

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

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March 8, 2018

# 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



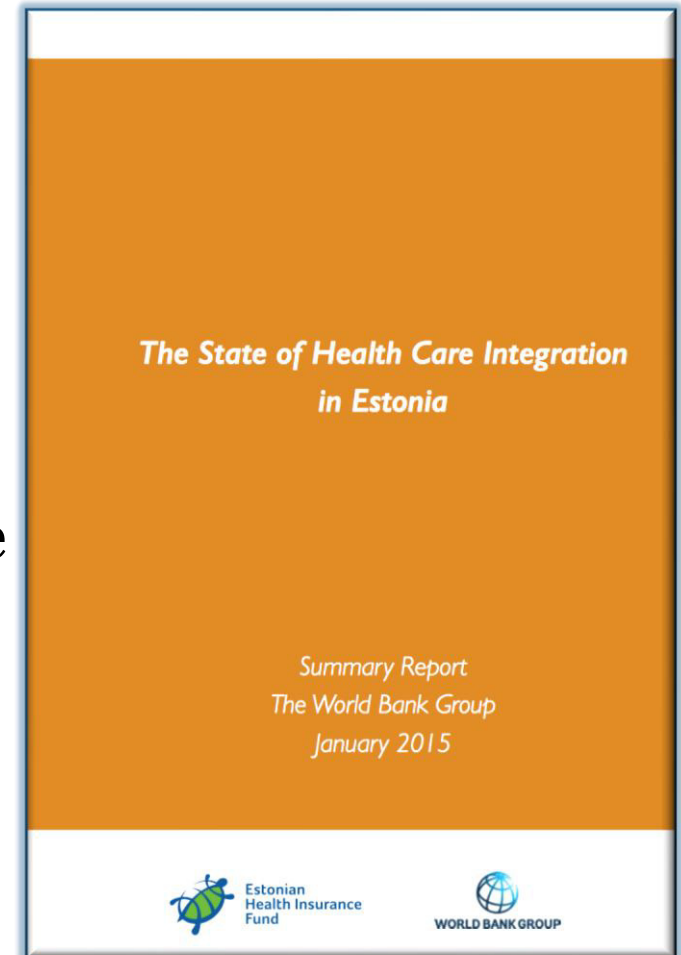
# Is Estonian health care system well integrated to be prepared for NCD?

