Health system challenges and opportunities for NCDs in ESTONIA

Taavi Lai, Anne Staehr Johansen

Background and process

The author team

Invited experts

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WHO Regional Office for Europe

- **Frederiek Mantingh** (Technical officer on NCD)
- **Joao Breda** (Programme manager on nutrition)
- **Jo Jewell** (Consultant on nutrition)
- **Melitta Jakab** (Health Policy Analyst)

WHO Country Office Estonia

- **Marge Reinap** (Head of Country Office)

Assessment as entry point to policy development

Standardized but flexible process

Multidisciplinary approach	Adaptation to country needs
Local and international team make a joint assessment	Dialogue, dialogue, dialogue

GUIDE

Three pillars of the assessment

Expected health gain

Achieve 25% mortality reduction for NCD by 2025

Core services

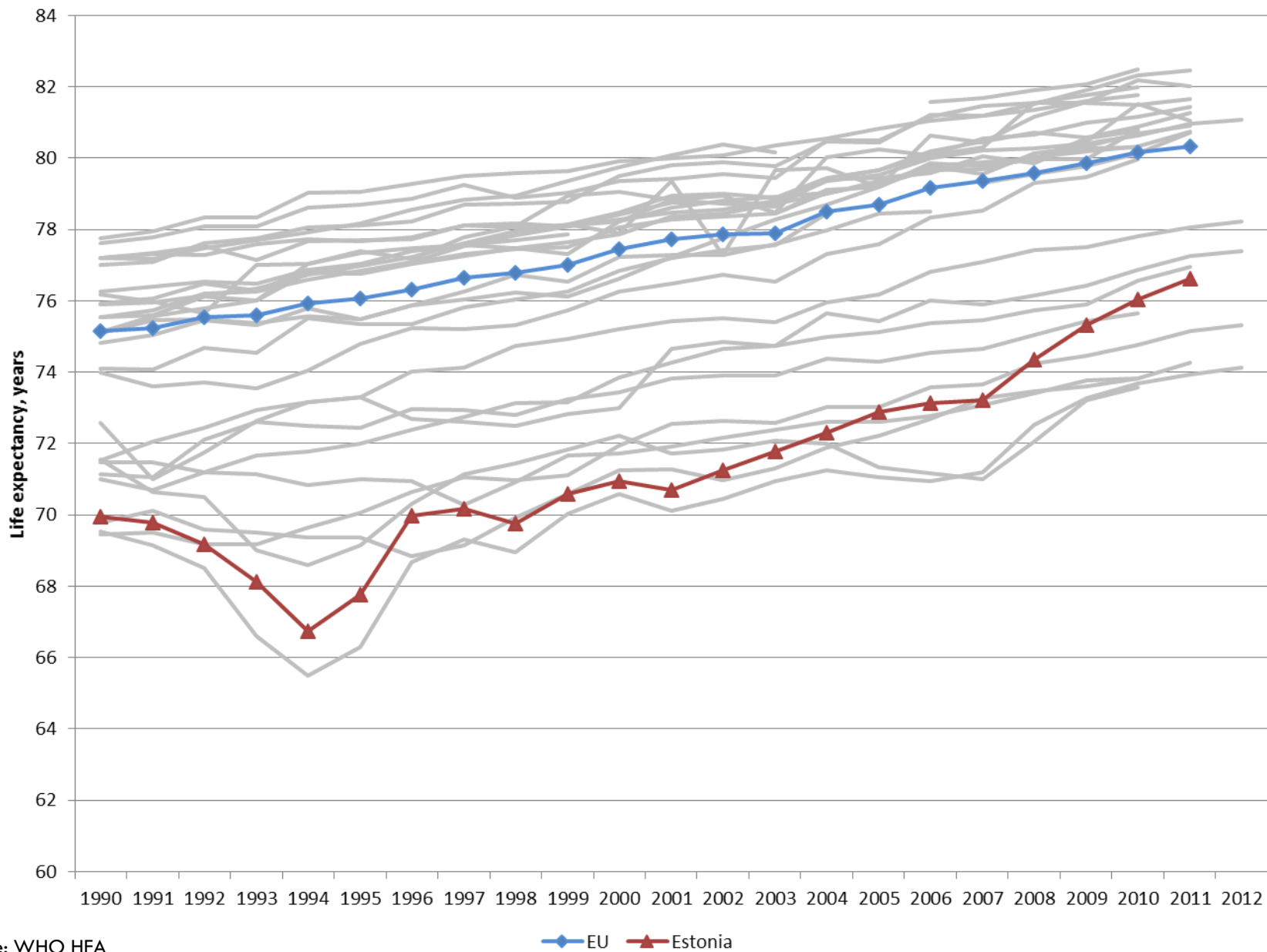Population interventions

Individual services

Health system strengthening through addressing health system <u>challenges</u> and responding to <u>opportunities</u> for scaling up coverage of core services

