ESTONIA
The development of family practice to support universal health coverage
Acknowledgements

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Background

At the time of the 1978 Declaration of Alma-Ata, which advocated for primary health care (PHC) for all (1), Estonia was under Soviet control and its health care system, which was based on the Soviet Semashko system, was generally underperforming. Under this system, health care was funded, delivered and controlled directly by the government (2). PHC was fragmented, with clinical services provided in large polyclinics by various specialists, while generalists were less numerous and often neglected, and family practice did not exist as a specialty (3–5).

Estonia regained its independence in 1991, and became engaged in overlapping political, social and economic reforms, with a strong leadership commitment to health system change (6). Echoing the Declaration of Alma-Ata, which identified PHC as the key to achieving the World Health Organization’s (WHO’s) goal of health for all (1), Estonia paired progress towards universal health insurance with the scaling-up of fundamental reforms of PHC centred on family practice (2,4). Estonia’s insurance and family practice model put PHC at the centre of the health care system, and the country has since achieved near universal health coverage, with high levels of service coverage and outcomes (6).
Intervention

At independence, Estonia inherited a specialist-dominant health care system with relatively poor infrastructure, a poorly paid workforce and declining health outcomes (7). In the early 1990s, Estonia began to introduce multifaceted PHC reforms (2). Parliament passed the Health Insurance Act in 1991, to secure public financing for nationwide social health insurance (SHI) (2). In 1993, Estonia became the first post-Soviet country to establish family practice as a medical specialty (4), with the goal of improving the quality of front-line PHC services and reducing reliance on hospital-based specialists. In addition to establishing a postgraduate training curriculum in family medicine, Estonia systematically retrained large numbers of practising physicians (primarily pediatricians and internal medicine specialists) as family practice specialists, and started a family residency training programme (7). Since 2007, the number of posts for residency trainees in family practice has increased; also, the number of active family doctors per 100 000 increased from 39.2 in 2000 to 71.9 per 100 000 in 2014 (8). Together, these steps have helped to elevate the status of family doctors and make them a key part of future health system reforms (9).
The Health Services Organization Act of 1994 created a pathway to move primary care service delivery away from large public polyclinics towards smaller, privately operated family practice clinics (4). In 1997, reforms mandated that all Estonians register with a family doctor; this provided the framework for nearly universal empanelment (sometimes referred to as rostering), a practice whereby all patients are assigned to a primary care physician. It thus established PHC as the first point of contact, and the usual source of care for most people within the health system (7). This goal was reinforced in 2001, when the Estonian Health Insurance Fund (EHIF) – a publicly financed health insurance system – was established as a public independent legal body; it was then further reinforced through the Health Services Organization Act of 2002 (2). Following these reforms, EHIF began contracting directly with private family doctors as a single purchaser, and providers are now paid with a sophisticated mix of capitation, fee-for-service, basic infrastructure and performance-based payments (10). Each family medicine doctor is responsible for a panel of about 1200–2000 patients, including providing services for their acute, chronic disease, preventive and promotive care needs. To strengthen the gatekeeping role of PHC, family doctors use evidence-based guidelines to manage care and reduce referrals to specialists, and patients are required to see their primary care doctor to obtain referrals to other levels of care (4, 7).

The performance-based payment system, known as the Quality Bonus Scheme (QBS), incentivizes the high-quality management of patients with chronic conditions, and the provision of key evidence-based screening tests (2, 11, 12). The QBS is under constant development, with indicators reviewed and revised yearly based on claims data (12). To further incentivize quality improvement, EHIF provides feedback to doctors based on their activity, and allows them to compare their results with others (12).
Barriers and facilitators to change

The transitional period of the early 1990s created a window of opportunity for Estonia to introduce multiple, often overlapping, reforms in financing and service delivery. Strong leadership and political commitment to the cause from key actors, including the Ministry of Social Affairs and the Estonian family doctors, were instrumental in getting reforms passed and implemented (4). Reforms were rolled out in every region except for the capital, Tallinn, where the heads of the polyclinics initially resisted change and advocated for the old Soviet system. As a result, reformers initially focused on scaling up family practices in smaller towns and rural areas (2,4). Outside the capital, there was early resistance from patients and specialists to the new requirement for the gatekeeping of referrals. This resistance has largely subsided as the government has introduced some specific pathways for specialist visits without family doctor referrals, and as the specialist training of family doctors has increased the scope of services delivered by primary care practices (2).