## World Bank study (2015)

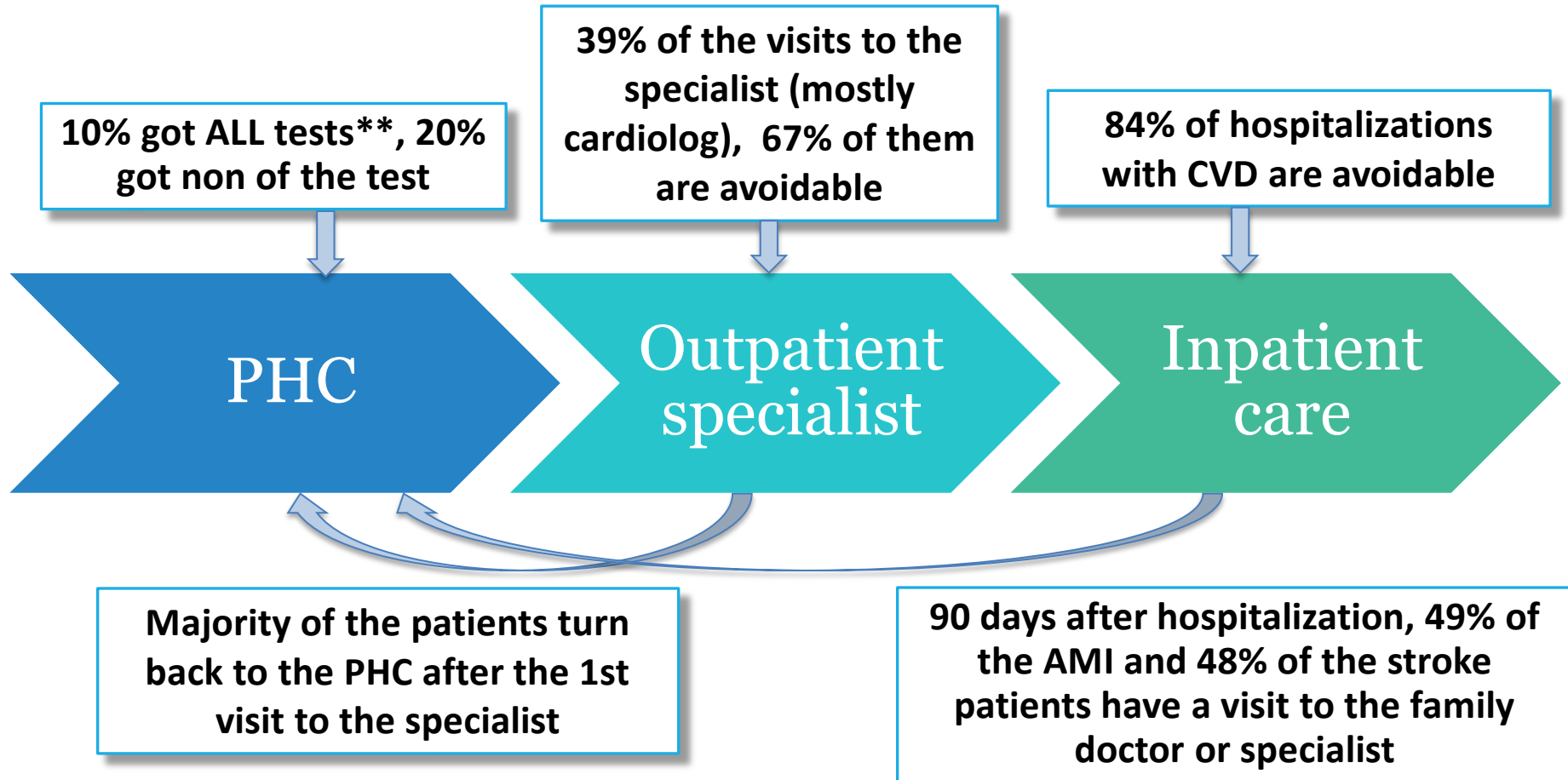
- Focus groups and key informant interviews
- Document review
- Data analysis (Estonian Health Insurance Fund's claims data, Census)

