The State of Health Care Integration in Estonia

Qualitative Research Results: Key Informant Interviews
The World Bank Group
December 2014

Introduction

In order to assess the integration of care in Estonia from a health system perspective, with a particular focus on the role of primary care, nine key informants were interviewed between August 29 and September 19 2014. The objective: to identify the root causes for performance shortcomings, factors maintaining the status quo, and possible policy entry points.

Representatives from the following main sector organizations were interviewed:
(i) Estonian Health Insurance Fund,
(ii) Ministry of Social Affairs,
(iii) Health Board,
(iv) National Institute for Health Development,
(v) Association of Family Physicians,
(vi) Cardiologist Association,
(vii) Nurses Association,
(viii) Hospitals - Tartu University Hospital and North-Estonia Regional Hospital.

Results

Summary

Delivery of care in appropriate care settings

Issue	Underlying problems	Relative importance	Root causes	Factors maintaining status quo
Avoidable hospital admissions	Social and health care separated	Low	Unclear roles and responsibilities for monitoring and case management in order to avoid acute episodes and hospitalization	▪ Political and governmental decisions behind the system design
Avoidable emergency care visits	Patient attitudes	High	Low trust in family physicians and their competence makes patients turn to emergency care	▪ Recent history (social-cultural) - family physicians were not seen as specialists before ▪ Uneven quality of family physicians
			Patients are impatient	▪ System is designed in a

			and use emergency care to avoid waiting for care.	way that emergency care visits are financially beneficial to hospitals and they do not refuse to serve such "clever" patients
	Long waiting times to see a specialist	Average	Lack of specialists	▪ State politics in the meaning of preparing specialists but also valuing them through financial incentives, lighter workload and possibility to develop
			Limited budget for insured/free medical care	▪ Depends on the distribution of money in the health care system
	Lack of prevention	Average	Currently no continuous and clear system of responsibilities and financing developed	▪ Responsibilities and financing being project-based
	Emergency care as a middle step towards hospitalization	Low	Number of hospital beds is severely limited therefore, when wanting to hospitalize a patient, the family physician sometimes has to send the patient to the emergency room	▪ The system is built in a way that hospitals' physical resources (number of beds) are quite limited and strongly regulated and hospitals are obliged to hold beds for emergency patients
Avoidable specialist visits	Incomplete services on primary care level	High	Limited human resource in primary care - quantity is borderline sufficient, average age is relatively high, workload is heavy	▪ State politics in the meaning of preparing family physicians but also nurses, and motivating them ▪ System design in terms of reviewing the responsibilities of family physicians and family nurses (much more potential in family nurse) ▪ System design and financing, which forces family physicians to calculate and weight all the time within a certain budget
			Limited financial resources for analyses and diagnostic procedures	
			Uneven quality of family physicians in terms of goals, attitude and physical resources	▪ System design and financing, which forces family physicians to be doctors and entrepreneurs at the same time

	Uneven quality of family physicians	Average	Different approaches to the role of family physician	▪ Family physicians' goals and attitude - whether it is more about doing business or helping patients ▪ System design and financing, which forces family physicians to be doctors and entrepreneurs at the same time
			Disparity of opportunities and capabilities between family physicians in urban and rural areas	▪ Better equipped physicians' offices in urban areas ▪ More efficient use of resources by consolidating into bigger centers
	Patient preference	Average	Low trust in family physicians and therefore patients demand referrals to specialists (by law, the family physician has no right to refuse)	▪ Recent history (social-cultural) - patients were used to seeing specialists when desired as family physicians were not seen as specialist before and there weren't any gate-keepers ▪ Uneven quality of family physicians
	Inappropriate division of responsibilities in preventive services	Low	Currently no continuous and clear system of responsibilities and financing developed	▪ Responsibilities and financing being project-based
Unnecessary extended hospital stays	Not considered a significant concern.	Low	Separation of social and health care systems may lead to discharge delays.	▪ Political and governmental decisions behind the system design.

