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

*1USD=0.8EUR

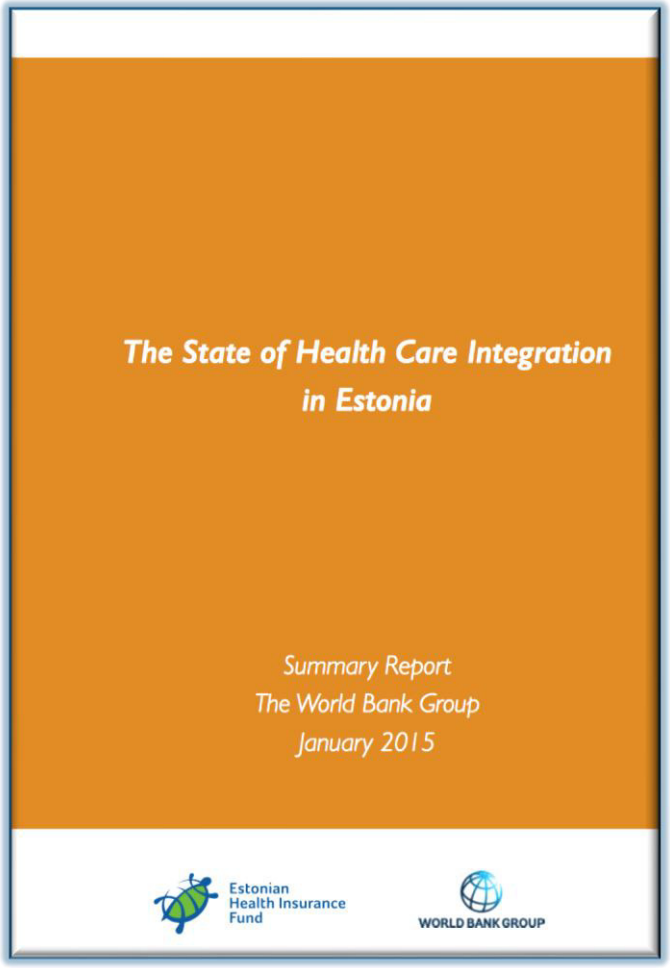
Is Estonian health care system well integrated to be prepared for NCD?

World Bank study (2015)

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

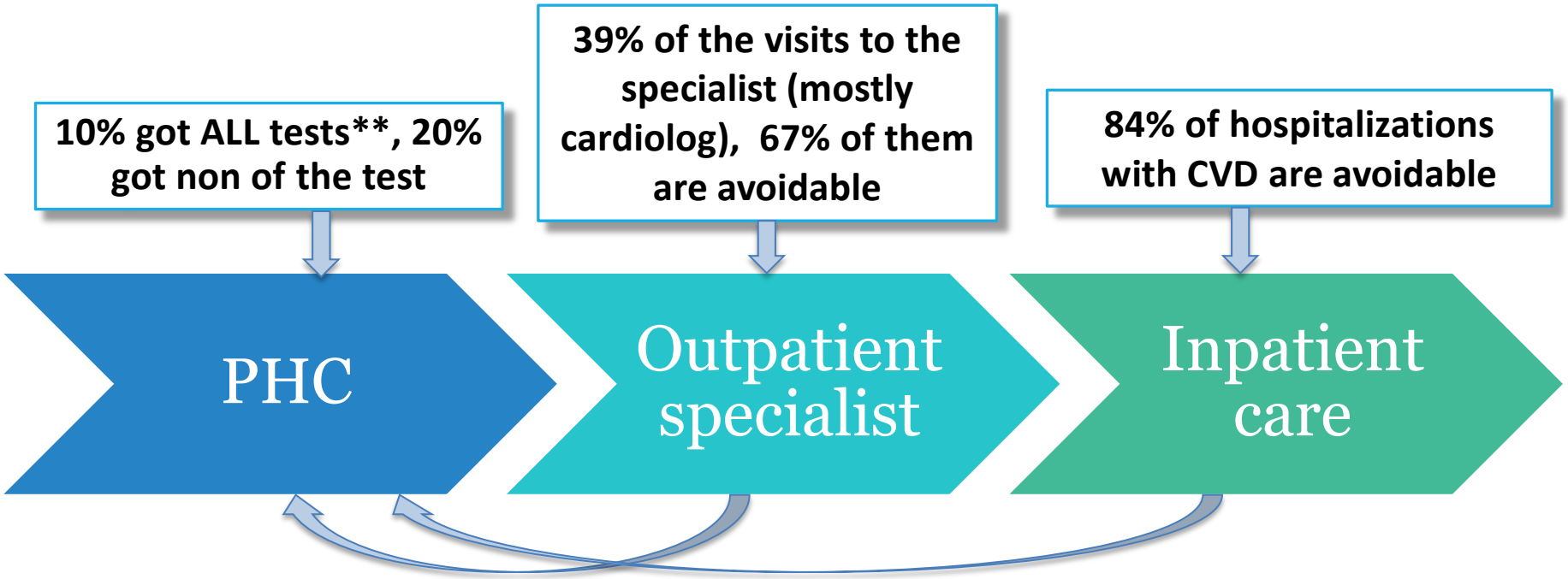
Study based on the hypothesis that care is well integrated if:

