

The State of Health Care Integration in Estonia

Qualitative Research Results: Focus Groups Discussions The World Bank Group December 2014

Introduction

To assess the integration of care in Estonia from a health system perspective, with a particular focus on the role of primary care, six focus groups were conducted between September 9-14th 2014. These focus groups were composed of: (1) family physicians; (2) nurses; (3) specialists, and (4) chronically ill patients (an urban group from Tallinn, a rural group from Viljandi, and a Russian-speaking group from Narva).

The objective of these focus groups was to identify key system performance issues resulting from weak integration of care, identify the root causes of performance shortcomings, and identify factors maintaining the status quo.

Results

Summary

Delivery of care in appropriate care settings

Issue	Underlying problems	Relative importance	Root causes	Factors maintaining status quo
Avoidable emergency care visits	Frivolous use of emergency care by patients	Low	Patient unwillingness to make an appointment and wait for healthcare.	<ul style="list-style-type: none"> Hospitals favor such visits, because it is beneficial Recent history (social-cultural) - patients were used to seeing specialists when desired
			Lack of awareness, or negative perceptions of the phone line that provides advice to those considering whether to seek emergency care.	<ul style="list-style-type: none"> Not enough attention paid to this channel - in terms of awareness and quality of service
	Emergency care acts as a middle step between primary care and	Average	Family physicians who want to admit their patient to hospital may not have access to other	<ul style="list-style-type: none"> System design limits available beds for non-emergencies and maintains beds for those admitted via emergency care.

	hospital		admission routes.	<ul style="list-style-type: none"> ▪ Lack of clear and effective admission system for family physicians
Avoidable hospital admissions	Prevention not efficient	Low	Unclear roles and responsibilities between social and health care systems for monitoring and case management to avoid acute episodes and hospitalization	<ul style="list-style-type: none"> ▪ Political and governmental decisions behind the system design - separateness of social and health care system, and lack of cooperation and coordination mechanisms
			Difficulty accessing social care prior to hospitalization.	<ul style="list-style-type: none"> ▪ Poorly resourced social care system, with unclear responsibilities.
Avoidable specialist visits	Insufficient groundwork with the patient on primary level	High	Family physicians' restricted budget inhibits extensive diagnostic procedures in primary care	<ul style="list-style-type: none"> ▪ Financing politics ▪ Incomplete guidelines and instructions about responsibilities of family physicians and specialists in terms of diagnostic procedures
			The system demands that the final diagnosis and treatment for chronic diseases can be started only by a specialist, not by a family physician.	<ul style="list-style-type: none"> ▪ Regulations, rules and guidelines in terms of responsibilities of family physicians and specialists
			Family physicians' heavy workload leads to insufficient information and patient preparation for specialist visits	<ul style="list-style-type: none"> ▪ System design and financing, which forces family physicians to be doctors and entrepreneurs at the same time ▪ Too many responsibilities set by the system on family physicians ▪ Lack of instructions on what content to input to the national e-system.

	Failure of family physicians to provide gate-keeping role	Average	Patients' uneven trust towards family physicians due to concerns about variation in quality and competence, particularly in rural areas.	<ul style="list-style-type: none"> ▪ System design and financing ▪ Family physicians' competing roles of care provision and running a business
	The low implementation of nurse resource	Average	Low trust towards nurses by patients and specialists	<ul style="list-style-type: none"> ▪ Recent history - patients and specialist are used to seeing nurses rather as assistants and secretaries than professionals ▪ Nurses have limited responsibilities and rights
Unnecessary extended hospital stays	Spillover from social care system	Average	Inadequate social care means patients remain in acute beds when they only need nursing care.	<ul style="list-style-type: none"> ▪ Poor financing and regulation of social care system

Coordination and continuity of care

Issue	Underlying problems	Relative importance	Root causes	Factors maintaining status quo
Inadequate acute inpatient follow-up care	Uncertainty in the responsibilities within health care system	Average	Limited number of hospital beds in acute care creates a situation where patients are moved too quickly to the next level and the next level is not ready for such patients	<ul style="list-style-type: none"> ▪ The system is built in such a way that acute care hospital beds have to be vacated in a very short time ▪ Overworked nurses not communicating across levels of care
	Uncertainty in the responsibilities of health care and social system	Average	Organizational separation of health care and social system, which means separate financing and poorly defined coordination mechanisms and processes	<ul style="list-style-type: none"> ▪ Full service package for a patient across two systems is not thought through

	Inadequate rehabilitation and physiotherapy services	High	Lack of services and long waiting times	<ul style="list-style-type: none"> Financing
			Patients feel that organizing and paying for this service is very much put onto themselves	<ul style="list-style-type: none"> The system is designed in a way that too big of a responsibility is put on the patient Poor communication in Russian-speaking areas
Incomplete hospital discharges	Inadequate information provided to patient	High	Nurses are too overworked to deliver task adequately	<ul style="list-style-type: none"> High turnover of patients on the wards Competing priorities
	Inadequate information provided to family physician	Average	Family physicians are not able to accurately grant sick leave due to lack of knowledge about why patient was admitted to hospital.	<ul style="list-style-type: none"> Specialists do not have time to send paperwork E-System not universal or cohesive
Unnecessary pre-operative diagnostic procedures	Specialists' doing more procedures than needed	Average	Defensive medicine	<ul style="list-style-type: none"> Non-fault liability insurance system means doctors face large claims.
	Duplicating analyses/ diagnostic procedures by specialists (already done by family physicians)	Average	Lack of clear instructions as to what analyses and diagnostic procedures should be done by the family physician and what by specialists	<ul style="list-style-type: none"> Financing by EHIF in case of hospitals is procedure based and is beneficial for the hospital (specialists)
Over- and under-provision of preventive services	Unclear roles and responsibilities for preventive services	Low	Family physicians do not consider preventive services their responsibility, and do not see the value of some types of preventive services.	<ul style="list-style-type: none"> Prevention system and responsibilities are not completely thought through
Limited provider continuity of	Long waiting times to see a specialist	High	Not enough insured/free visits available	<ul style="list-style-type: none"> Financing Poorly organized and planned human (specialist) resources
			Difficulties in making an	