Population health

LE in Estonia and EU

Avoidable mortality

Source: based on Statistics Estonia
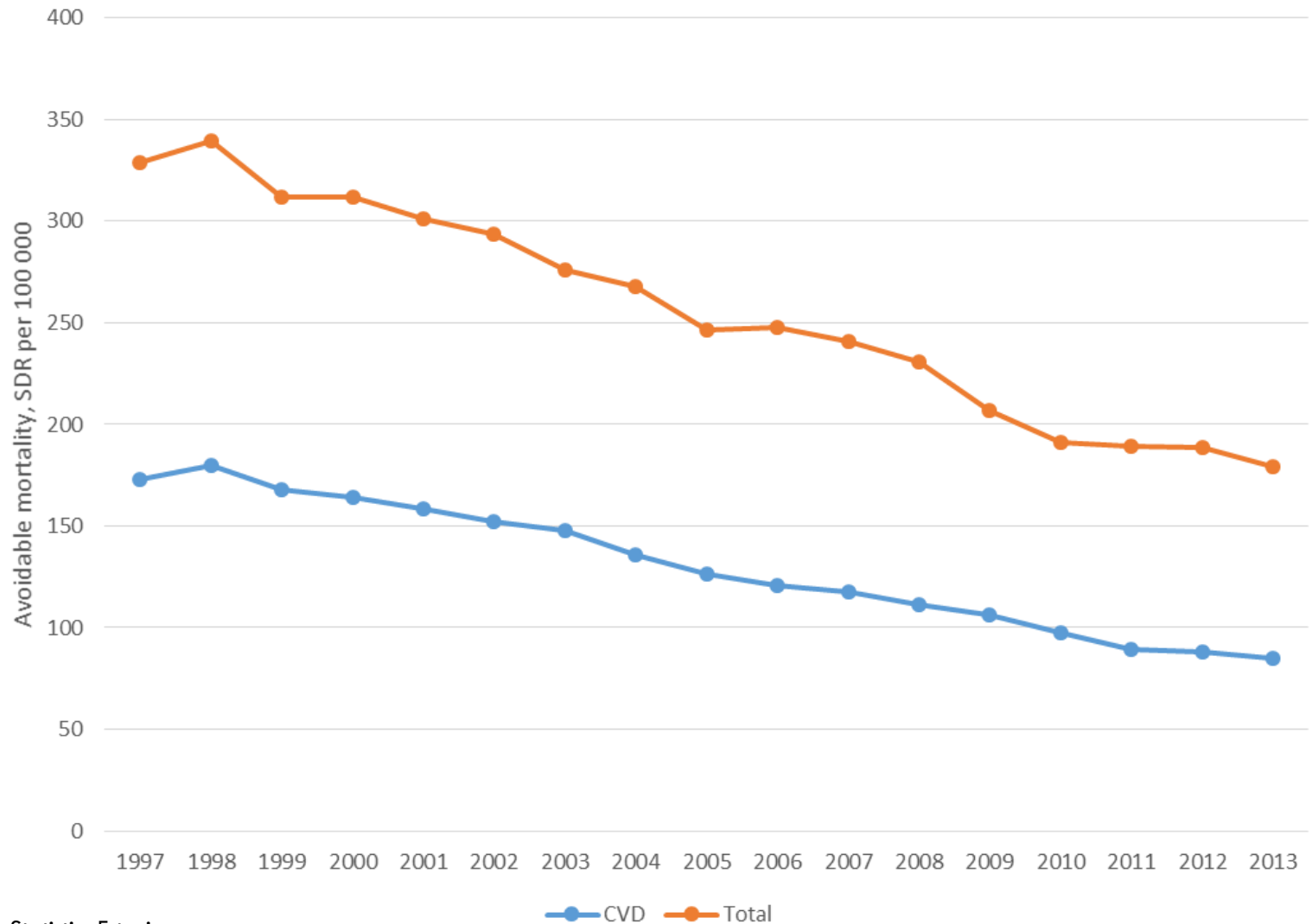
Risk attributable burden
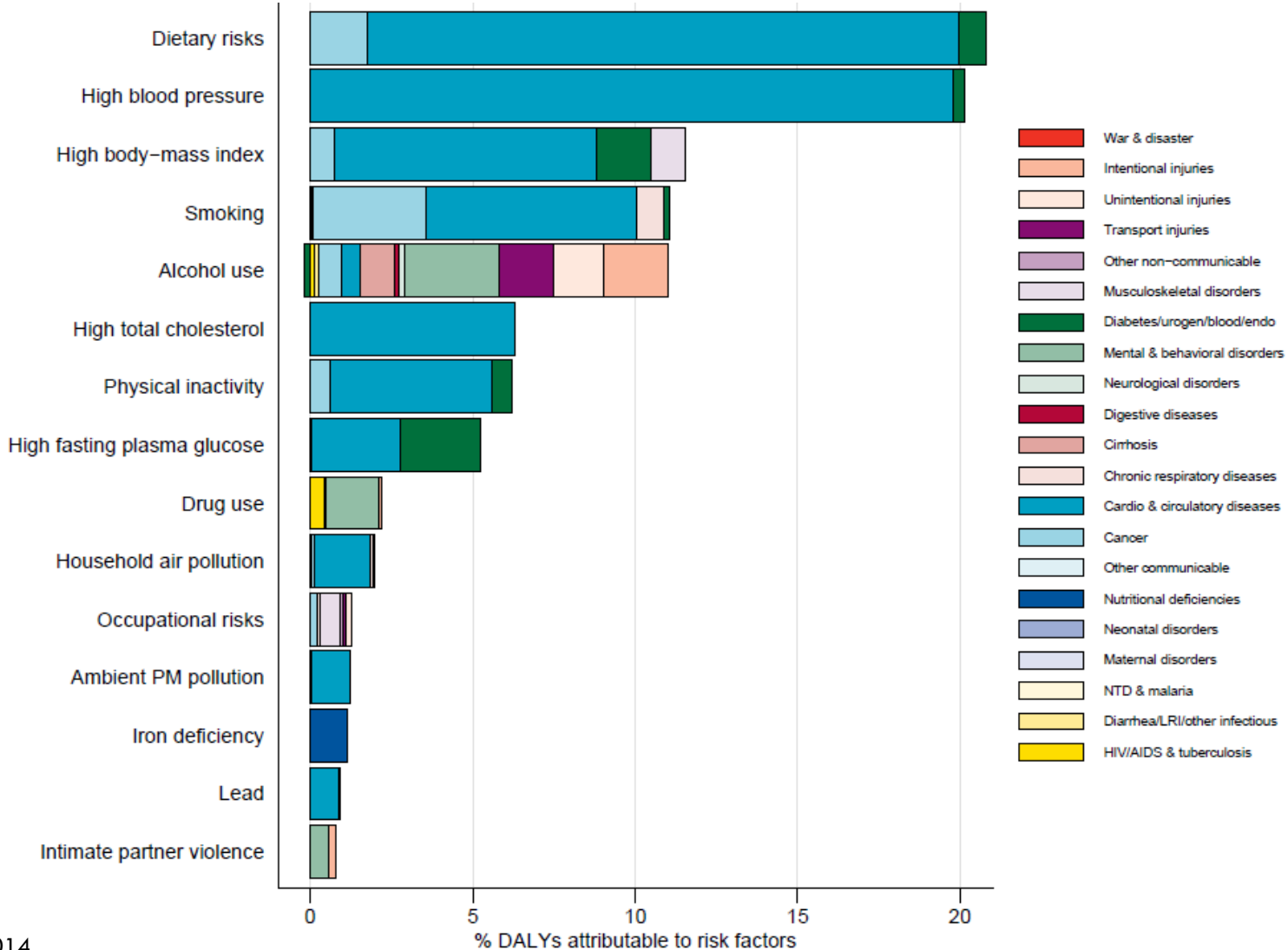
In summary