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



Source: https://www.haigekassa.ee/en/state-health-care-integration-estonia

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



*5 more visits to the doctor compared to average patient
** according to theh 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**

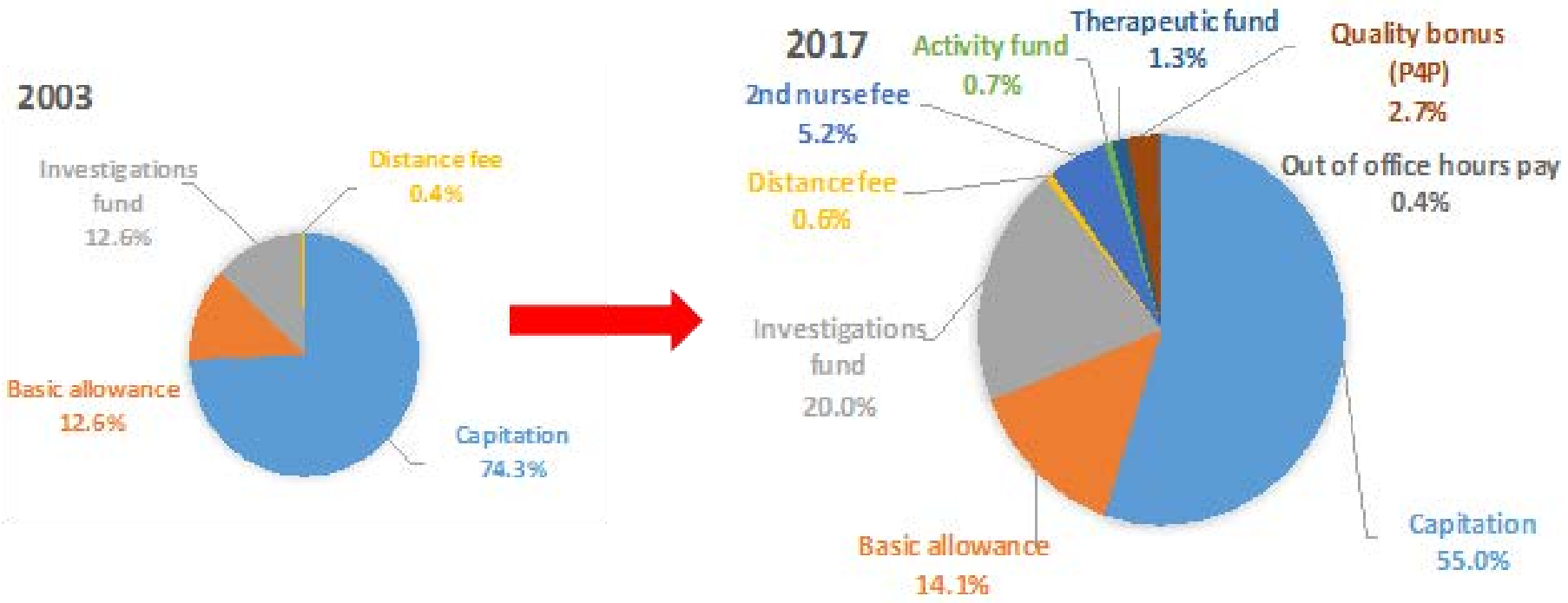
Refining traditional payment methods may help