care			appointment to see a specialist	
	Low trust towards specialist care outside Tallinn and Tartu	Average	Patients outside Tallinn and Tartu may not seek the help they need or move from specialist to specialist.	<ul style="list-style-type: none"> ▪ Incentives for high quality specialists to be based in Tallinn and Tartu ▪ Perceived incompetence of rural specialists
	Discontinuity of care for older patients	High	A step between different levels is missing in older patients' care - need for geriatric departments	<ul style="list-style-type: none"> ▪ Full service package is not thought through for older patients
			Unclear division of responsibilities and incomplete cooperation between social and health care systems	<ul style="list-style-type: none"> ▪ Political and governmental decisions behind the system design - separateness of social and health care system
	Inconsistent and incomplete information flow	High	The current state-run e-platform is not functioning well and does not correspond well to the needs of medical care providers	<ul style="list-style-type: none"> ▪ The structure and content of the e-system has not been agreed upon and filling guidelines/manuals is not thought through ▪ Lack of instructions and rules regarding what information is required for referrals and completing e-records
			Bigger hospitals have their own information systems, these are incompatible and making the situation especially difficult for family physicians	
			Incomplete and inconsistent information provided by doctors to each other for referrals and filling out the medical records e-platform.	

Delivery of Care in Appropriate Care Settings

The current healthcare system officially designates primary care providers as gate-keepers to healthcare; however in reality the system does not fully work in this way. Family physicians, nurses and specialists all considered that delivery of healthcare in Estonia is biased towards specialists, and in some cases towards emergency care (as a middle step between family physicians and hospitals).

The current process for people with chronic diseases is that they receive a diagnosis from a specialist, and then revert to family physicians for ongoing observation and care. However, people with chronic diseases largely do not consider this system satisfactory – they express a preference for care provided by specialists, and would favor an increase in specialist-based care, including self-referral to a specialist without gate keeping by the family physician. They do not express any preferences for inpatient care.

The following sections examine the views of family physicians, specialists, nurses, and people with chronic diseases in more detail.

1. Avoidable emergency care visits

Specialists, family physicians and patients alike considered that some emergency care visits could be avoided, though they differed on their assessment of the underlying causes for avoidable emergency care visits.

Specialists criticized patients' frivolous use of emergency care for minor issues, noting that there were insufficient disincentives for visiting the emergency room unnecessarily.

"People who shouldn't do it turn to them. An artificial nail is broken. If they'd have to pay 50 Euro then maybe they might think about it, if they should turn to a medical facility with that." (specialist)

"In Finland they bill you if you call the ambulance without reason." (specialist)

Patients claimed that they could reduce their use of emergency care if they had other options for reassurance and advice about appropriate next steps, whether by calling an ambulance or seeking different forms of help, when they have a health problem. The existing 1220 helpline aims to provide this service, but it is underused, both due to low awareness of the service's existence, and whether or not there is a charge associated with its use, and due to a variation in the personnel on the line, whether the person is kind, friendly and gives good advice or the person is arrogant and makes your trouble seem ridiculous.

"I have called them and my foot was so swollen. I hit it myself. And since I'm diabetic then I don't know where I hit it because I fainted. But I've hit it and it is so swollen. But they told me right away to put cabbage leaves and fleawort on it and that it will reduce ... and they talked so nicely." (patient, rural, Viljandi)

"Well, it is being overworked and really, they are overworked because many might go for no reason but ... there's the helpline ... Goodness, how often we have called because of the kids

simply – because of grandkids – you call that helpline and you ask what you should do first, you don't have to right away [go to the emergency room] ...” (patient, Tallinn)

“By the way, that helpline is really good, I mean the help there ... well, that family physician number I mean. That you call and ask for advice. And I have been told twice not to play around, to end the call and call an ambulance.” (patient, Tallinn)

Patients also visited the emergency room on the instructions of their family physicians, not as an emergency but as a route to hospital admission. There are insufficient hospital beds to meet the need, and processes to admit patients are unclear and often depend on having a good relationship with a specialist in the hospital. After calling round various hospitals and invariably being told there are no available beds, family physicians sometimes resort to sending their patients to the emergency room, knowing that hospitals have specific beds available for patients admitted via this route.

“Actually the artificial occupancy rate is ... during this summer here I've heard back several times that oh, we don't have availability, call this other department. Then it turns out that the other department doesn't have availability either, call the first one back. And then they tell me to send them through the emergency room. It turned out that both had availabilities.” (family physician)

“I don't call any more, I send them to the emergency room.” (family physician)

2. Avoidable hospital admissions

All focus group participants recognized that the decision to admit someone to hospital is not made lightly: it is limited, and strongly regulated.