Coordination and continuity of care across care settings

Issue	Underlying problems	Relative importance	Root causes	Factors maintaining status quo
Inadequate acute inpatient follow-up	Insufficient clarity of roles and responsibilities of health care	High	Lack of human resources to provide in-home nursing	▪ Political and governmental decisions behind the system design
			Organizational separation of health care and social system, which means	

care	and social system		separate financing and poorly defined coordination mechanisms and processes Health and social systems are not equal; the social system is less well funded. Cooperation between those systems works on goodwill, but often there is a lack of good relations because of being overworked, lack of human resources and uncertainty as to which side pays	
	Inadequate access to rehabilitation and physiotherapy services after discharge	High	Theoretically the system has been developed, but it does not satisfy the existing need due to poor financing (compared to acute care) and organization, and insufficient physical and human resources	▪ The system design prioritizes acute care. ▪ Different languages (Estonian and Russian)
Incomplete hospital discharges	Insufficient sharing of important instructions and information with the patient, family physician or other specialist	Average	Lack and overload of specialists, nurses and caregivers. The salary of nurses and caregivers is also critically low (therefore there's a high turnover among them)	▪ State politics in the sense of preparing medical personnel but also valuing them through financial incentives, lighter workload and possibility to develop
Unnecessary pre-operative diagnostic procedures	Not considered a significant concern at present	Low	▪ Not many unnecessary or duplicate diagnostic procedures currently occur.	▪ Difficult to regulate ▪ The rise of defensive medicine
Over- and under-provision of preventive services	Insufficient preventive services	Low	Currently no continuous and clear system of roles, responsibilities and financing has been developed for preventive care.	▪ Responsibilities and financing are project-based, not consistent ▪ The system design prioritizes acute care
Limited provider continuity of	Inconsistent and incomplete information flow across	High	Incomplete and inconsistent information provided by doctors to each other for referrals and filling out the	▪ The purpose of the national e-system has not been agreed upon on state (political) level

care	levels		medical records e-platform.	and therefore the structure and guidelines/manuals are not thought through and communicated ▪ Competing, non-integrated e-platforms in use to compensate for the problems of the national e-platform ▪ Incomplete guidelines and requirements for inputting to the national e-platform
			The current state-run e-platform is considered still raw, not functioning well and not corresponding well to the needs of medical specialists as well as to the needs of patients	
			Bigger hospitals have their own information systems, these are incompatible and parties are not very willing to come to agreements	
			Providers of care outside the EHIF system do not share information.	▪ No requirement for privately-funded providers to share information with the rest of the health care system.
	Long waiting times to see a specialist	High	Limited budget for insured/free medical care	▪ Depends on the distribution of money the in health care system
			Lack of qualified specialists	▪ State politics in the sense of preparing specialists but also valuing them through financial incentives, lighter workload and possibility to develop
			Lack of motivating salaries and heavy workload of specialists	

Delivery of Care in Appropriate Care Settings

In Estonia, primary care is intended to provide a gatekeeper function for the health system. However, while key informants recognized this intention, they noted that in reality there are challenges to that role that result in delivery of care in Estonia being focused at the specialist and emergency care level.

1. Avoidable hospital admissions

Key informants reported that the decision to admit a patient to hospital is not made lightly: capacity is limited, and the decision is strongly regulated. The question of who should be responsible for monitoring and case management for chronically ill patients (especially old people who live alone) in order to avoid acute episodes and hospitalization is unresolved: currently the social and health care systems function quite separately in terms of both responsibilities and financing.

2. Avoidable emergency care visits

The majority of hospital admissions are made via the emergency room. The informants considered the main reason that patients access emergency care, when it could have been avoided, are (1) patient attitudes towards family physicians, (2) deterioration of health due to long waits to be seen by a family physician or a specialist and poor preventive care, and (3) family physicians admitting their patients to hospitals, as there is no other referral route for inpatient care, maintained by the fact that emergency care visits are financially beneficial to hospitals.

2.1 Patient attitudes

Patient distrust of the competence and quality of their family physicians is considered a key factor that leads patients to directly access emergency care.

"First of all, the health-related behavior of country people is different, they don't use doctors for every little thing, it's like they have more common sense. And then when they do go, they go for something that is something and now the quality of family physicians in rural area is even more inconsistent than in town and in rural areas you can't go to the emergency room right away. In Tallinn the low quality is remedied by the emergency room."