Professional primary care organizations take part in discussions around health reform, and are committed to ongoing learnings and adjustments (6). EHIF continues to have a close relationship with the Estonian Family Doctors Association, and both organizations regularly work together to reach outcomes suitable for both parties (12). The Estonian Family Doctors Association has strong continuing medical education resources, and programmes for improving practice and quality. Furthermore, these programmes have been codified into formal credentialing and certification programmes, maintained by EHIF, to accredit certified providers; family doctors who fulfil the criteria are eligible for additional payments.
These and other reforms have led to an ongoing modernization and improvement of Estonia’s health care system. In addition, since the mid-1990s, significant investment has been made in information technology. This has led to the creation of a strong eHealth system, including a countrywide Electronic Health Records System and an ePrescription system. The eHealth system helps with care coordination and delivery, and improves access to care. Each patient has a single national health record that links to the health system and all health care providers, and the EHIF receives all its billing data electronically (2,6).

The primary care reforms in Estonia have been largely successful; however, remaining challenges include overreliance on solo practices, underinvestment in practice infrastructure and difficulty in recruiting family doctors to rural areas. To address the infrastructure challenge, European Union (EU) structural funds are being applied to establish new PHC centres, which will help solo practices to broaden the scope of services they provide and strengthen coordination of care (2,9,8).

Long wait times to access services have been a concern, especially to those with chronic diseases. Various initiatives have been introduced to help address this issue, including implementing 24-hour primary care call centres, and an enhanced care management pilot to start to build nurse–doctor team capacity and proactively address the health needs of the most complex patients (2). In 2004, Estonia formally joined the EU, which led to a migration spike of well-trained Estonian health care providers to neighbouring EU countries. This has since decreased, but a key challenge that remains is the shortage of human resources, particularly family nurses, most notably in rural areas (2,12,13).
Impact

Estonia has reached near universal health coverage, with around 95% of its population covered through EHIF (6). The reforms have also translated into significant improvements in health outcomes. For example, life expectancy at birth rose from 71 years in 2000 to 78 years in 2015 (13). Amenable mortality rates (i.e. deaths that should not occur in the presence of timely and effective health care) have halved since 2000 for both women and men; this is the largest reduction in the EU. Clearly, Estonia’s strong health system has contributed to gains in life expectancy through preventive health services and treatment actions (8). Maternal and child health indicators have improved significantly; from 1990 to 2015, the maternal mortality ratio decreased from 42 to nine deaths per 100 000 live births (14) and, between 1990 and 2017, the under-5 mortality rate decreased from 10 to three deaths per 1000 live births (15).
The way forward

Estonia is a strong example of how the scaling-up of paired PHC coverage, financing and service delivery reforms can have a long-term impact on the population. The political environment since the 1990s has been favourable to sequential reform, with the country’s leadership committed to creating a people-centred health system (4,13). A multifaceted approach to implementing reforms – including collaborating with and empowering family doctors, enshrining improvement targets within payment structures, and creating an environment of continued testing and learning – have also been critical to the success of PHC in Estonia (4). The comprehensive reforms of the 1990s have continued to be adapted and enhanced, to improve performance and meet population needs, including centralizing aspects of PHC organization in 2012 to improve efficiency of care (6,13).

Estonia is still facing demographic and epidemiological changes, including increasing rates of noncommunicable diseases, large mortality differentials between men and women, and an ageing population (12). Nearly 5% of the population still lacks regular health coverage. Cardiovascular disease remains a major public health concern in Estonia, as does the prevalence of adult obesity, which increased by nearly 40% between 2000 and 2015 (13). Estonia is in the process of applying EU structural funds to improve health care infrastructure, including establishing new group-based PHC centres to help manage chronic conditions through larger multidisciplinary teams (13). Scaling up workforce training and retention within PHC over the long term is a growing challenge (11). Recent changes, including plans to increase the training of family nurses and multidisciplinary care teams (2,4,13), are important steps in ensuring that the health care system is ready to meet the changing needs of the population. Estonia remains committed to the Declaration of Alma-Ata and serves as an example to other countries on how to provide effective PHC for all.
References


12. Interview with Pille Banhard, Member of the Management Board Estonian Health Insurance Fund & Külli Friedemann, Head of Primary Care Package Development Division Estonian Health Insurance Fund, 15 August 2018.