The issue of appropriate hospital admissions was raised by specialists. In their opinion, more effective prevention of acute conditions would reduce the need for hospital admissions, especially for chronic patients. However, the challenges of coordination between health and social care systems make this challenging.

There are no official cooperation and coordination mechanisms, processes and responsibilities between the social and health care systems in Estonia. It can be hard for a person to access social care at all until they are admitted to hospital, a particular challenge for older people who live alone or in rural areas and need assistance in activities of daily living, transportation and supervision. The social and healthcare systems are separately run and financed, with the social system considered weaker. Cooperation between two systems currently depends on goodwill from both sides rather than any basis in official regulations. This makes it hard to clarify which system is responsible for particular tasks, overall monitoring of patients, and case management. Where the primary care provider and social care provider have good relations and the desire to cooperate then the system works. In reality there is a lack of good relations and in many cases neither of the sides wants to take responsibility because of being overworked, lacking human resources and the question of who will cover the cost. Inadequate social care can lead to avoidable hospital admissions.

“A person with social problems will not get help until their health is in such poor condition that they end up in the hospital. There they will wash them. They'll get medication. The

problem is that they won't take their medication at home. But it is extremely difficult to delegate that to a social worker. One does not want to listen to the other. Instead of connecting with each other. Referring to the social stage. Extremely difficult. People take up expensive hospital beds.” (specialist)

There was also the question of appropriateness of admission setting. Given that health care is better financed and regulated than social care, respondents considered that hospitals and hospices sometimes took on responsibility for the care and financial implications of patients better suited to the social care system, for example a nursing home. The respondents considered that there should be better coordination of what type of care is most appropriate for different patients' needs, to address the default option of hospital admission, and better planning for where these patients should go next.

“The Helsinki University hospital will not get a patient who has had 3 strokes. It would be a first-time one. Patients requiring nursing care are sent elsewhere before they reach the university hospital.” (specialist)

“One third of the elderly who receive nursing care should be in a retirement home. The EHIF will pay for it if we have them. The nursing home pension would not cover it. And they don't want to go. The family can't afford it. The local government won't pay either.” (specialist)

3. Avoidable specialist visits

Patients and medical care providers had different views on this topic together with their own strong reasons and arguments. Medical care providers saw the need and opportunities to decrease specialist visits, patients on the other hand wanted to have more possibilities to see a specialist.

Specialists welcomed the designated gate-keeping role of family physicians, and expressed a preference for it to be more systematically observed, with family physicians conducting the basic information gathering, analysis and diagnostic procedures in advance of referrals to specialists, as opposed to the current system where these tasks inefficiently fall to specialists.

“The market is not regulated. What the specialist has to do and what the family physician should do. 80% of my cardiology appointment time I am doing the job of the family physician. There's no adequate documentation, no system as to how the patient actually gets to see a specialist. Why they can sign themselves up.” (specialist)

Specialists particularly struggle with referrals from family physicians that, due to an absence of any specific guidelines or instructions about how to make a referral, are often either overloaded with unnecessary information or lack any essential information at all. This is made worse by the lack of a common, smoothly operating e-system: every party inputting to the national e-system interprets and inputs to it in their own way. Both specialists and family physicians felt the need for guidelines and instructions for providing relevant patient information in the e-system and on referrals.

“We have not agreed upon the content. What we want from the digital case history. One person wants everything in detail. I would like the necessary things to be written down. Realistic problems. Not writing everything down, just in case. It is horrible.” (specialist)

“That’s the thing with the family physician’s referral, when it comes. My diagnosis is just a cough and then I have to read what time [when, by clock] they did the leucocytes. I can’t even read it with my glasses. Why do you send that? Half a page.” (specialist)

The main barrier to family physicians conducting these basic analysis and diagnostic procedures is the burden on the budgets of family physicians.

“I guess it also starts with financing. If there was a little bit more money, they would run the tests themselves. There would be an interest. They would continue on with it.” (specialist)

To save valuable specialist time, specialists consider that patients should be better prepared by a family physician or nurse for the visit, with explanations in advance about what is needed or what questions the patient should be prepared to answer, such as the names of their current medication.

“And I can be more effective if the patient has the information. They can talk about it. Patients are uneducated. They take ten green, blue, yellow pills. But what are they? They should write down the names. They wait for three months to see the specialist. And then we just stare at each other, not understanding each other. There are many problems here actually.” (specialist)

Family physicians considered their role to be to proceed with care according to the scheme set by the specialist, and to observe the patient’s progress. However, they reported that they would like to do better groundwork with the patient before sending the patient to the specialist – but the way in which healthcare is currently financed creates barriers to achieving this.

Family physicians say that they would need additional budget to conduct the basic analysis and diagnostic procedures that specialists want from them. The disincentive to invest in basic analysis and diagnosis extends to the cost of using the results to start treatment, as medication is more expensive for family physicians than for specialists, who can require a higher patient co-payment. Moreover, the system demands that the final diagnosis and treatment for chronic diseases can be started only by a specialist, not by a family physician.

“The possibilities for running tests ... we have the Holters, we do it ourselves ... from the cardiologic aspect we can run tests on the heart, we might not have to refer them to specialists as much but since you can’t start treatment on your own, can’t prescribe medication at such a big discount [patient’s copayment is higher], maybe they should review the conditions for discounts and if certain criteria are met then all doctors should have the opportunity to start treatment.” (family physician)

Even if the budget was available, family physicians have an ever-growing patient list, and are continually being given responsibility for tasks they do not consider a key part of the doctor’s role. While their expressed ambition is to focus on doctors’ work and help specialists, they feel overworked and lacking in capacity to do so.