2.2 Waiting times

Waiting times to see a family physician or a specialist can be long, due to insufficient human and financial resources. Patients often directly access emergency care to avoid the wait, particularly in urban settings.

"…we have lines here at the North Estonia Medical Center and I am sure there are lines at the East-Tallinn Central Hospital's emergency room as well. I think that half of this problem is still the same thing, it's all in people's heads – if they can't get to the family

physician right away, let's say that you are at work and you have an hour for coffee break and you have the time to go to the doctor and for example if you can't get in then you think that you can go to the emergency room and be seen quickly."

Another incentive for patients to directly access emergency care is to expedite their own care process, knowing that they can have all necessary tests and procedures done right away in the emergency room.

"You don't have to see a specialist or go to the hospital right away with everything. Our emergency rooms work like this right now that the patient comes to the emergency room, which is the most expensive. There all the tests and things are done fast."

On the other hand, sick patients who choose to respect the official system and wait for primary care or specialist appointment may find their health condition worsening in the intervening period due to the long waiting time, to the extent that they now need emergency care. Insufficient preventive care, with lack of access to preventive care centers, contributes to this problem.

2.3 Lack of reliable inpatient referral process

With the severely limited hospital intake capacity, it can be very difficult for family physicians to directly admit their patients to a hospital. They send their patients instead to emergency care as a middle step towards hospitalization, knowing that patients presenting to emergency care are prioritized for admission to hospitals, and that hospitals are obliged to hold inpatient beds for patients entering via emergency care, as opposed to patients being referred from outside the hospital.

"Hospital's intake capacity is … we can't take them, we don't have spots, we don't have personnel, we don't have contracts. We work at the internal medicine clinic, for example with our capacity we must first guarantee that emergency care patients are admitted. The family physician communicates with our specialist, through the clinic or directly through the head of the department, of course they find other solutions but the pressure is rather great."

3. Avoidable specialist visits

Until recently, patients self-referred directly to specialists, and have not yet accepted the newly designated gatekeeping role of primary care. Key informants considered that primary care could play a role in reducing avoidable specialist visits by more effective gate keeping; however the current effectiveness of this function is marred by the following underlying problems:

3.1 Insufficient services available

Insufficient services available at the primary care level, including insufficient preventive services (a) for people with chronic diseases, and (b) for the general public. These services are limited due to inadequate human resources and financial resources for analysis and diagnosis in primary care, inconsistent quality of family physicians, and the division of responsibilities in preventive services.

3.2 Human resources

At present, the supply of family physicians is generally considered borderline sufficient, but with a large proportion nearing retirement, there is predicted to be an insufficient supply of

young family physicians replacing them to meet the needs of the aging population. Moreover, these new physicians cluster in the cities. The predicted deficit in numbers of family physicians, along with the increasing demands of an aging population and a very heavy workload, reduces their capacity to provide in-depth individual care, and increases their impetus to refer patients to specialist care.

"… the age composition of family physicians is rather big, average age is 52, there are approximately 170 family physicians aged 63-79 and when these family physicians decide to retire at one point, it will be very complicated to guarantee medical care for people in areas located outside of Tallinn and Tartu, even with the beginner's allowance. There are family physicians graduating from the university but the coverage…. if there were available lists, could be bigger. It's up in the air, it is very difficult to plan."

The workload for family physicians in rural areas is even greater, often including being available 24 hours a day, for a wide range of services, and significant, time-consuming housekeeping tasks.

"…for example if you have to go to Leisi township and you know that you have to start the wood burner in the morning or you remain in Tallinn, you have a nice house, you have everything … you go and do your family physician's work, you are not a caretaker or have to come in at 7 in the morning and turn on the heaters to be able to work … all those domestic problems that you have there."

"…in rural areas it is that you have your own community there and it could be that those family health centers, the doctors as well as nurses, they feel that they are there 24/7, every neighbor is calling you all the time and thinks that you are prepared at any time … that you run into them at a concert or at a bonfire and right away you have people around you, waiting for you to dispense pills."