- Excellent progress on health outcomes in Estonia

➔ Gap with EU is closing

- Continued progress requires addressing NCD risk factors:
  - Diet
  - Hypertension
  - Smoking
  - Alcohol
  - Physical inactivity

Core interventions and services

Population interventions
Score card

| Voluntary Global Targets	Core interventions
30% reduction in the prevalence of current tobacco use	Good progress especially on tobacco taxes with the exception of smoke free environments
20% reduction in the harmful use of alcohol	Further efforts are needed to implement WHO recommended core interventions
Halt the rise in diabetes and obesity 30% reduction in salt intake 10% reduction in inactivity	Further efforts are needed to implement WHO recommended core interventions

Individual services
Main findings

- Early detection of cardiometabolic conditions still inadequate

- Improvement in risk stratification for the management of NCD patients

- Progress on counseling of NCD patients

- Quality Bonus System ➔ improved prevention and disease management for CVD, hypertension, diabetes (type II), and post acute-myocardial infarction

Lack of data a major challenge

- No information about true prevalence of NCDs

  ➔ Inability to monitor progress over time

- No information on clinical outcomes

  ➔ Providers are operating in the blind about the effects of their care (in both in- and out-patient settings)

- Score card not possible, but some evidence…

Improved disease management
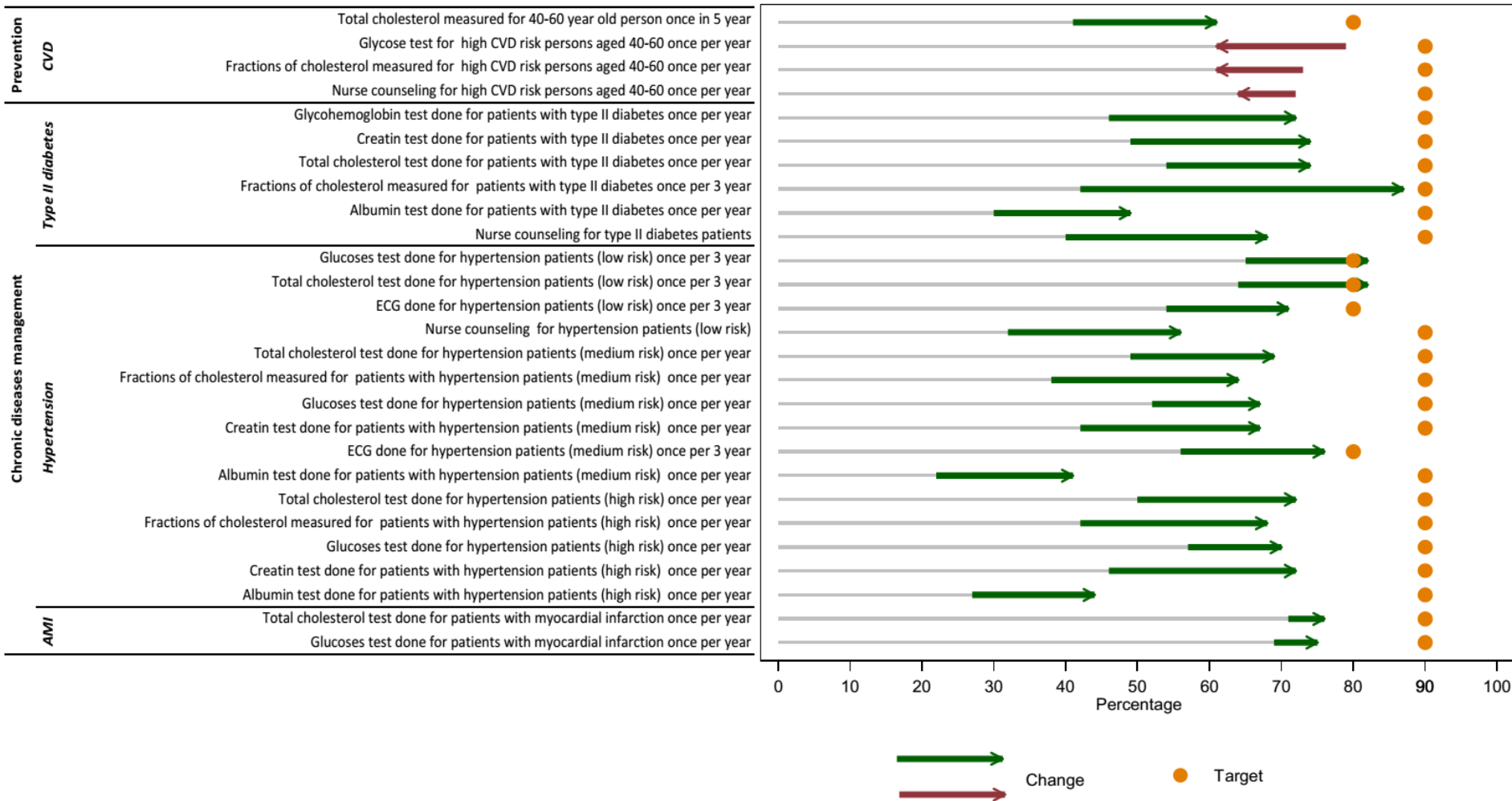
Inadequate hypertension awareness and adherence