For example, there is currently a debate about whether family physicians should be responsible for preventive care.

“A doctor’s job is to cure sick people, not prevent illnesses. Yes, the nurses can counsel them a little bit about quitting smoking and ... but it has to come from elsewhere as well, not only the family physician.” (family physician)

Family physicians have also inherited some responsibilities of school doctors. In the past, most schools had a school doctor and a school nurse. Now the system has evolved to only include school nurses, and some of the tasks and requirements previously undertaken by the school doctor fall to the family physician, without any additional budget or resources.

“Schools’ healthcare has been pushed onto us now for just a thank you, there are all those guidelines, everything we have to measure. They got rid of school doctors almost overnight and now it’s like that.” (family physician)

Another barrier is the heavy workload of family physicians, which includes not just care provision, but all the aspects of running a business. Family physicians admitted that they spend so much time dealing with financial, administrative, and personnel issues that they often do not have enough time to spend getting to focus on patients’ problems in depth, so it often seems safer to send the patient to a specialist.

“Not doing enough doctor’s work, maybe one third or one fourth of the time is when you can concentrate on the medical aspect... on being a doctor. You have to think about the economy, about the time, the patient’s possibilities and all the many obligations, that you must do before and after, to have in your reports.” (family physician)

One solution to expand the capacity of family physicians could be task shifting to nurses. Family physicians recognize that their nurses have the ambition to do more work that corresponds to their profession rather than being confined to their traditional roles of scheduling and basic tasks like weighing and measuring school children. However, there is a lack of patient trust towards nurses, who prefer receiving care and advice from a doctor.

“Patients don’t trust the nurses. The patient comes to the center and says they want to see a doctor, not to talk to some nurse.” (family physician)

Nurses

Nurses consider that they have the education, training, and desire to help family physicians and specialists much more than they are currently able to do. In order to achieve that, they would need to overcome not just patients’ lack of trust, but also specialists’ lack of confidence in their abilities. While family physicians recognize the resource that nurses offer, currently nurses who work for specialists are disempowered from making even simple clinical decisions like giving medication for a headache. Both these issues contribute to the brain drain of nurses leaving Estonia to work abroad. Nurses are keen to see their skills being better valued, by themselves, by the public, and by physicians.

“That the nurse is just an assistant of some sort who doesn’t really know anything. But when the doctor says, come here, the nurse will show you how to give a shot. Then they believe you. You are doing the right thing then.” (nurse)

“There was a doctor who was a despot. When he came, everyone was shaking. The caregivers disappeared, the nurses stuck around. Some younger nurses did not come to the

visits, knowing that they might run out crying. Since I was in one department for two years, there was one nurse who stood up to the doctor. The environment improved. We must value ourselves as nurses. And ask to stand up for ourselves, that I am someone and you don't just come and do this to me. These old molds will be broken by new blood.” (nurse)

Pulmonology, diabetes and cardiology nurses felt sufficiently prepared to act more independently to provide care for chronically ill patients and in preventive care, such as smoking prevention. They identified valuable specialist and family physician time that could be saved if patients could approach these nurses directly, without the extra current step of a referral from family physicians or specialists, which they considered unnecessary, obstructive and resource-consuming.

“The patients can't see the [pulmonology, diabetes or cardiology] nurse on their own. They must always have a referral from the family physician or the specialist or they must pay. But in my opinion it is crazy when a person decides to give up smoking. But they can't come on their own, they must go and get a referral of some sort. This is a huge thing that needs to be fixed.” (nurse)

“Yes, the nurse can advise them in every way, we have people with asthma. The person might have something wrong with their inhalator. Some simple issue. And basically they can't just drop by the nurse's office.” (nurse)

“Diabetes problems, problems with insulin shots, problems with glucometers. First they have to see the family physician. Get a referral. In my opinion, that is additional work for the family physician as well. And it is pointless work. The nurse's appointments are not so expensive [for EHIF] in my opinion, that the patient couldn't turn to them directly. We have sometimes been yelled at for seeing a patient, breaking the law a little bit. They must have someone who referred them to us. It could be without referrals...” (nurse)

Patients

Patient's trust towards family physicians varied according to their perceived quality, competence and qualifications. Some patients fully trusted their family physician while others preferred to avoid primary care because of lack of trust towards family physicians, considering that family physicians did not know enough. These patients sought a referral to the desired specialist or considered patients should be able to access specialist visits directly, without a referral. This was particularly the case with patients in urban settings.

“I think that those family physicians, they are very different. There most certainly are very good family physicians and very great specialists and there are those who are less ...” (patient, Tallinn)

“Patients simply go on their own, passing by the family physician. They don't trust, as it was said here that people don't trust their family physicians, they don't trust their qualification.” (patient, Tallinn)

Rural patients were more likely to have good relations and trust their family physicians than urban patients, and less likely to prefer specialist care, given the extra effort required to visit

a non-local specialist – though their attitudes towards family physicians depended on whether their services were accessible, and whether the physician had physical resources.

“I praise them very highly. Very, very, very. All the time, they never say no, doesn’t matter what your complaint is. They will check it out right away. They are willing to do everything. Everything is very, very good. Tests, they refer you everywhere. Heart. Here and there. So I won’t say a single bad word.” (patient, rural, Viljandi)

4. Unnecessarily extended inpatient stays

The respondents considered that the length of admission is kept as short as possible. Indeed, patients felt that sometimes specialists discharged them from hospital too early, without adequately considering the risks, and specialists noted that the imperative to make hospital beds available resulted in patients being moved on to the next stage of care before they were entirely ready to do so.

