

**WHO Mission to Estonia
on the Development of the Primary Care sector**

Mission report

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March 2006, Tallinn, Estonia

Table of content

Purpose of the mission 3
Comments on the concept paper on primary care 3
Links between the concept paper on primary care and other strategic documents being developed 4
Recommendations on the policy development process itself..... 5
Stewardship role of the Ministry of Social Affairs and support from WHO 6
Annex 1: Comments on the Strategic Lines for Primary health Care 7
Annex 2: Proposed Outline of a Strategic Document for Primary Health Care..... 13
Annex 3: WHO Health System Framework Adapted for Improvement 14
Annex 4: Proposed Process for the Development of the Health Care Delivery Strategy 16
Annex 5: People Met during this Mission..... 17
Annex 6: Program of the Mission 18

Purpose of the mission

1. To discuss the strategy paper on Primary Care development put together by the Estonian Ministry of Social Affairs (MOSA).
2. To make recommendations for the next phase of development of the primary care sector, to be reflected in a strategic plan to be developed by the MOSA.

People met: See list of people met in *Annex 5* and program in *Annex 6*.

Comments on the concept paper on primary care

The WHO team (Jarno Habicht, Rifat Atun and Bruno Bouchet) discussed the paper entitled “primary health care development lines” with the MoSA and provided comments on its content and next steps. The main comments are:

- ✓ The current document is a good concept paper that is trying to define better the vision of the primary healthcare system in the future;
- ✓ The intent to expand primary care beyond just curative general medical care is good, involving other health professionals (for better integration of care) and other levels of the system (for better continuity of care);
- ✓ The document remains conceptual and is not a strategic plan for action by the MOSA and its partners/stakeholders of the health system. The latter needs to be developed.

The detailed comments are reproduced in *Annex 1*, and an outline for such a primary care development strategy paper is proposed in *Annex 2*.

Links between the concept paper on primary care and other strategic documents being developed

Several documents of strategic importance for the health system are being developed concurrently by various stakeholders on primary care, hospital reform, and emergency medical services. In the meantime, the Ministry is also developing a health policy paper, which was analyzed by WHO, and it is not clear how the other three documents link to it.

Because it is important to strengthen consistency between concurrent efforts to develop a national health policy, the MoSA should consider the following ideas:

- ✓ The vision of the MoSA to further develop the national health policy in Estonia could be articulated around a limited number of strategic lines, one of them being the strengthening of the health system (health system development);
- ✓ The strengthening of the health system would be easier to design if a conceptual framework, such as the WHO health systems framework was used and both objectives to achieve and changes to make were clearly linked;
- ✓ The three strategic papers being developed on primary care, hospital reform, and emergency medical services are all components of the healthcare delivery function of the health system. For this reason, they need to be (re)designed jointly if one expects to improve the performance of the entire health system around patients' needs.

A detailed description of the WHO health system framework and its potential use are reproduced in *Annex 3*.

The following box highlights the potential links between the various documents being developed and how the national health policy paper could be organized.

ESTONIA NATIONAL HEALTH POLICY FOR THE NEXT 5 YEARS

- A. Introduction, Background, etc.
- B. Strategic lines
 - 1. Strategic line 1 (for example, population empowerment)
 - 2. Strategic line 2: Strengthening health system
 - i. Description of the health system framework: goals and functions
 - ii. Function 1: Stewardship
 - iii. Function 2: Health financing
 - iv. Function 3: Resource generation
 - v. Function 4: Service delivery
 - a. Primary care sector (see outline in annex 2)
 - b. Emergency medical services and ambulance sector
 - c. Hospital sector
 - 3. Strategic line 3: (for example, intersectoral collaboration)
- C. Monitoring and evaluation plan
- D. Etc.
- E. Conclusion

Recommendations on the policy development process itself

The MoSA has an important role to play to facilitate communication between stakeholders (association of family doctors, health insurance fund, emergency services doctors, hospitals, etc) and lead the joint planning of the next phase of development of the health system.