HTN awareness and adherence
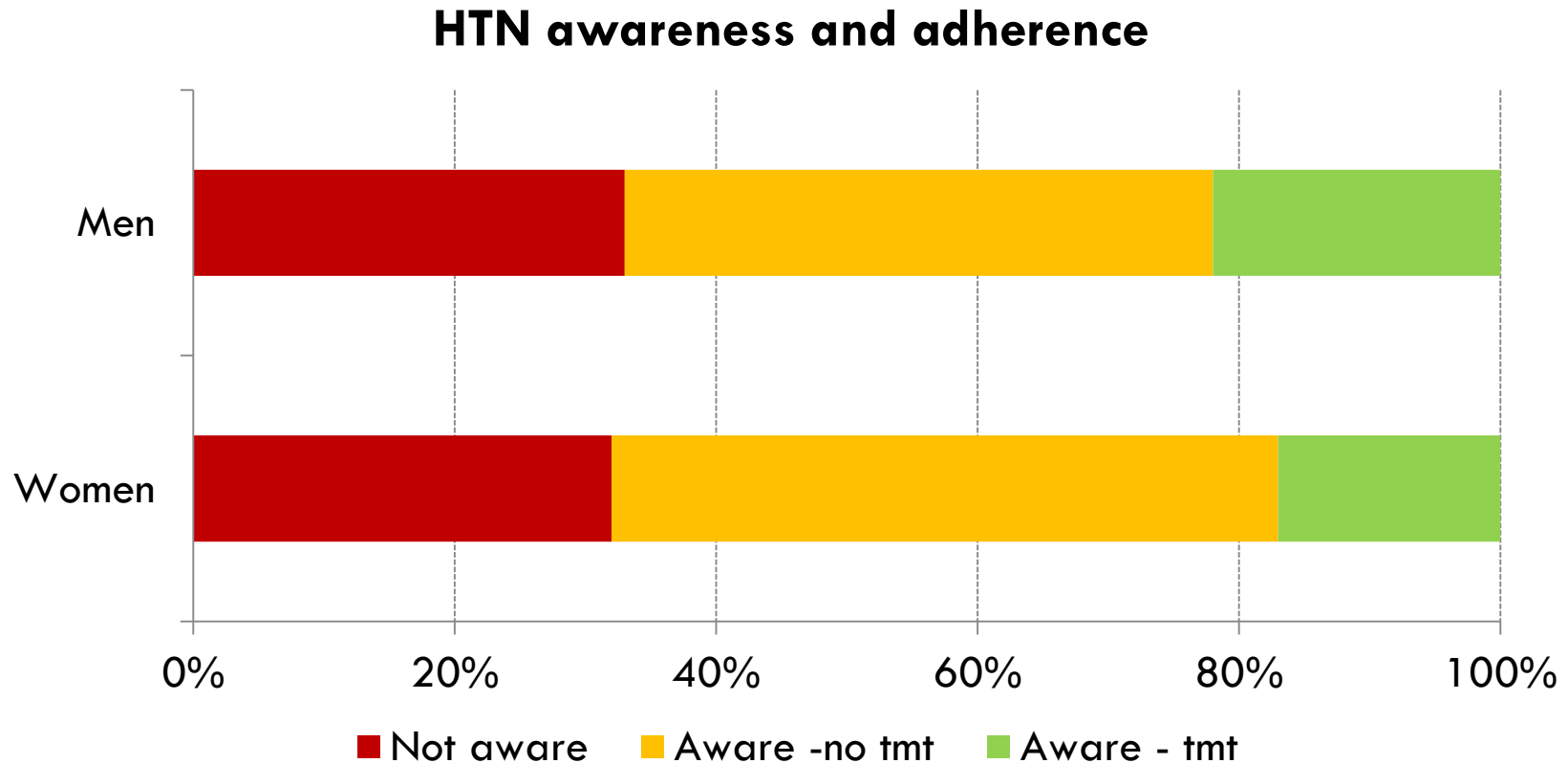
Increasing diabetes mortality

