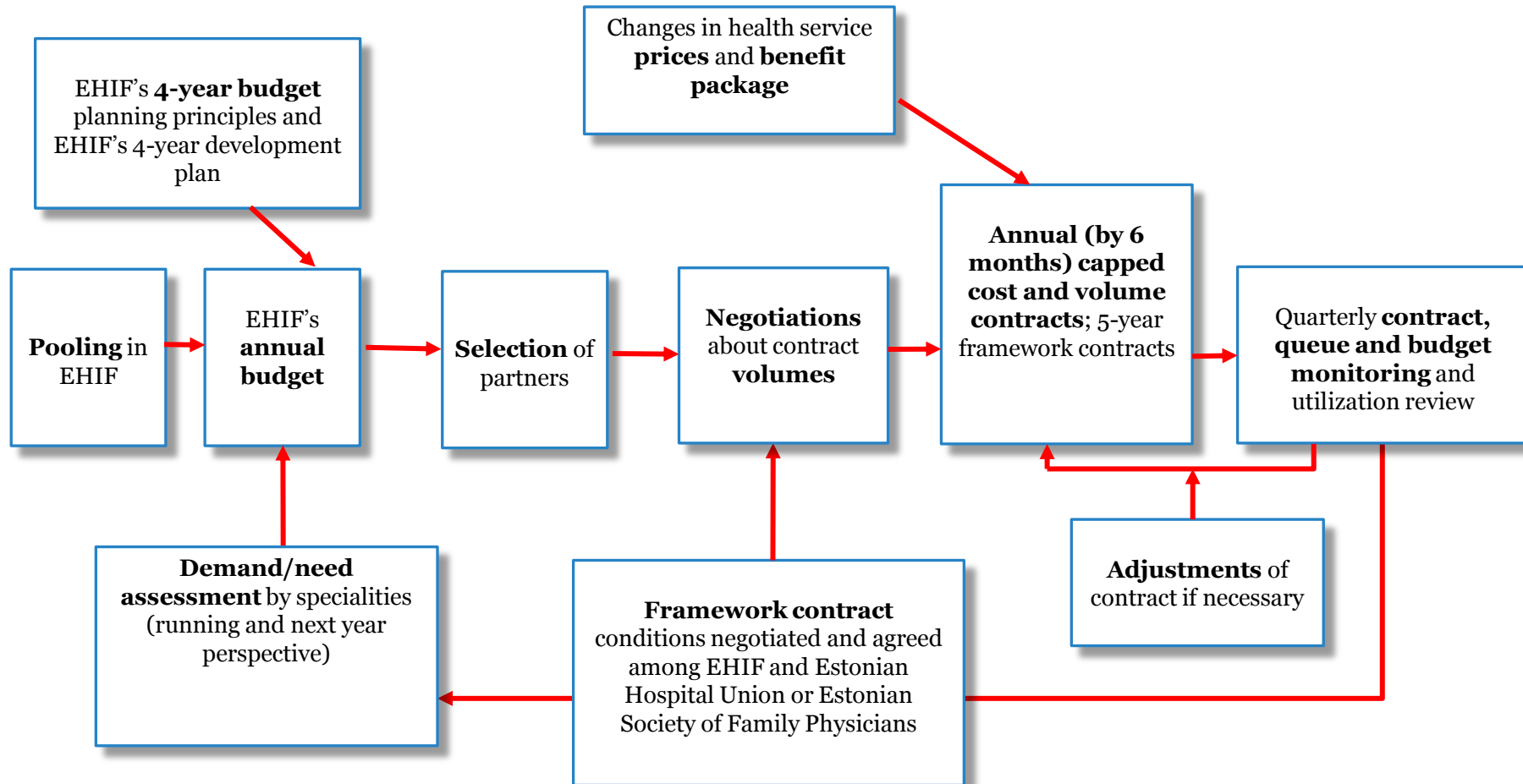


- Global budget with performance indicators (rural hospitals)
- Piloting integrated care model (hospital+PHC center)
- Pay for patient management
- Episode based payment

Looking back – how we have done that in PHC



BUT, payment methods are just one aspect of strategic purchasing



Service delivery model is changing

- Primary care: family doctor+nurse, mostly solo practices
- Hospitals: independent entities
- Primary and specialist care split



- Primary care: group practices, extended team (home nurse, midwife, physiotherapist)
- Hospital networks

E-Consultation: one example how to enhance care integration

- Family doctor can consult with specialist through health information system without referring patient
- Each specialty has defined referral criteria by specialties
- Started in 2013 with few specialties, gradual scale up
- Initiated by family doctors and their strong leadership
- Complex implementation process: development of clinical criteria, IT system, training, payment scheme, getting buy-in of doctors...

The screenshot shows a digital referral form titled "Digitaalne saatekirj". The patient's name is "ERET JAANSON" and the date is "12.02.2014". The form is for a referral to "otorinolaringoloogia" (otolaryngology) at "SA Põhja-Eesti Regionaalhaigla e-visit". The form includes fields for "Suunatud erialale" (Specialty), "või uuringule/teenusele" (or examination/service), "või asutusse" (or institution), and "või arstile" (or doctor). The "Vajadusel suunamise eesmärgi täpsustus" (Specification of the purpose of referral, if necessary) field is empty. The "Põhidiagnoos" (Primary diagnosis) is "J01.0 Äge ülalõuarkepõletik e maksillaarsinu(s)it e haimoriit" (Acute maxillary sinusitis or rhinosinusitis). The "Ravilugu" (History) field contains a detailed clinical note in Estonian, mentioning symptoms like nasal congestion and discharge, and a recent visit to a general practitioner. The "Märkus" (Remarks) field is empty. The form also includes buttons for "Tüüpil...", "Manus...", "Lisa arvelt...", "Lisa loendist...", "Lisa raviloost...", "Lisa retsept...", "Lisa uur ja prots", "Lisa laborist...", and "Printi...".

Key messages

Financial incentives across different levels of care are important to improve care integration

- **Blending payment methods** enables to mitigate negative side-effects of single payment method
- **Strategic purchasing** in much more than payment methods
- **Health financing reforms have to be aligned** with broader **health service delivery** reforms

Clinicians buy-in and **leadership** is crucial if complex change

Good quality data is a precondition for monitoring the performance of providers