After its initial health system restructuring being considered a success story in the region, Estonia is now facing the challenge of “fine tuning” its healthcare delivery models and processes in order to improve clinical performance. This continuous adaptation process is the normal way of achieving step-by-step improvements and requires the concerted effort of many stakeholders under the leadership of the MoSA. In other words, there is no special crisis or burning issue at the moment.

From the discussions we had, it does not seem that there is a problem of access to health care, but rather some efficiency issues (too many hospitals and beds, duplication of exams, overuse of ambulance services for non-emergencies) and maybe also issues of quality/safety (but it is not really measured and no data was presented). The use of previous formal evaluations (such as the specific evaluation of primary care¹ and also of the entire health system²) could be a very useful starting point for identifying root causes of issues and make proposals for changes.

A proposal for the development process of the healthcare delivery function is in *Annex 4*.

¹ *Advisory Support to Primary Health Care Evaluation Model: Estonia PHC Evaluation Project*. Draft Report. WHO, December 2004

² Rifat Atun & al. *Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats*. Technical Report. WHO, 2005.

Stewardship role of the Ministry of Social Affairs and support from WHO

The MoSA is obviously the steward of the health system and must lead any new developments. This requires that a unit/department and a team (with a team leader) be identified in the MoSA to coordinate this work, the outputs of which would be one strategic plan for the development of the healthcare delivery system with primary care as the entry point (as it is for the patient), as part of the health system development strategy of the national health policy.

If resources are available, WHO can assist in the finalization of such a strategy, but significant preparatory work must be done by local groups first, under the coordination of the MoSA. The further support can be negotiated through WHO Country Office during the coming year.

Annex 1: Comments on the Strategic Lines for Primary health Care

These comments complement the discussions and debriefing that happened with the Ministry of Social Affairs during this mission.

I. Issues and challenges with the primary care sector are well documented in previous national and international evaluations.

Much has been achieved in Estonia as regards health system strengthening and PHC development but a number of challenges remain, which have been identified through a thorough evaluation of the primary care system³. These challenges include:

1. Organization and Stewardship

- Successful teamwork is variable
 - There is apparent tension between the doctors' and nurses' role
 - Skill substitution and delegation highly variable
- PHC remains fragmented with multiple points of entry
 - Critical mass not defined
 - The emergency services led out-of-hours service and the use of hospital specialists for PHC services is expensive
- The referral-counter referral system remains fractured with some specialities not informing FPs of patient history and consultations
- The workload of FPs is increasing
 - Some additional work is not remunerated (e.g. disability forms)
 - There is excessive administration with limited management expertise of many family doctors to run a business
- The existing legislative framework prevents development of large partnerships and expansion of a practice size beyond 2,000 patients. This limits flexible working practices and the development of a critical mass

2. Financing and resource allocation

- Per capita financing with performance related pay has been introduced successfully, but limited incentive systems for providing additional services
- The payment systems encourage referrals: there is evidence of cost shifting e.g. ENT
- Bonus scheme has been introduced for managing chronic services, quality not measured and not adequately rewarded
- There is imbalance of funding for hospital and PHC services
- There is inadequate financing for urban areas

³ *Advisory Support to Primary Health Care Evaluation Model: Estonia PHC Evaluation Project. Draft Report.* WHO, December 2004

- PHC infrastructure is in need of capital investment to bring PHC centres to a standard that will encourage provision of expanded services, enable development of extended PHC and achieve secondary-to-primary shift. But, as market forces factor is not included in the funding formula capital investment in cities is very difficult and unaffordable—this limits service expansion opportunities
3. Service delivery
- The scope and the breadth of services provided remains variable
 - Opportunities for extended primary care remain limited and currently not rewarded
 - The system still retains a curative focus with inadequate incentives for health promotion and disease prevention
 - Chronic disease management still remains, to a large extent, under the control of narrow specialists—who want to control their patient group
4. Resource Generation
- Human resource shortage is a key problem. In particular, there is a shortage of family nurses and difficulty in attracting doctors to rural areas: hence, rural doctors find it difficult to find locums
 - There is limited flexibility at practice level to reconfigure human resource requirements to enable more efficient use of available skills