However, one challenge identified was unnecessarily extended inpatient stays for patients whose care needs would be better suited to the social care system. Respondents observed that due to the social care system being less well resourced and regulated than the health care system, patients often remain admitted to a hospice longer than they should, and when they are discharged back to their social care-run nursing home, they are often sent back for admission to the health care system after a short time.

“That the hospice doesn’t become a nursing home.” (specialist)

Coordination and Continuity of Care Across Care Settings

Inadequate acute inpatient follow-up care and limited provider continuity across levels of ambulatory care were identified by all focus groups as the most critical issues. Incomplete hospital discharges, particularly in terms of further instructions for the patient, primary care provider, hospice or nursing home after an acute hospital admission were a particular concern of specialists and nurses, while family physicians had some concerns about primary prevention.

5. Inadequate acute inpatient follow-up care

All focus groups expressed concerns that after an admission to hospital, patients are very often left alone; this is a particular concern for older patients and those with co-morbidities and chronic diseases. Specialists and nurses noted confusion as to which care setting patients who have limited or no ability to take care of themselves should be referred next and who should be responsible - health care or social care. Patients and family physicians expressed concerns about the poor availability and accessibility of rehabilitation and physiotherapy services.

Inadequate follow-up care due to unclear responsibilities

Specialists and nurses expressed a lack of clarity as to who is responsible for coordinating follow-up care, which they considered to be primarily a healthcare issue, rather than a problem at the health/social care nexus. They described that the shortage of hospital beds means patients are rapidly moved on to the next stage of care, sometimes prematurely, to

make more acute beds available, without adequate preparation of the relevant healthcare providers for the specific needs of each patient at this next stage.

“If in the old days the patient used to be in for two months. You knew that person. You knew the good and the bad. But now, let’s say three-four days. You are compiling a new chart all the time. You are meeting new people all the time and then they are gone again and you’ll have someone new again.” (nurse)

“They sent them to rehabilitation very quickly, to us. Rehabilitation can’t do anything because the patient is not ready for it yet and would need follow-up care, not nursing.” (nurse)

Still, the issue of social and health care system being separate did not go unnoticed - in the opinion of specialists and nurses, patients should get a full package of coordinated, planned services that extends from acute care to recovery, over both systems.

“The political choices in medical care should be done based on the amount of money that is available to us. Needs to be effective and humane. Many patients receive the treatment and then nothing else. Follow-up care and all should be in the package. We do a hip replacement but some sort of exercises ... As soon as they are better – out.” (specialist)

“Our very big drawback is the referral of elderly people. Because there aren’t many of those follow-up care and nursing places. And we do all this hard work but if there’s no family behind them then there is a problem as to what will happen to that person next.” (specialist)
“At home it is also that medicine and social care are fractured, it is very difficult to get home nurses ... there are social care services. Because if you have a family, children, then all those things that you want to get at home, you have to pay for them.” (nurse)

Inadequate follow-up rehabilitation and physiotherapy

The difficulty in securing adequate rehabilitation and physiotherapy was especially important to family physicians and patients. Family physicians feel responsible for organizing physiotherapy for their patients but in reality there is not much that they can do. They can make referrals to rehabilitation but the patient may not receive the therapy due to long waiting times caused by insufficient availability of services.

“When there is surgery, they’ve done surgery on a fracture, they would need physical therapy right after the hospital but they are sent home on sick leave and then it is the family physician who must organize rehabilitation, which is rather complicated as we know.” (family physician)

“First you send them to a rehabilitation specialist, the waiting times are a month or two ... then they send them to physical therapy, you wait another two months.” (family physician)
“Actually, based on my understanding, when a person comes and I diagnose them with arthritis, they should go to the rehabilitation specialist right away and get physical therapy immediately, not in 3-4 months or 6 months later.” (family physician)

Patients feel that after acute care they have been left alone and have to actively secure their own rehabilitation services, including compiling a rehabilitation plan, and organizing visits to get the services, and even then they may not receive the service that is planned or may get it to a lesser extent. Similarly to family physicians, patients identified the bottleneck as long waiting times, in addition to high co-payments.

“Follow-up care should be better organized. One thing I’d like to mention, that I can’t get over is the rehabilitation plan. It is a waste of paper on my side and the EHIF just sends money somewhere. I had a 5-year rehabilitation plan they made but I haven’t received a single service.” (patient, rural, Viljandi)

“You have to do all of that on your own, they just recommend things, that you could do this or that and then you see on your own. They give you hints that there they have that and our own clinic has this, you can go there or go ask there, they have told you everything but you have to book it all on your own.” (patient, Tallinn)

“I might receive rehabilitation but for some reason they’ll give me only 5 days – what can they do in 5 days. I think that there should be at least 8, 8-10 days would be necessary, or even 10-12, I would have asked for that.” (patient Russian, Narva)

“For example the family physician gives a referral to another doctor ... physical therapist. And you wait a long time to see them as well, you can’t get to them, finally you get a referral to the pool.” (patient Russian, Narva)

In the Russian-speaking region of Narva, the language barrier only compounds the confusion and challenges of organizing rehabilitation and physiotherapy. Even less information is available about how to access the services, and Russian-speaking doctors struggle to translate and act on Estonian information about their patients after a hospital admission, and have difficulties communicating with other parts of the healthcare system to understand where and how they can make referrals.