One possible solution recognized for addressing both the insufficient numbers and work burden of family physicians would be task shifting, by reviewing the respective responsibilities of family physicians and family nurses. With the influx of young nurses with higher levels of training, skills, abilities and ambitions, there is significant potential for increasing their responsibilities, and the system is already moving in this direction; however, the general public is not yet fully prepared to accept a consultation with a nurse in the role of a professional, as nurses have historically assumed more of a secretarial role.

3.3 Financial resources for analyses and diagnostic procedures

Family physicians make referrals to specialists for analyses and diagnostic procedures because of limited funding or incentives for these procedures. In turn, specialists receive funding per procedure from EHIF. Key informants described the current process, which increases EHIF costs, as a win-win for both family physicians and specialists.

"The family physician predominantly has capitation fees, is list-based and there are certain other things. The interests overlap, if you have the human resource, the family physician does less for the same amount of money, the specialists in the area have more work and they make more money, in this way EHIF puts more money into it than in an area where the family physician does more for the same amount of money and there is less specialist care… Doesn't matter what kind of a system you have, each of them has its drawbacks. Therefore it is pretty good that we have combined elements from different

ones in Estonia, but currently I would say that the differentiation component could be strengthened, decreasing the importance of capitation fees a little. You have to have capitation fees, it makes a lot of sense but what is added to it, there could be more of it and it should be more differentiated."

3.4 Uneven quality of family physicians

Different approaches to the role of family physician
The diversity in the approach that family physicians in Estonia take to their work contributes to the uneven quality of the care they provide. Key informants describe some family physicians as having a business focus, interested in running an effective business that fulfils quality standards; others take a care provision approach, focused on helping and healing their patients, with a distaste for the concept of 'doing business'. These differing approaches are reflected in how family physicians make referrals and consult specialists via e-consultation and in other ways, with those who take the care provision approach doing so in a more comprehensive way.

Physical resources
There is a significant disparity of opportunities and capability between family physicians in rural and urban areas. In bigger towns family physicians have more opportunities to conduct procedures and tests, and they can make better use of their resources by consolidating into bigger centers, enabling the sharing of costs and resources, and increasing their capacity. Meanwhile in rural areas family physicians' offices are often less well equipped, with less access to resources, and located further from places where tests and procedures can be done.

Another barrier is language: family physicians working in Russian-speaking areas like Ida-Virumaa are isolated from training and information accessible to the country's Estonian-speaking family physicians, and are inhibited in their communication and integration with other parts of the health system. Importantly, they cannot easily use the country-wide electronic healthcare information system.

"In Ida-Virumaa things are even worse, there the doctors live in their own information space. But, oh well, now things are bad because entering data in the healthcare information system can't be done in Russian. And now they are in real trouble because they can't enter that data in Estonian. Do you know how they currently issue disability documentation? They have some typical forms in Estonian, then they get on the phone, call that official and tell them what is going on with that person and then the official, who is not very apt in languages either, gets the information and then they come to an agreement as to what to do with that person next. Yes, the regions in Estonia are very different. Yes, we need actual additional resources to organize the primary care and social care over there in Virumaa."

3.5 Patient preference
Patients, accustomed to seeking care from specialists, and lacking trust in family physicians, tend to request referral to a specialist; family physicians do not have the legal right to refuse to make that referral.

3.6 Division of responsibilities in preventive services

The key informants considered that other than monitoring indicators like cholesterol or blood glucose, family physicians were not best placed to deliver preventive services, due both to their already heavy workload, and lack of expertise and experience in preventive medicine.

"In the family physician's list there might be one to two people a year who have a heart attack, depending on the age composition of the list. That is very little experience. That would be the biggest message from me."

In order to decrease referrals to specialists for preventive services, they recommended securing the appropriate financing and scaling up the use of preventive care offices, staffed by specialized nurses, providing tailored preventive services for patients with different types of chronic diseases, like diabetes or heart disease.