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

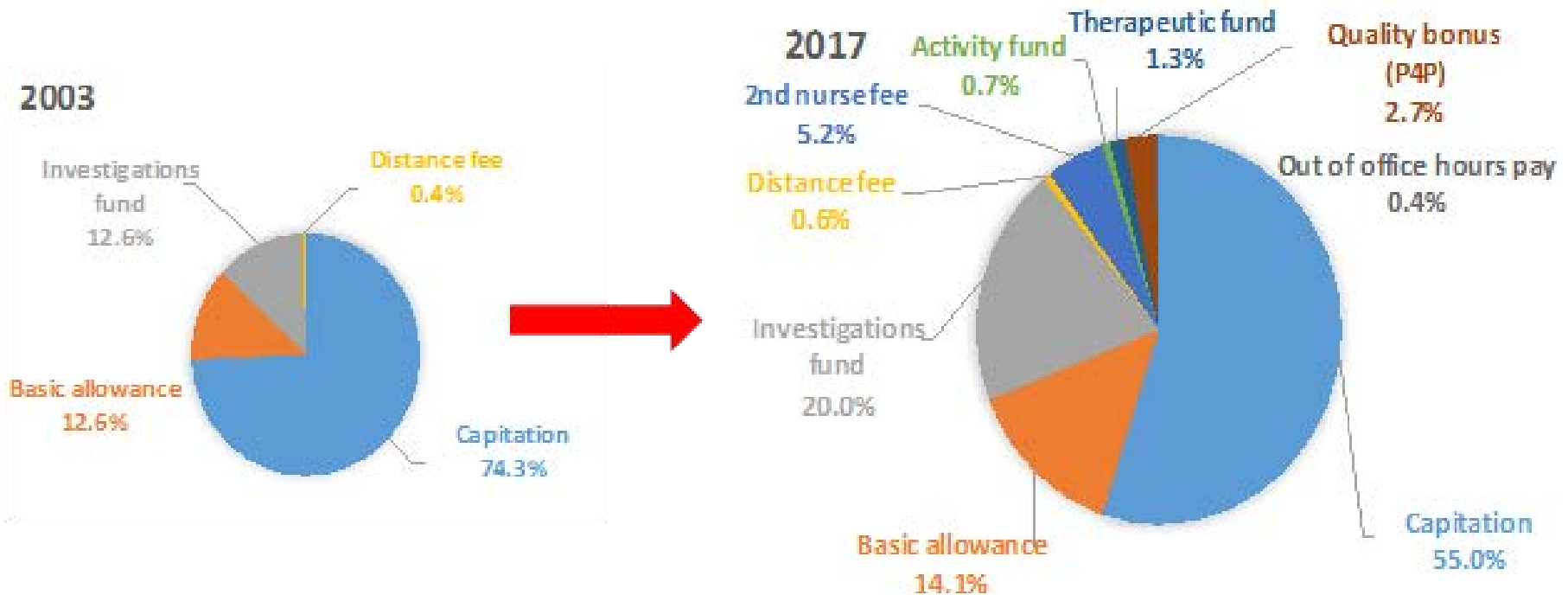


- Revision of P4P to incentivize more adherence to the guidelines
- New PHC Center payment model