SDR per 100,000 (all ages)

Estonia
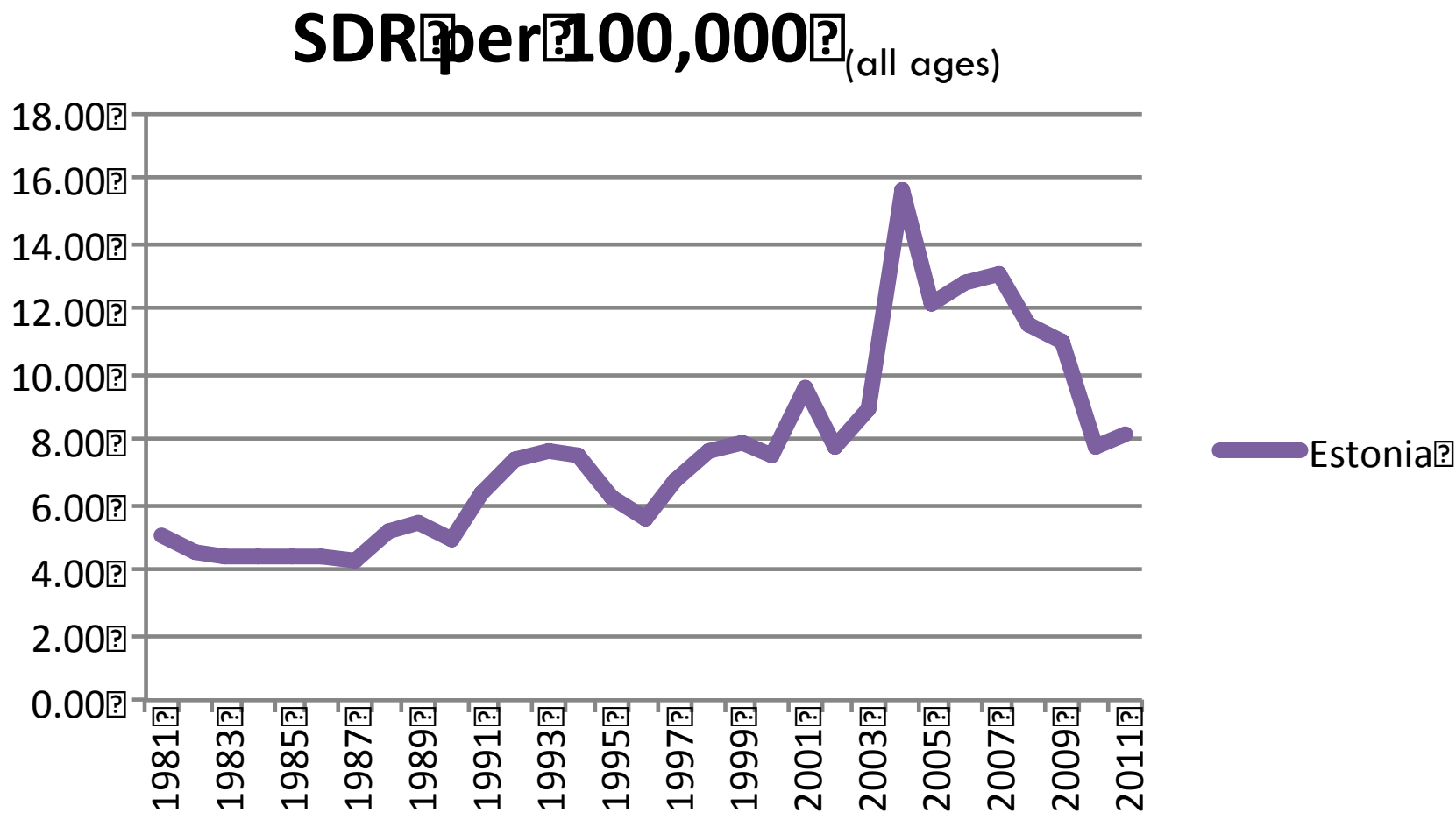
Source: WHO HFA-DB

Declining diabetes mortality elsewhere

SDR per 100,000 (all ages)