" *Those programs that are funded by EHIF and they provide very nice support and there is funding for certain training. To have money for prevention…"*

"In 2001-2012 there was a cardiovascular disease prevention program. It included family physicians. In the beginning there were 100 family physicians, then it was 200 and in the end almost all of the family physicians participated, sending their patients. We conducted seminars, trained family physicians and everything was very purposeful and was a very nice operation. Now we are waiting. EHIF wanted to wait and see if the results of that program have taken root in Estonian medical care. Some patients were used to turning to those preventive care offices during the course of the program. And they wanted to come here much more than go to the family physician. As of 2007 we were not allowed to measure cholesterol levels or do screening. Only the family physician could do that and we were allowed to work only with the patients that were referred by family physicians. But the problem was all the people who were used to the program. And they really liked that when they came to our office, there was a specially trained nurse who talked to them a lot and they could run all of those tests. Now, when they go to their family physician, they might be very busy there and the nurse there has not received special training."

4. Unnecessarily extended inpatient stays

Key informants reported that inpatient stays are kept as short as possible. However, the social care system and the health system currently function quite separately, and their lack of cooperation may contribute to unnecessarily extended inpatient stays.

Coordination and Continuity of Care Across Care Settings

The most important issue in coordination and continuity of care, identified by all key informants, is inadequate follow-up after discharge from inpatient care. Also universally identified as important issues is insufficient care/service coordination and continuity between levels of ambulatory care. Key informants who work directly with patients highlight incomplete hospital discharges, particularly in relation to secondary prevention and post-discharge instructions for the patient and primary care provider. Primary prevention and unnecessary pre-operative diagnostic procedures were considered secondary issues. This section explores factors causing and maintaining these issues.

5. Inadequate acute inpatient follow-up care

It was universally acknowledged that after an episode of hospitalization, patients often did not receive adequate post-hospital care and support. A lack of access and availability of rehabilitation and physiotherapy services, and a lack of clarity as to whose responsibility it is to make a referral for these services, means that either patients do not access these services, or when the services are provided, it is not always in an adequately timely manner. These issues can be particularly difficult for those with co-morbidities and chronic illnesses.

"Unfortunately often the doctors at the hospital do their job but now you'd also need recovery and rehabilitation and that part is lacking. And the first half of the job … I wouldn't say it is cancelled out but …"

"Everything associated with rehabilitation, it exists, there are departments, there is also funding from the Estonian Health Insurance Fund but it is for very specific conditions and at some point co-payments will come into play, it being accessible to people or not."

Another key issue is a lack of clarity on whether health or social services should be responsible for supporting people who have post-discharge nursing needs, and limited ability to care for themselves.

"Then the next step, what will happen to that person afterwards, there is a lot of room for development. This is a follow-up care phase where there's no longer continuous diagnostic procedures, the medical procedures are not as complicated but where the person is still not ready to go home and they would need certain additional … also medical care. Or people for whom it is limited to nursing care, there's this follow-up care period and that is rather neglected still."

The root causes of the inadequate acute inpatient follow-up care, in order of likely impact are:

5.1 Insufficient clarity of roles and responsibilities between health and social care

There are significant incentives to discharge patients from acute inpatient care: there is high demand for the relatively small number of hospital beds, and acute care is expensive. However, there can be a lack of clarity, or resources, regarding where to discharge patients: there is a lack of human resources for in-home nursing to provide continuity of care.

"…and where should that patient belong to? Not a single doctor wants them in acute care, so we'll just send them to nursing care. And then the person comes there and then the nurses have a say and then we'll sit around the table, trying to figure out what to do with that person."

One of the biggest challenges is at the border between health and social care.
All key informants identified poorly defined coordination mechanisms, processes and responsibilities result in a lack of clarity in where either system begins or ends. This issue is particularly pertinent with the aging population, particularly for those living alone in rural areas, who increasingly need residential care, or assistance in activities of daily living, and accessing healthcare, for example transportation.

"These days the higher the life expectancy, the more questions arise – where does active medical treatment begin and end, where does social care begin. And this has to do with

caring for people, for example nursing care vs. nursing home. So yes, treating an elderly person vs. caring for an elderly person."

"…90-year-old person is writing and complaining that they are angry at their family physician because the family physician is not organizing transportation to go to the hospital to see an eye specialist. They are old, sick and can't see. They need to go and see an eye specialist in Tallinn but the family physician is not organizing transportation. The fact that the family physician is not organizing transportation is not an issue of healthcare. The issue is why this family physician is not communicating with the local social worker, who should make an appointment with an eye specialist for that 90-year-old patient if they can't do it themselves. That belongs to the field of social care./…/Who has to make the appointment for the patient. Does a nurse do home visits? Has the family physician's nurse visited? Does the social worker know what the situation is at home?"