“And also – to ask for a referral to Haapsalu, to a more specialized place – it is more like a, well, sanatorium, to treat oneself a little because my shoulder is not working, my knees, everything that has to do with bones and muscle – it’s impossible to get that. The family physician says that we can’t do that, go to the Pension Board, the Pension Board is surprised, saying that the family physician must do that, I go to the family physician again and they tell me they don’t know anything about it, they don’t have such possibilities ...” (patient Russian, Narva)

6. Incomplete hospital discharges

All focus groups felt that when releasing patients from the hospital it is very important to give thorough instructions to the patient, the family physician but also to family members if necessary; however they recognized that this did not always happen.

Specialists felt that prior to discharge, patients received insufficient information or counseling about how to recover and stay well. Both specialists and nurses identified this as

the nurses' role, but nurses reported being unable to do it properly due to rapid patient turnover and a heavy workload leaving them with little time for the task.

"The nurse talks to the patient as a counselor, how to take medication, where to go for rehabilitation, why they should take their medication. Someone has to tell the patient that if they don't take the two blood thinners after getting stents after a heart attack then they'll be back in a month. They have not been advised enough." (specialist)

"The family must receive counselling. I can see it in case of the elderly. Diabetes diagnosed, medication prescribed. We set a diet. The next day the family is there, bringing sweet pastries. They will eat what they like." (specialist)

Family physicians received inadequate information from specialists after their patients are discharged from hospital, and particularly highlighted their frustration that despite this lack of information, they are called upon to provide sick leave documentation after a hospital admission, without knowing anything about the patient's illness, when specialists, who have detailed information about the patient's condition, could better complete this task.

"I don't want to give out sick leave when I don't know anything about the illness, the sick leave is for two months, the patients never see me. Why can't the specialist issue sick leave? They could give it for as long as it is needed. Why does the family physician have to do that?" (family physician)

Patients, however, generally express satisfaction with the information, instructions and guidelines that they receive after a hospital admission. This may be because they do not know what they ought to expect, nor whether they are receiving the "correct" advice.

"All instructions are given clearly. After heart surgery, they walked with me in the hallway, gave all the instructions. In my experience it is completely sufficient." (patient, rural, Viljandi)

7. Unnecessary pre-operative diagnostic procedures

Both specialists and family physicians identified unnecessary pre-operative diagnostic procedures as a concern. Specialists recognized that they conducted more procedures than strictly necessary, motivated by a combination of defensive medicine (reducing the risk of missing something important), and the fact that EHIF funding is procedure-based, and therefore more procedures are more lucrative for the hospital. However, they did admit that some procedures may not only be unnecessary, but also potentially harmful to patients.

"EHIF funding is test-based. Before the economic decline there was actually a time when young colleagues came to hospitals. They knew – there's a lot of money, you can run tests, let's do everything. Everything was CT scanned. Then they started to figure out, what to do with the results. Such a waste and in some cases damaging to the patient, the unnecessary radiation from the scan. This still goes on today. It is unusual for a patient to get through admittance to our department upstairs without getting a CT scan of some organ." (specialist)

“To keep the hospital afloat, lots of tests must be run. There’s no need to treat, that takes money away. But running tests is beneficial. Especially when you can do it using equipment that costs a lot of money, because it is profitable. That is unavoidable. That is part of this model. I can’t say it is good or bad but it simply is like that, right.” (specialist)

“Regardless of promises, the Minister has not changed the non-fault liability insurance system. Looking at the free movement of patients directive at the current moment, the doctor has no protection. If they are at fault, they will face very large claims. The doctors do as many things as possible to secure their backs.” (specialist)

Meanwhile family physicians expressed frustration about the duplication by specialists of diagnostic procedures they have already undertaken and paid for at a primary care level. This behavior insults family physicians, as their budget for diagnostic procedures is very limited, and they have to put considerable thought and investment into each procedure they decide to undertake. Family physicians suggested that clearer instructions about what should be done by specialists and what by family physicians would help avoid duplication.

“Many things are done twice. Sometimes you think that it is shameful to send them without tests and then when you see that they’ve run them all again almost the same day ... and then you wonder why you worked so hard at it.” (family physician)

“Sometimes when you send them without running the tests then they yell at you, how come the patient has been sent without any tests and the family physician hasn’t done anything.” (family physician)

“There should be specific treatment guidelines. For each illness, what should the family physician do, what is done at a higher level and if it is there in black and white then that’s it. I take it, open up the book and see, OK, they have decreased urine output, male, what do I have to do and what I can leave to the specialist without any concern.” (family physician)

Patient expectations also encourage unnecessary procedures. Russian-language patients in Narva expressed their expectation that if you are in hospital patients should receive a thorough examination of their health, not restricted to investigating and treating the presenting complaint.

8. Over- and under-provision of preventive services

Prevention was a concern mainly of family physicians and patients, and the question of interest was not so much the quantity of services, but who should be providing them.

Family physicians are currently responsible for many preventive services, but they do not consider it their role. While they are willing to hand out education documents about health promotion, and have their nurses provide advice, they feel that given their professional training and heavy workload, the focus of family physicians should be on diagnosis and treatment, while social services should take responsibility for prevention. They also disagree with approaches like monitoring blood cholesterol levels, considering preventive strategies like exercise promotion to be more effective.