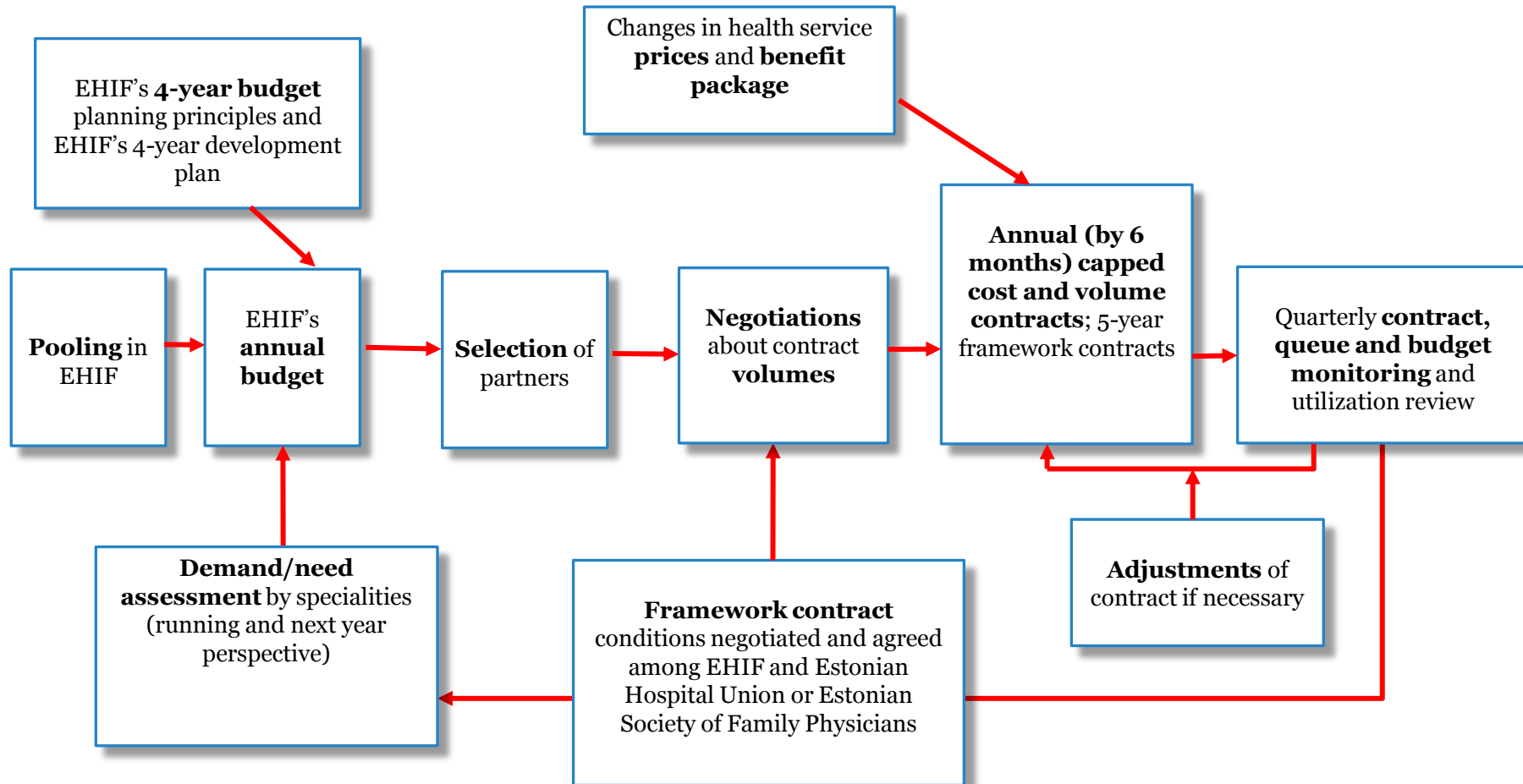


- Global budget with performance indicators (rural hospitals)
- Piloting integrated care model (hospital+PHC center)
- Pay for patient management
- Episode based payment

# 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...

Digitaalne saatekirj

Patsient: [redacted] Number: [redacted]

Suunatud erialale: E270 otorinolaringoloogia

või uuringule/teenusela e-visit SA Põhja-Eesti Regionaalhaigla e-visit

või asutusse: NB! Hetkel võimalus vaid PERH-s, valikus veel e-konsultatsioon

või arstile: TIS vahendusel, lisaks 3002-eriarsti esmane vastuvõtt-võimalus teha saatekirju TIS-i-ITK, TLH, LTKH, PERH, TÜK???

Vajadusel suunamise eesmärgi täpsustus: [redacted] Tüüpil...

Citol Citol märkus: Saatekirjale lisatud 0 dokumenti Manus...

Põhidiagnoos: J01.0 Äge ülalõuarkepõletik e maksillaarsinu(s)it e haimoriit

Kaasnevad diagnoosid: [redacted] Lisa arvelt...  
Lisa loendist...

Ravilugu: \*12.02.2014 ERET JAANSON: ca 2 nädalat nohu, millega kaasub hais ninas. Sudafedi ei julgenud võtta, tegelikult alates sügisest on "hais ninas". Jaanuari alguses olnud nohust tervenens. Tegelikult alates augustist on vahelduvalt nohu ja mingi lõhna teke ninas. Lõhn tekib ehk 2 nädalaste vahedega. Otkoobris pöördus suunatuna perearsti poolt erarraliselt hambaarstile, kuna tekkis mingi "punn" hambakaarele (vasemale ülalõualuule tekkis mädakolle hambajuur "suretatud"). Sai amoxic. 500 mg x2 5 päeva. Hiljem eemaldati ka tarkusehammas, mis ei olnud põletikus, kuid arvatud, et kaasvas Promenstruaalse sündroomi tõttu kastab dolmeni, mida varasemalt väljastanud günekoloog. Doonoriks ei võeta, kuna ikka hemoglobiin madal. 12.02.2014 14:01: Hemoglobiin 126 g/L [norm 118 - 150]

Märkus: [redacted] Prindi...

Suunaja: D02494 ERET JAANSON Kuupäev: 12.02.2014 Ravilugu nr: 37

IR < > + - - ✓ ✗ + Lisa samasugune... Saada Sule

# 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