Separate financing systems contribute to the confusion and can create barriers to integration. Health and social systems are not viewed as equal: while the health care system is funded by EHIF, the social system partly depends on funds from local municipalities, which varies according to their wealth, and contributes to a variation in quality of services. Cooperation between the social system and health system currently depends on good will from both sides rather than on official regulations.

"Now, when we are beginning to develop first-level centers, the one recommendation is to have a social worker on the premises at the healthcare center. But when it comes to that recommendation, the issue is that the healthcare system cannot fund providing of social services. Which kind of means that the money we are offering to the applicants here cannot be used to develop the space used by those working in the social field. This is a legal conflict because the social field and healthcare field are separated. And here's the issue, we have to resort to legal trickery. Trickery might be a bad word but we must look for a legal solution here."

In reality, that good will is not always present, due in part to concerns about taking responsibility when they are overworked, have inadequate human resources, and there is a lack of clarity of who will cover the costs. Or else people are deterred from cooperating due to the risk of complaints resulting from sharing confidential information across sectors.

"During the last few years we have strongly recommended that family physicians cooperate with social workers and they could have their phone numbers handy, who to go to. But often they don't like to contact them. Either they are afraid of being indiscreet [afraid to violate patient's/ family privacy], getting involved in [unpleasant, personal] situations They are afraid to give someone work or forward the issue. I don't know. But we have had cases here and there which end in the displeased person contacting the ministry."

5.2 Inadequate access to rehabilitation and physiotherapy post-discharge

Estonia has a developed rehabilitation and physiotherapy system with guidelines, centers and rehabilitation plans for patients; however the country's health system is focused on acute care, and the current system for rehabilitation and physiotherapy does not meet the extent of existing need, resulting in long waiting times that mean follow-up care is not provided in a timely manner, or at all. Services are only available in certain geographies, mainly in the bigger urban centers, complicating access for people who live in rural areas. Furthermore, EHIF only funds services for specific conditions.

"…when it comes to rehabilitation and physiotherapy, it exists, there are departments, there is funding from the Estonian Health Insurance Fund but they are for very specific conditions …".

However, funding itself is not the main limiting factor: insufficient physical and human resources to meet demand mean that even patients' copayment does not enable access to services.

"And then of course rehabilitation and physiotherapy that used to be rather decent during the Soviet time. It is weird to say that but 20-30 years ago it was decent and everyone went to a sanatorium as well. In today's conditions, we cannot afford activities as "luxurious" as that, i.e. involving so much manpower. But we could definitely afford systematic work going into it."

6. Incomplete hospital discharges

Key informants recognized the importance of giving specific guidelines and instructions to the patient before discharge, and sharing information about the patient with the family, physician and specialists in different settings; however they also recognized that often patients leave the hospital without these steps being taken. Patients are discharged not knowing what to do next or how to recover, without anyone conveying information about their condition or treatment plans to their family physicians or specialists, and – considered to be a primary issue for incomplete discharges – without advice and plans in place for secondary prevention.

"The doctor simply says that you continue care based on the same guidelines … healed … but there could be many procedures that the doctor does not pay attention to. For example, that it is necessary to advise a family member on certain matters, it could be nutritional, sexual issues, everything, the person with the diagnosis goes home and they are in shock anyways and the family around them has needs or children and all. Someone has to say and explain to the patient as well as the patient's family about their medical condition and this and that will happen soon and then they can do this and that…"

The root cause for incomplete hospital discharge is considered to be lack of capacity due to insufficient numbers of specialists, nurses and caregivers (healthcare assistants) in hospitals, and in the case of nurses and caregivers, high turnover, associated with low salaries.

"The caregiver turnover rate is very high. Nurses too, but especially caregivers. A caregiver's job is not your typical cleaning job. But when we look at the pay scale then in reality they are in the lowest tier of the pay scale.

Key informants considered investment in administrative capacity would allow reorganization of the roles and responsibilities of medical personnel to improve discharge processes.