II. The current paper is more a concept paper than a PHC development strategy

Given these challenges, the paper currently presented (Primary Health Care Development Lines for 2006-2010) is best positioned as a 'Concept Paper', focusing on:

- (i) A clearer definition of family medicine and primary health care in the Estonian context to inform the current legislation
- (ii) Better articulation of the horizontal linkages between the existing family medicine services with the primary care activities delivered by the emergency care services, schools, occupational health units, social workers, community nurses and hospitals. In addition, the paper should better articulate the need for greater integration with municipalities, public health function and environmental health.

III. General Comments on the Organization and Content of the current development lines document

Comments on organization of current development lines document

1. *Comment:* For a non-informed audience, the overall logic of the document is difficult to follow. This is mainly because there is no description of what this document is about and what it is trying to achieve. It takes a long time to guess, more than to understand, that it is about strengthening further the primary care services as a natural and incremental process in the health system development of Estonia, motivated by the implementation of a long term vision rather than responding to a specific crisis or problem.

Recommendations:

- Add a front page with information on who wrote the paper, mentioning the Ministry of Social Affairs, the date, the version, and the nature of the document (draft for revision). The title should be more explicit, such as “strategy” or “policy” paper, rather than development lines.
 - Add an introduction paragraph that explains why this policy paper is being written, the context and timing in the policy development process, and what is it trying to achieve.
 - Forecast the outline of the paper and the logic of the information presented and the links between chapters and paragraphs (from the evaluation of the current stage of development to the vision of the next one). Give an overview of the paper so that we know what to expect.
 - Explain that this policy is not specifically developed because of serious and specific issues in the primary care sector, but rather as the next logical stage of development of the primary care level.
2. *Comment:* Most paragraphs under the first chapter (original situation) present a lot of data, but the real information (more precisely what exactly are the issues or the conclusion?) is missing.

Recommendations:

- Clearly indicate the message that is coming from the analysis of the data and whether this is an issue or not.
- When information is available, the causes of the issues should also be discussed, so that we understand better why it happened.
- From the reading of the current paper, it was possible to identify the following issues: too much use of ambulance services rather than family physician services; Too many home visits to children; Duplication of work between school and occupational doctors on one hand and family physicians on the other; gaps in the number and distribution of family physicians across counties;

- Classify issues under the following categories: access/coverage; quality of care; irrational utilization/efficiency; financing; equity; etc. This is because addressing them would require different strategies and would influence therefore the content of the strategy described in the next chapter. A health system framework can support in building such logic.
3. *Comment:* The document does not mention any formal and comprehensive evaluation of the primary care sector.

Recommendations:

- Summarize the main findings and refer to the work of WHO/Rifat Atun on the evaluation of the PHC model in Estonia. This can complement other studies available on Estonian PHC system and helps to identify actions to develop PHC further.

General Comments on the Content of the Strategy

4. *Comment:* The document does not explain how the challenges identified by a systematic evaluation (WHO/Rifat Atun 2004 and University of Tartu 2004) will be addressed through the proposed strategy. This is a serious shortcoming of this strategy.

Recommendations:

- Explain how the proposed strategy will address the challenges mentioned in the evaluation of the primary care sector (pp. 81 & 82 of the WHO provided PHC report 2004).
- Identify potential contradictions between the strategy and the issues identified through the evaluation. For example, the strategy proposes to expand the scope of services and managerial roles of family physicians. This is not consistent with the findings of the evaluation (shortage of doctors, level of effort beyond existing resources, etc.)

5. *Comment:* The strategy sounds more theoretical than pragmatic: defining the concept of primary health care rather than focusing on issues to address and results to achieve. Adapting the PHC concept in the context of Estonia is fine, but the expected benefits should be clearer. At the end, it does not matter what we call it (primary care, primary health care, primary level of care, etc.)