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

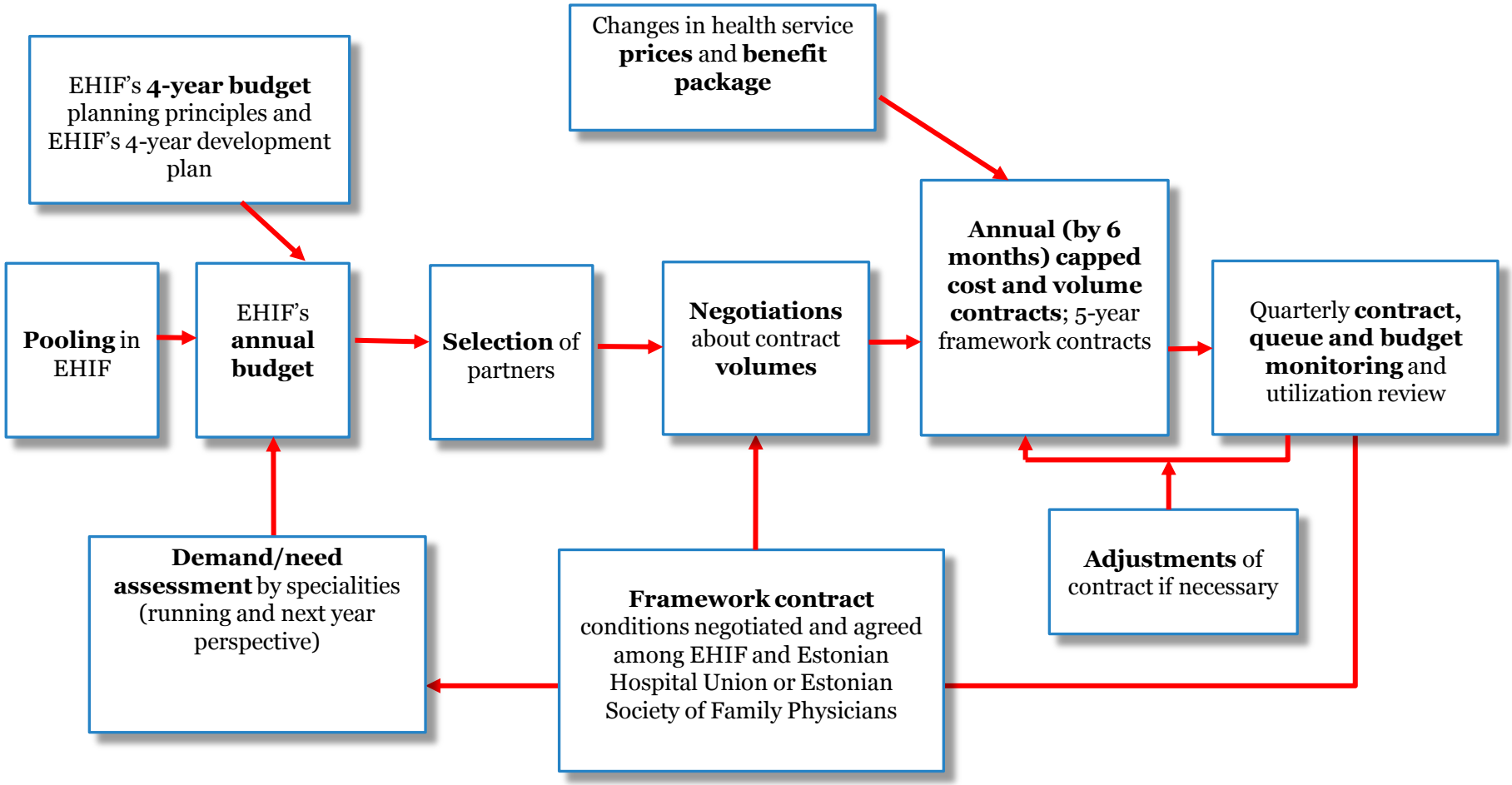
- Revision of P4P to incentivize more adherence to the guidelines
- New PHC Center payment model

- 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



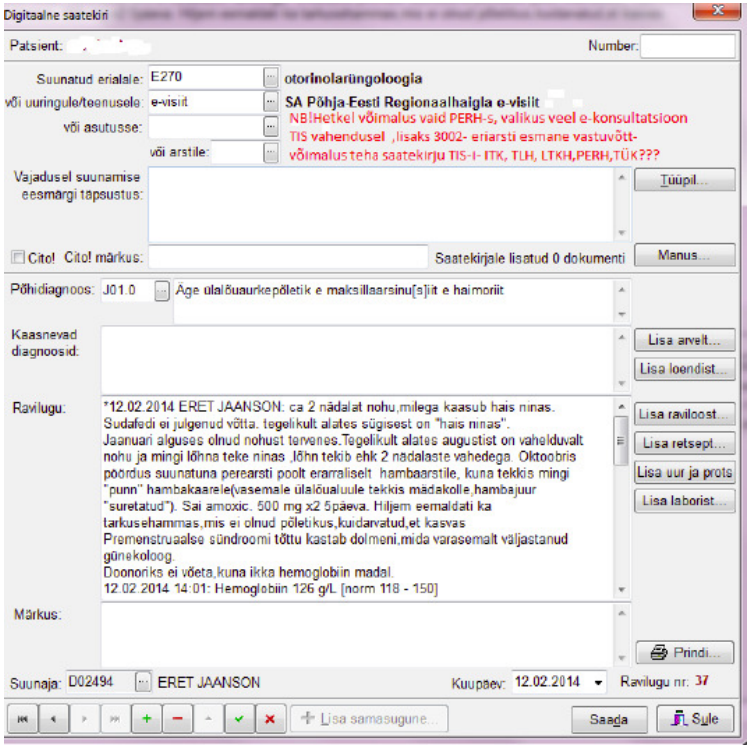
Service delivery model is changing

- 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…



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