The one thing is also that you can delegate a lot to secretaries. /…/ …all this paperwork takes up a lot of the doctor's time. We now have secretaries in medicine. During the 9-10 years that I've been in Tallinn, secretaries have become significantly better. Now the department that I used to be in charge of has had two secretaries for several years and now a third one part time. We can save medical specialists' time a lot in this way."

In addition to the human resources challenges in hospitals, Ida-Viru county, which operates in the Russian language, has additional problems with maintaining medical personnel quality, as there are language barriers to communication across the health service, in addition to accessing training and informational seminars.

"When we think about other counties now then Ida-Viru county is one with a separate life of its own. When we are talking about the area there up to Jõhvi and Kohtla-Järve where the Ida-Viru Central Hospital is located then it still kind of qualifies as quality in the sense of medical care. But what is Narva … well, I've been there myself … I have been to Narva at least once a year and I communicate with my colleagues working in Narva very often but I do have the feeling that modern quality requirements do not apply there. I am not talking about the language."

7. Unnecessary pre-operative diagnostic procedures

Doctors make decisions about the need for diagnostic procedures, with the purpose of monitoring risks and gaining insight into a patient's condition. Key informants were of the opinion that few unnecessary or duplicate diagnostic procedures occur in Estonian healthcare, and lacked an appetite to introduce regulation, which was not generally considered necessary.

"Yes … this is called defensive medicine and it's common in the developed world. It is done … the doctor does it, the hospital does and in an era where the doctor's word is believed much less than machine testing then often, to prove something to the patient but often to oneself and a colleague or to exclude something, machine tests are still used. And in case there is a dispute, these days everyone is eager to demand their rights and complain and whatever, everyone wants the decisions to be supported by tests. I'm of the opinion that all this is not necessary. But in every specific case, where do I draw the line where I, as a doctor, am prepared to put up with the uncertainty, that some things have not been completed, when I think that it is not very important for the patient, those are such subjective decisions and then I ask myself, why take the risk. And on the other hand it's that tests are always associated with side effects and risks and then we take those risks. It is very difficult to give one specific answer but it seems that, well, we could achieve an equally good impact in medicine with a smaller number of tests but no one on the outside can say that, this cannot be done through standardizations, it is a difficult subject."

8. Over- and under-provision of preventive services

Insufficient preventive services is a key issue in Estonia. The general attitude towards preventive services is very positive as prevention is recognized as much cheaper than acute care, helping to save money, physical resources and the time of doctors and medical personnel.

"By the way, the amount of money that was used on our preventive program was so small. I compared that the work we did during one year in our heart health office was equal to the treatment of one patient, when we had an acute patient, we did an angioplasty on 3-4 blood vessels, all kinds of intensive care on top of it. We counseled hundreds and hundreds of patients during the year for the same amount of money that it cost us to treat an acute patient at the hospital. So the cost of prevention is actually small. Very small compared to active treatment. Prevention should be clearly separate from active treatment because otherwise it will get lost in it. Hospital management is not interested because all those

expensive active treatment procedures are also profitable for the hospital… And for the cardiologist, if he's doing prevention or providing active treatment, when you have a patient in bed then you need to treat them right away and they don't have the time."

However, health services do not routinely provide preventive services due to an unsustainable funding approach: respondents report that preventive services are run and financed as one-time projects by EHIF and others; since acute care is the priority for hospitals, prevention is invariably deprioritized when the funding comes to an end, even though the benefits of preventive care are recognized.

"Everyone understands that we need prevention but it is still secondary."

Refer to Section 2.5 for further discussion of prevention.

9. Limited provider continuity and impaired patient provider relations in ambulatory care

The two main obstacles to provider continuity in ambulatory care are information flow between the levels of care, and long waiting times.

Information flow
There is a lack of instructions and rules governing how information is shared, the guidelines and mechanisms are incomplete, and as a result, doctors (family physicians and specialists) making referrals or filling in the medical records e-platform share information inconsistently.

"…that is information between the specialist and the family physician. Again, seeing and knowing both sides, you can't lay blame on either, saying that you are like this and like that – no, you are; but we see this on one hand … again, the referrals from family physicians vary, the information that comes with the patient, what has been done before the patient reaches specialist care … often the tests have not been done, no proper referral, no information sent with the patient and also, on the other hand, after specialist care – what tests were done, no information is sent back to the family physician."