Recommendations:

- Explain how the proposed strategy will improve the performance of the health system in terms of effectiveness (better health for citizens), efficiency (more rational use of services and decreased costs/patient), and higher satisfaction (of all involved).

6. *Comment:* The actions proposed in the strategy are not always very clear and well organized.

Recommendations:

- Explain which changes will be made under the main functions of a health system: regulations, monitoring and evaluation, training of PHC providers, health financing, service delivery, etc. and relate them to an improvement objective and/or a specific issue. Maybe using the WHO health system framework would help reorganize the document and develop the content of the next phase.
- Describe more explicitly the additional services that primary care teams will provide and how the training curriculum will be adapted to build the new skills, as well as the other changes that need to happen for implementation of new services (reorganize premises, get new equipment, develop new guidelines, adjust quality indicators, etc.).

7. *Comment:* The implementation of the changes seems to rely only on new regulations. Centralized planning with little participation of decentralized units and end-users, command and control systems, and overuse of regulations are usually barriers to building an improvement dynamic at the facility level.

Recommendations:

- Present a strategy whose design involves the primary care teams, whose content increases authority and not just responsibility, whose financial management is more flexible and whose overall implementation motivates students to become family doctors and the existing ones to remain in the country.
- Make sure to identify the conditions to be met before the next development of the primary care can take place. Main message is that primary care teams will be asked to do more, but how is that compensated with additional resources and incentives?

IV. An opportunity exists to develop a primary health care strategy that is part of a more comprehensive health service delivery strategy for Estonia.

Given the stage of development and the challenges which remain and stakeholder views of the need for further advancement of PHC level, there is an opportunity and a clear need to develop a more detailed and complementary paper which articulates in detail the PHC Strategy for Estonia over the next five to ten year period—a strategy which is informed by and one which links with the Hospital Master Plan and the Emergency Medicine Services Strategy paper.

Such a PHC Strategy could usefully articulate:

- a clear vision and objectives,
- achievements to date
- unmet needs
- changes in PHC level which need to be made to achieve these objectives,
- changes in other health system elements which need to be made, as part of a broader health system strengthening effort, to help achieve PHC level objectives

- the mechanisms to achieve these objectives,
- financial implications of the desired changes and funding sources,
- the feasibility of achieving change and
- the metrics to measure achievements.

The PHC Strategy document could incorporate a ‘Performance Management Framework’ with a set of agreed ‘high-level indicators’ to monitor improvements in key objectives such as equity, efficiency, effectiveness and user satisfaction.

The PHC strategy could benefit from a framework agreed upon by all stakeholders, which clarifies the links between the objectives of the health system and the role of the PHC level. It can help identify the changes to make under the health service delivery function. The WHO health system framework could be useful as a starting point.

The PHC Strategy document could draw on a number of detailed analyses that were completed recently, and other sources of information, for example:

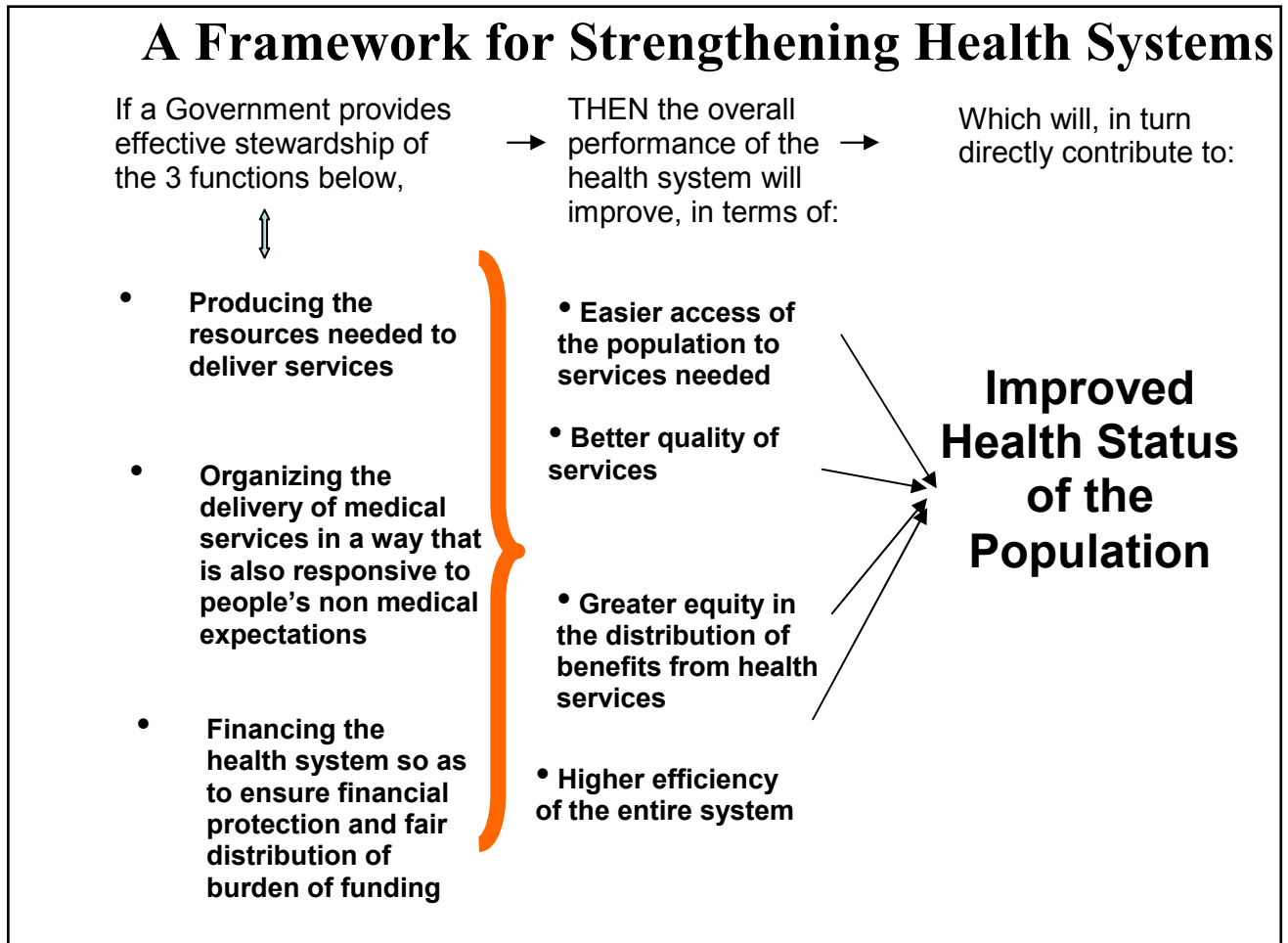
- (a) WHO-Atun RA. (2006) Estonian Health System: analysis of strengths, weaknesses, opportunities and threats. World Health Organization Regional Office for Europe. (2006) (pp1-90)
- (b) Atun, R.A., (2006) Evaluation of the Primary Health Care Reforms in Estonia. The World Health Organization Regional Office for Europe. Copenhagen (pp1-112)
- (c) Estonia Health Systems in Transition Report (2005) European Observatory on Health Systems and Policy
- (d) Reports of the Estonian Health Insurance Fund (2003,2004,2005)
- (e) Recent locally generated evidence
- (f) Regional and international evidence

Annex 2: Proposed Outline of a Strategic Document for Primary Health Care

The structure of the PHC Strategy Paper could comprise:

1. Executive Summary
 2. The Health System Context in Estonia
 - a. Changes in the broad context
 - i. Changing demand patterns
 - ii. Epidemiological transition
 - iii. Demographic issues
 - iv. Social expectations
 - v. Economic and financing trends
 - vi. Impact of the EU entry
 3. Development of Primary Care in Estonia
 - a. Key Achievements
 - b. Key Challenges which remain
 - c. Barriers to development
 4. Health Policy/Strategy Objectives of the Estonian Health System and PHC level
 5. Stakeholder views
 6. Strategic Options for PHC to address key challenges, and meet policy objectives (for example enhancing equity, improving efficiency, extending user choice, addressing effectiveness)
 7. The way forward—Strategic choice and the rationale:
 8. Financing options and sustainability
 9. Implementation Plan
 10. Risk assessment
-

Annex 3: WHO Health System Framework Adapted for Improvement



How to use the framework for the development of a strategy for strengthening health system?