CIS
Estonia
EU (before 2004)
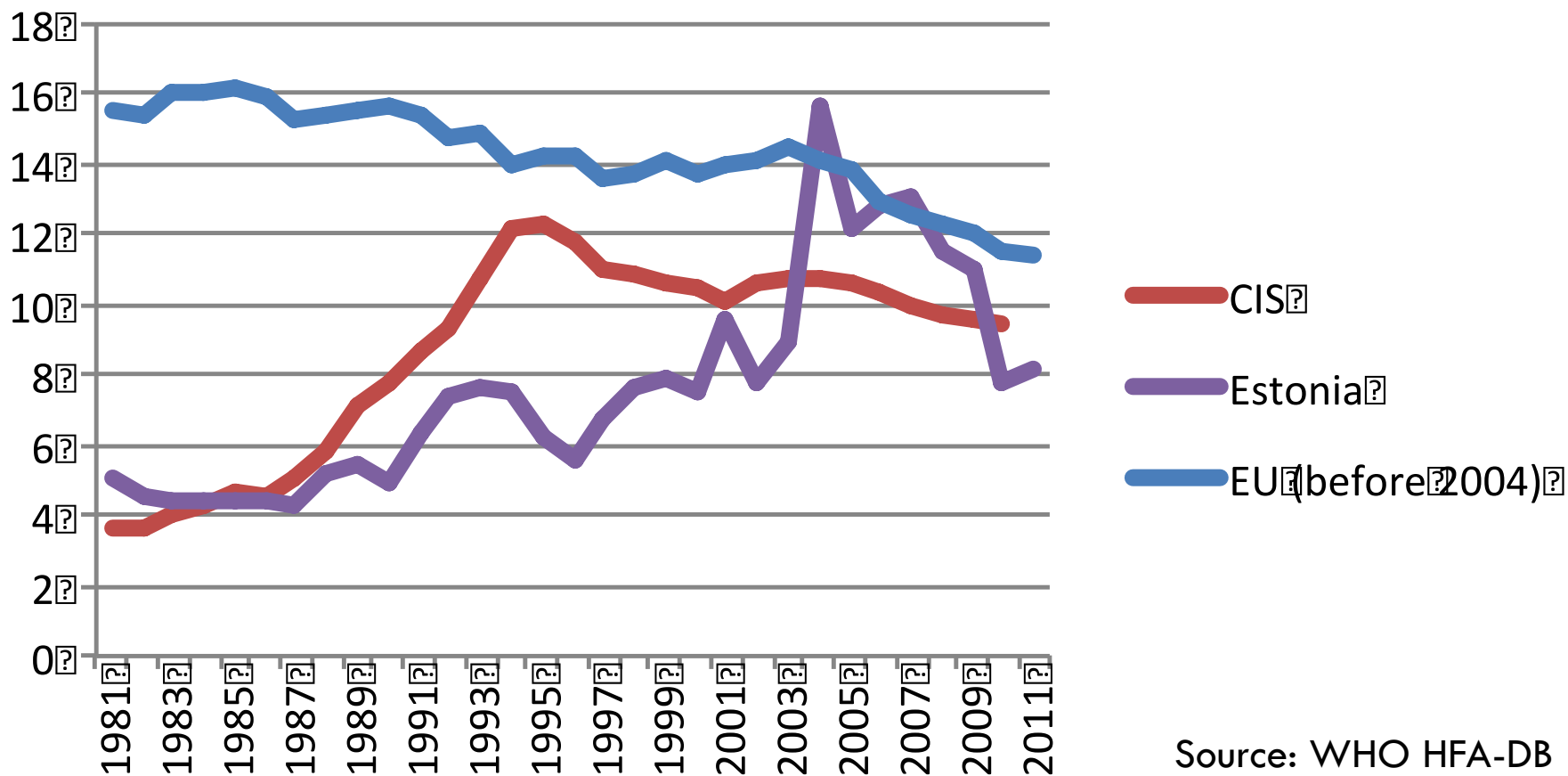
Source: WHO HFA-DB