“In my opinion it is going in a completely wrong direction - checking cholesterol levels. Sending elderly to the pool or something - that would be prevention, not checking cholesterol levels several times a year. What do I prevent by doing that? Insanely high cholesterol levels requiring treatment, they are already receiving treatment. /.../ The doctor doesn't need to prevent. The social side must do prevention.” (family physician)

“Doctors have to treat people, not prevent diseases. Yes, of course the nurses can advise them a bit when it comes to quitting smoking and ... but it must come from elsewhere as well, not just the family physician.” (family physician)

“Those leaflets are very good. It is good to hand them out sometimes.” (family physician)

Patients felt that they ought to take responsibility for their own health. They considered it the family physicians' and specialists' role to help them do that by alerting them to potential health risks, but what the patients chose to do with that information was up to them.

“For example, I had a CT scan, then came to find out results – the doctor looked at it and said that the results are within limits for your age. I'm sorry but I'm thinking I'm in the beginning stages of Parkinson's or Alzheimer based on those symptoms. Instead of me sitting and waiting, they could do something to prevent it now ... otherwise later it's hop and done.” (patient, Russian, Narva)

“The best treatment is that you see what suits you the best ... if you wake up in the morning and feel pain, you'll be like – you're getting so old, then you phone your massage therapist, ask them to come over and then you feel good again. Or you go swimming somewhere, which is the best thing.” (patient, Tallinn)

“I will say that as long as everything is right in here (in my head) and I can move then I'm the one, me-me, who can do something to prevent.” (patient, Tallinn)

“But if a person does not stick to the regimen... When you have hypertension and they still drink alcohol daily. And if they still eat lard, then it is clear.” (patient, rural, Viljandi)

9. Limited provider continuity and impaired patient provider relations across levels of ambulatory care

Limited provider continuity across levels of ambulatory care manifests in different aspects, which are long waiting times to see a specialist, variation in quality of specialist care outside Tallinn and Tartu, challenges in providing continuous elderly patient care, and incomplete information flow between levels. These challenges are considered by target groups below.

9.1 Waiting times to see specialists

The booking processes for an appointment to see a specialist was identified as very frustrating, involving long waits, and restrictions in making future appointments.

“That really made me furious. There is one number to call for appointments. They make appointments only from 7.30 to 8.00. The whole time calling constantly, but no answer. And

then at 8.00: no, we are not making any more appointments. I tried from 7.30 to 8.00 the whole week.” (patient, rural, Viljandi)

“The waiting times are too long to see a specialist and on the internet you can’t make appointments too far ahead, it’s approximately two months right now but if you want to make it in 4-5 months for example then you can’t do it because they don’t make those available. Which means that if you have a specific doctor you would like to see and they might have an availability in 4-5 months, you can’t count on that and you have to see someone less good then.” (patient, Tallinn)

All groups expressed concern about the length of waiting times to see specialists, but patients were particularly frustrated.

“But waiting times to see specialists are really very long. When you need it then it is way too much. When you need to see a neurologist, you wait three months. I think by then you’ve either become disabled or you’ve gotten better in the meantime.” (patient, rural, Viljandi)

Rather than waiting several months for an appointment covered by their health insurance, and risk their health further deteriorating while they wait, patients who can financially afford it often decide to pay independently for a more timely consultation, sometimes at a private clinic. Patients recognized that extra capacity clearly exists in the system, and felt that the health insurance system could do more to better finance specialists to access this capacity and reduce waiting times.

“Well, yes, and then it is unavoidable. I think there is a private clinic, Maramaa. They go there.” (patient, rural, Viljandi)

“But you see, there is this “nice” problem with the specialist. If you are in trouble and you slap money on the table then you’ll see the specialist the next day or the next hour or the next minute. But if you put yourself on that waiting list then ... I have taken people to Tartu, helped them. Taken them there by car. People wait behind the door, they wait two and a half hours. No one goes in. And only then do they call his name. We went and asked two, three times, saying that the doctor was there. And no, that was the hours for paid visits but no one came.” (patient, rural, Viljandi)

“To better finance specialists because as far as I understand, the doctors would have the time but they don’t have the money, or they don’t have the financing to see more patients, that is why the waiting times are so long, under-financed”. (patient, Tallinn)

“The government should have such a system where the doctor who has all appointments filled up for the next 5 months, they could pay them extra ...” (patient, Russian, Narva)

9.2 Perceived specialist care quality outside Tallinn and Tartu

Patients prefer to see specialists in the urban centers of Tallinn and Tartu, where development opportunities and physical resources attract the biggest concentration of professional, ambitious specialists who deliver trusted services that satisfy their patients. Specialists in smaller regional hospitals are considered to have 'average' specialists, while patients from Viljandi county and Narva deem their local specialists indifferent and arrogant, with poorer professional skills than those in the cities. This results in patients outside the cities moving from one specialist to the next, or not seeking help at all.