1. It must be understood that this framework is not set in stone and its adaptation by countries is perfectly valid if it is the result of a logical approach by stakeholders of the health system.
2. The intermediate objectives of improving access, quality, equity and efficiency (and maybe others) must serve as the starting point for the development of a strategy. Every strategy development process must start with the question: what do we want to improve?
3. Issues with the intermediate objectives must be explicit and preferably quantified, using the results of previous evaluations done.
4. The development of the strategy must always keep in mind the client's perspectives. Improving the situation of a specific group of stakeholders might represent a means to this

end, but is not the primary objective of a health strategy because this is not a goal of the health system. The response to the question on improvement objective must clearly indicate a benefit to the patient/population.

5. The 4 functions must be used to identify potential changes to make that might lead to improvement. A change is not an improvement until proven otherwise through testing or unless there is sufficient universal evidence that testing on a small scale is not necessary in this particular context.
6. In order to identify the changes to make, we must identify and list sub-functions (under each of the 4 functions) that are linked to the improvement objectives. For example, under the stewardship function, one might want to include: health legislation and regulations, health information system, health system performance monitoring, development and approval of evidence-based clinical practice guidelines, etc.
7. Ideas for changes come from the identification of root-causes of issues and barriers to achieving the explicit objectives. Because it makes explicit the sub-functions, the framework can help identify the root-causes of poor performance.
8. Functions and intermediate objectives are not linked one-to-one: an improvement related to any of the intermediate objectives will come from multiple changes that pertain to several or all of the 4 functions. This reflects the importance of a systems approach.
9. The framework is used as the basis to identify indicators if improvement, and therefore the development of a monitoring and evaluation system for the national health strategy.
10. A change in the system will be the result of one or multiple interventions. For example, delegating the development of clinical practice guidelines to professional associations (a change, compared to a situation where the ministry is issuing the guidelines), will require reallocation of responsibilities and resources, training professional associations, developing new dissemination mechanisms, etc. All those interventions have a cost, which will allow developing a budget for the implementation of the national health policy.

Annex 4: Proposed Process for the Development of the Health Care Delivery Strategy

The following process is a proposal for the MoSA to consider, in its position of leader and facilitator of the development of a national health policy, to which the delivery function of the health system belongs.

1. Identify the MoSA department/unit in charge of leading the development of the healthcare delivery strategy.
2. Establish a task force on health service delivery, including but not limited to professional associations of primary care physicians, emergency specialists, ambulance services, hospital specialists and associations, associations of healthcare providers, medical universities involved in research on health system and training of providers, and health insurance fund.
3. Organize first meeting to develop the terms of reference of the task force, after clarification of the output to be produced: a short (10 pages?) strategic document to improve the healthcare service delivery function of the health system, as part of the national health policy for the next 5 years. The terms of reference should include a calendar of meetings and milestones and be consistent with the policy development process in Estonia (decision-making process and key-dates to be made explicit to all members of the task force).
4. Develop and agree on a health system framework, starting from the WHO one, and get the members of the task force familiar with its rationale and use (see annex 3)
5. Review existing evaluations of the healthcare delivery sector (including primary care, ambulances, and hospitals) and identify priority issues with healthcare delivery services and objectives for improvement (using the framework as the basis).
6. Identify causes of poor performance and of priority issues listed. Link specific issues mentioned by (and related to) a specific stakeholder with a consequence on population health.
7. Develop the sub-functions relevant to the priority issues and organization under each of the main 4 functions.
8. Suggest changes and interventions, along with a budget for implementation and a timetable.
9. Define the roles and responsibilities of various stakeholders in the implementation of the interventions and the overall strategy.
10. Link this strategy to the overall health system strategy and national health policy development.