Health system challenges and opportunities

15 health system challenges and opportunities to respond to NCDs

Political commitment to NCDs	**Explicit priority setting approaches**	**Inter-agency cooperation**	**Citizen empowerment**
Effective model of service delivery	**Coordination across providers**	**Regionalization**	**Incentive systems**
Integration of evidence into practice	**Distribution and mix of human resources**	**Access to quality medicines for chronic diseases**	**Effective management**
Adequate information solutions	**Managing change**	**Ensuring access and financial protection**	

Population interventions: Opportunities

Increasing political commitment to health

Whole-of-government approach of NHP

Basic foundation

Intersectoral steering committee oversees health action

Green papers on tobacco and alcohol

Individual services: opportunities

Primary health care in the centre of the system

Excellent physical infrastructure

Strong foundation

Extensive e-health system

Well trained HRH, especially strong nursing education

Key health system challenges

Governance and accountability
- Fragmented vision in key policy documents for improving NCDs
- Who is responsible for NCD outcomes?

Inter-agency cooperation
- Intersectoral steering committee does not have sufficient levers for joint action

Information solutions
- Lots of data but insufficient analyses
- Epidemiological information and needs assessments to underlie policy development
- Absence of real-time, clinical outcome data

Key health system challenges (2)

Model of care
- Insufficient focus on individual health promotion, disease prevention
- Inadequate management of NCDs
- Lack of patient education schools, foot clinics, etc.

Coordination
- Non-systematic discharge procedures and weak interface across levels of care and providers
- Opportunities in e-health system not exploited

Incentives
- Insufficient incentives to treat patients at lowest level of care
- Incentives to increase volume of secondary and tertiary care services

Key health system challenges (3)

Human Resources for Health

- Lack of key allied health professionals (e,g., dieticians, diabetes nurses, podiatrists)
- Inadequate competences in health promotion and disease prevention

Citizen Empowerment

- Citizen empowerment efforts still in infancy
- Patient organizations weak

Recommendations

Recommendations

Governance and accountability
- Include NCDs into NHP w/ clear outcome targets and consider a self-standing NCD strategy
- Assign responsibility for NCD outcomes and hold institutions accountable

Inter-agency cooperation
- Strengthen intersectoral steering committee with levers for joint action (e.g. joint budgeting)
- Strengthen coordination

Information solutions
- Support use and analysis of all available data as well as develop research capacities
- Develop clinical data bases that provide real-time outcome data to clinicians
- Enable patient-outcome analysis over time and across providers
- Develop web-based patient portal for patients with NCDs to input data into their electronic patient record

Recommendations

Model of care
- Explore models that allow physical or virtual care integration and expansion of solo practices
- Establish patient education schools, foot clinics for diabetes
- Expand focus on health promotion and disease prevention in PHC

Coordination
- Systematize discharge procedures and ensure full use of shared electronic health records
- Define care pathways and responsibility by level
- Establish provider panels to improve coordination

Incentives
- Address incentive alignment across levels of care (e.g. bundled payments)

Information solutions
- Develop real-time, clinical outcome data sources
- Chronic disease management incl. shared records
- Enable patient outcome analysis over time and across providers

Key health system challenges (3)

Human Resources for Health

- Establish needed training programs for key allied health professionals (e,g., dieticians, diabetes nurses, podiatrists)
- Develop training programs to build competences in health promotion and disease prevention

Citizen Empowerment

- Establish health literacy programs in schools and elsewhere
- Strengthen capacity of patient organizations

Summary

Stronger outcome orientation and measurement at all levels

Better alignment of policies, roles, levers, and accountability arrangements

Greater focus on the interface across levels of care through new organizational modalities and more comprehensive incentives

Further development and better use of e-health system

☐ Main pieces to further improve NCD outcomes are in place

☐ Greater focus on health promotion and disease prevention in both population and individual services

☐ Further improvement through more people-centred approaches

Thank you!