"A very well known doctor said that my condition was due to age. My friend went to Maramaa [private clinic], gave me the name of a doctor. I am still being treated by that doctor. When I went to see him, he called out to the nurse to get an ambulance!" (patient, rural, Viljandi)

"My cardiologist referred me to the pulmonologist all the time. The pulmonologist sent me to the cardiologist. I used up a couple of inhalators too. And that took two, three years. And in the end it was a heart problem." (patient, rural, Viljandi)

"There are good doctors, people go to them but there are those who just sit on that position but they are known and people don't go to them... (patient, Russian, Narva)

"I was called to Tallinn, my daughter said: mom, come here, we'll call you an ambulance and they will do a full check-up if they can't do it in Narva. When someone needs something, they call an ambulance, they take you in right away, do everything with great attention, all diagnoses have been made and you are back in your own rhythm of life, having received all the necessary treatment and you live on, consulting the doctor if necessary." (patient, Russian, Narva)

"But I do have to praise Tartu. Because I have had thyroid surgery in Tartu and there was a waiting list. My time was brought forward. I turned up there like a plane crash. Not a single test or analysis with me. A clean whistle. I thought that they'd send me back in a heartbeat. But they didn't send me back because the surgeon told me in the hallway: "Did you think the butcher would let you leave? No, we'll admit you". And so they did surgery on me and there everything was organized very fast. All those test, all the samples." (patient, rural, Viljandi)

9.3 Discontinuity of care across levels for older patients

With an aging population, medical care providers expressed a need to think through the whole service package for older patients to meet their complex needs, with a particular focus on long term solutions to maintain their health and avoid expensive acute nursing care. There was support for the introduction of geriatric departments to meet these needs.

"That is the most complicated group. Because they are so worn out. There is no hygiene, there are bed sores. And at the same time no one can do anything. Usually they are very old and need care. And then they don't want to put them in acute care because it is pointless.

And we receive family physicians' referrals. Sometimes we are angry of course and how can they just write that they don't have information. And I completely understand, what could the family physician do. Because the patient does not walk any more. Dementia. Often they live alone. They have children somewhere, in Russia, in Germany, in Finland. And they haven't received any medical care for a long time. No tests for a long time, not to mention x-rays. And the specialist has nothing to write there. And then we have to guess, figure out what to do with them. This is actually not the role of nursing care. We should have a diagnosis and we review the treatment plan. And if their condition changes, we make changes. This should be the idea of it. In my opinion, this won't be fixed in Estonia until they create geriatric departments. Like most developed countries. In Estonia they've only talked about them. I apologize but this issue will not go away. There are a lot of elderly people and it is one of the most important things. It seems so right now." (specialist)

"When they come to nursing, we have no other data besides the fact they had surgery. They require a lot of work. They shouldn't be in nursing. They should be in follow-up care. The right place would be a geriatric department, which doesn't exist in our country. Where an elderly person would be with their multiple problems. They get checked out, their needs are reviewed. Will they go home, receive home nursing care. Home care. Or they will go to a nursing home where they will receive care 24 hours a day. This would save money. Now they end up with us. They come to us during an acute phase. We must have more doctors than required in nursing. To do a job that was not done properly the first time." (nurse)

Again, the unclear division of responsibilities and incomplete cooperation between health and social care systems was identified as a challenge for continuity of care for older people. As the social system is weaker than the health care system, old patients often end up in the health care system, with neither system fully prepared to coordinate the care needed.

"One thing is that there are so many social problems that ... I'm so sick and tired already ... when the patient is at a nursing hospital and for example they tell them that they have to leave on that specific date, take them home, we don't have a place for them and their relatives come to us to ask what they should do – this is not a medical issue, it is a social issue. That's one thing." (family physician)

"Some patients could be in day care. What is lacking is free transportation. It's like you'll be taking the elderly person from home to kindergarten. Your child you'll get dressed in 15 minutes. An elderly person you'll dress for an hour, if they are in a wheelchair or stiff. Whining. Worse than a little kid. And then you have to drive them or order transportation, which costs money. It would be so expensive. We tried to have day care but no. Transportation was the issue." (nurse)

9.4 Information flow

Both specialists and family doctors again identified lack of a coherent, universal electronic care record with a clear structure and data entry rules as inhibiting the communication needed to promote continuity of care. Every big hospital has its own system, leaving family physicians to navigate between different e-systems, which is both difficult and very time

consuming (even opening each system takes time). They felt the need for one common e-system that is well regulated and easy to use.

“Every big hospital considers it prestigious to have their own IT system and just go ahead and try to log in! There are three different places to view x-rays /.../. Horribly complicated.” (family physician)

“I don’t have the time to open them up, opening them up takes a long time already.” (family physician)

“In my opinion Estonia is so small that there could be only one patient database. For example, when I open up x-rays then all the ones that have been taken will come up. When I open up labs, everything that the patient has had done in labs comes up.” (family physician)

Specialists’ biggest concern was the content of the digital records’ platform – without clear guidelines for what to input to the system, these have become jammed with unstructured and unnecessary information that makes the system slow, particularly during peak hours, and difficult to retrieve relevant information about their patients, or make sense of referrals by family physicians.

“And the digital medical records are not satisfactory either. The patient says that I have everything on the computer. But opening it up, opening the digital medical record up takes a long time. Especially today. It is impossible at noon, during the peak hour. But all that falls under the appointment time. And then I don’t know who to look for, who to look at. Where can I get that information? Under which doctor ... And now they’ll have prescriptions there as well. I think soon it will all seize up.” (specialist)

“The digital medical records will be overtaxed. I don’t know what will happen in 10 years. Today I had a patient who had lots of illnesses. I was looking for the recent fracture. Can’t find it. So much data. Each broken finger is written up.” (specialist)

“This excitement about computers as solvers of all problems is deceiving. The specialist is not the one to organize the information. Let someone else do that. I wrote my piece. I don’t want to send you a thorough review after every little while. It is not a blog. Reading the long texts take time.” (specialist)