State-run medical records e-platform earned special attention and criticism from respondents. The current state-run platform was implemented in 2004, but there is still a lack of clarity at the state (political) level regarding its primary purpose: whether an analytical tool to monitor and evaluate health at the population level, or a clinical tool for healthcare providers (and patients) to use in the course of daily healthcare.

"When the medical records e-platform was created in 2004 then it wasn't really … and since everyone was so enthusiastic and in a rush, then we didn't really discuss and raise more specific questions and thus also answers to the question if this records platform is a compilation of people's medical records to evaluate the medical condition of the population on the scientific level … or is this a tool to view the medical records of each Estonian inhabitant almost in real time. Those are two completely different things in principle."

This lack of clarity is reflected in the training materials, which are considered to be poorly thought through and poorly communicated. As a result, the system is perceived as neither functioning well nor corresponding well to the needs of either medical specialists or patients.

"I'm afraid to say, you are recording here, but it's a little bit like a mass grave, everything is piled in there … there has been a lot of criticism and many recommendations, that it could be more structured, easier to use

The confusion around the state-run medical records e-platform led to bigger hospitals creating their own information systems to meet clinical needs, which are now well embedded. These different systems are incompatible and sharing information between hospitals is rather a matter of agreement, but due to competition between bigger hospitals, and language barriers between Estonian and Russian language systems, parties are often unwilling or unable to come to those agreements.

"and then of course it's this … compatibility of databases, first level, who's using a couple of versions of their electronic records, in specialist care where you can also use different electronic information systems … those information systems don't all talk to each other … and of course it's the medical care facilities who have invested in their own information systems, we have done, it meets our needs and the others say the exact same thing and then you have to … it's like two goats on a footbridge, who will survive. It is not reasonable to say let's make a new one but those agreements, whose will be kept – very difficult. We are such a liberal country and all but there probably could be a central place for decision-making."

Key Informants were of the opinion that there should be a common state-run e-platform but they saw that achieving this requires decision making on the highest political level, strong management of the process (human resources) and, of course, financial motivation.

"Someone has to make the decision. Of course you must include those involved. It is very easy for me to say this, that things must be like that but, oh well, people who are in those positions, they must make those decisions and achieve the consensus."

"… in that sense I agree with those who say that there must be a connection between the data the hospital submits to the information system and the money they receive. There must be some sort of a connection."

Waiting times

Patients circumnavigating systems due to long waiting times, associated with EHIF funding processes, is another contributor to discontinuity of care. Patients unwilling or unable to continue waiting within the EHIF-funded healthcare system may opt instead to pay for healthcare privately; however privately funded healthcare is not associated with any obligations on the part of the provider to share patient information with other healthcare providers: any information sharing is done only as a matter of goodwill.

"If the hospital can say "pay us 5000 € and you can have your surgery right away" or the alternative is to come back in six months when it's your turn on the waiting list then actually they have the medical resources but they don't have contractual financial resources. And when such proposals are made to our patients, which we've heard in complaints, then naturally it makes the patient uncomfortable and it confuses us as well. We know that contracts are what they are. The way the EHIF has distributed funds."

Another root cause of waiting lists is human resources: there are insufficient qualified specialists, for two main reasons:

Despite training an increasing number of specialists, the overall number is not rising sufficiently as these overworked specialists are leaving Estonia for places offering better salaries, development opportunities, and working conditions.

"People are working at full power and many colleagues also work somewhere in Rapla or Paide to maintain cardiology service there. This is a big problem in Estonia. When you ask me what the problems are then I can foresee one big problem. Currently many of my colleagues are working overtime./…./ Everyone who has gone to Finland or Sweden says that the work speed is much slower there. You have much more time there and you can develop yourself further and you don't run around at the same speed as in Estonia."

In addition, specialists cluster in the bigger urban centers, meaning that those living in rural areas and smaller towns have to organize transportation and figure out where to go. For older people, even making an appointment with the specialist could be difficult due to issues with transport and other practicalities at the intersection of health and social care.