Annex 5: People Met during this Mission

Name	Position	Institution
Raul Adlas	Chief	Tallinn Emergency Medical Service
Tiia Arro	Analyst	Department of Health Care (Ministry of Social Affairs)
Heidi Gil	Head	Department of Health Care (Ministry of Social Affairs)
Jarno Habicht	Head of Office/Liaison Officer	WHO
Diana Ingerainen	Family doctor	Estonian Society of Family Doctors
Ruth Kalda	Assistant Professor and Researcher	Department Of Polyclinic And Family Medicine (University of Tartu)
Ursel Kedars	Chief Specialist,	Health Care Unit (Ministry of Social Affairs)
Ago Korgvee	Director	Tartu University Clinics
Peeter Laasik	Deputy Minister of Health	(Ministry of Social Affairs)
Andrus Lipand	Chief Specialist	Department of Public Health (Ministry of Social Affairs)
Heidi Ingrid Maaroos	Professor	Department Of Polyclinic And Family Medicine (University of Tartu)
Mari Meren	Chief Specialist	Department of Public Health (Ministry of Social Affairs)
Ella-Karin Nurm	Head	Department of Public Health (Ministry of Social Affairs)
Elen Ohov	Adviser for Health Care Administration Resources	Department of Health Care (Ministry of Social Affairs)
Heli Paluste	Chief Specialist	Department of Health Care (Ministry of Social Affairs)
Kaja Põlluste	Researcher	Clinic for Internal Medicine (University of Tartu)
Alar Sepp	Head	Healthcare Policy Unit (Ministry of Social Affairs)
Madis Tiik	Head and Member of Board	Estonian Society of Family Doctors
Helvi Tarien	Head of Health Care Services Department	Health Care Services Department Estonian Health Insurance Fund

Annex 6: Program of the Mission

Tuesday 21.03.2006

10.00 – 14.00 Meeting with Ministry of Social Affairs

Venue: Room 543, Ministry of Social Affairs

(tentative list of attendances: I Normet; H Gil, A Sepp, H Paluste, U Kedars, Ü-K Nurm, M Reinap, E Ohov, I Saame)

10.00 – 10.15 – Welcome

10.15 – 10.40 – Current reform plans in health sector (MoSA)

10.40 – 11.00 – Overview of PHC reform plans (MoSA)

11.00 – 11.30 – Discussion

11.30 – 11.45 – Coffee Break

11.45 – 13.00 – Feedback to written reform document (WHO)

13.00 – 14.00 - Discussion

15.00 – 18.00 Meetings with PHC partners

Venue: WHO Country Office

15.00 – 16.00 Department of family medicine, University of Tartu (H-I Maaros, R Kalda)

16.00 – 17.00 Estonian Society of Family Doctors (M Tiik, D Ingerainen)

17.00 – 18.00 Estonian Health Insurance Fund (A Vask, H Tarien)

Wednesday 22.03.2006

9.00 – 11.00 Meetings with PHC partners (cont ...)

Venue: WHO Country Office

9.00 – 10.00 Estonian Nurses Union (E Pruuden)

10.00 – 11.00 Estonian emergency care specialists (A Kõrgevee, R Adlas)

11.00 – 12.30 Expert time and lunch

12.30 – 14.00 First list of suggestion to streamline PHC reforms presented to Ministry of Social Affairs

Venue: Room 543, Ministry of Social Affairs

(tentative list of attendances: P Laasik, I Normet; H Gil, A Sepp, H Paluste, U Kedars, Ü-K Nurm, M Reinap, E Ohov, I Saame)

12.30 – 13.00 Presentation (WHO)

13.00 – 14.00 Discussion
