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References

1. Commission of the European Communities Directorate-General Research Contract Number SP21-CT-2003-501586, Description of Work
2. Work Package 11: Final Report On Case Study 5 Estonia / Finland, part of SP3 – In depth Case Studies – Vertical Analysis
3. WP11 covers two deliverables:
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Leading Contractor and Contribution to DL11 Content
PRAXIS, lead the work on WP11, and the corresponding DL11. Contribution was made by:
- IESE Business School – University of Navarra: Magdalene Rosenmöller. The contribution of IESE is based on the guidance during the research as well as on the Professional Review.
- Key expertise in European Healthcare: Anu Laas, Anneken Metsoja, Auni Tamm

Availability

DL11: Final Report on Case Study 5 Estonia / Finland is available to the project partners on the project's internal website on the IESE Global Campus, hosted by IESE, the Project Coordinator. Part of the work has already been presented publicly in different settings, and journal publications in different journals will follow. The Coordinator & PRAXIS are currently planning to publish book entitled "Patient Mobility in the European Union: Learning from experience" encompassing the findings and recommendations of this Case Study together with Ireland/Northern Ireland, Spain, Slovenia, Belgium, Veneto and additional complementary studies from Malta, Germany and France.

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PATIENT MOBILITY IN THE EUROPEAN UNION

Final Report on Case Study 5: Estonia / Finland

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Executive summary

The objective of this case study is to get a first comprehensive understanding of the current extent in patient mobility from and to Estonia, the willingness of the Estonian population to seek treatment abroad and to assess the possible impact enhanced patient mobility may have on the Estonian health system and its providers. On the other side we were interested in knowing Estonian provider's plans for treating foreign patients and identifying existing cross-border collaborations. Although the original aim was to concentrate on patient mobility between Estonia and Finland, in the course of the study it became apparent that new knowledge on patient mobility issues can be provided by broadening the scope to other neighbouring countries, specially Estonian-Latvian border-region.

The research conducted from February 2004 to August 2005 consisted of documentary analysis, analysis of statistics available from Statistical Office of Estonia, STAKES from Finland and of data obtained for the project from Estonian Health Insurance Fund and from providers of health care. A representative population survey using face-to-face interviews and a questionnaire-based patient survey in Estonian spas were carried out, and 25 interviews were conducted with representatives of providers and stakeholders in health policy in Estonia and Finland, including Estonian Minister of Social Affairs.

Estonian health care system is based on private and public autonomous health care providers, financed mostly by through contracts with the social health insurance scheme administrator Estonian Health Insurance Fund. The regulatory environment on one hand and limitations of public spending on the other should give incentives for providers to engage in treatment of temporary visitors and to seek contracts for elective care of foreign patients.

Regarding outbound patient mobility, Estonia has a transparent well-established legal regulation, aimed for those needing treatment not available in Estonia. The total number of applications for prior authorization for treatment abroad used to be low – less than 30 in total annually, doubling however since Estonia became member of EU in 2004. The growth in number of applications signals two issues: firstly, that the patients and their families are taking more initiative to explore also treatment options outside home country, and secondly, that awareness of the right to apply for publicly paid treatment abroad has increased. The most frequent country of destination has been Finland, followed by Sweden and Russia. The most frequent reasons for not granting the authorization were treatment availability in Estonia, sought treatment not being considered evidence-based by a specialist panel and that application was made post-factum after treatment had already been received. The last reason was more frequent among Russian-speaking population, suggesting that information about the prior authorization procedure may not be well available for this population group.

The increased interest in the treatment options abroad was confirmed by the population survey carried out in September 2004. While only 2% of the population had had any experience with health care abroad during the last 3 years, 81 % of the respondents stated they would consider treatment abroad, if the service is not available in Estonia. One of every four respondents stated in the hypothetical interview situation that he/she would prefer treatment abroad even in case it is available in Estonia. Relative factor analysis showed that

the decision to seek treatment abroad in both instances was mostly dependent on whether the treatment would be covered from public revenues or not.

Extent of foreign patients having treatment in Estonia is difficult to assess. Although Estonian health care providers keep detailed data, these records contain medical and financial data, including data whether the treatment was paid by EHIF or privately. However, these records do not include data on country of origin of the patient. The exception here are the Estonian spa's which attract 70% of their clients from abroad, mostly from Finland and Sweden, but increasingly also from Russia and Germany. Patient mobility is happening also in other areas of health care where out-of-pocket payments are high in the countries, such as dental care. Some dental care providers in bigger cities estimated that 10-30% of their patients are from abroad. Usage of dental care by foreign visitors was also confirmed in the survey carried out by the project among foreign guests in Estonian spas. In the survey, the spa guests identified as biggest obstacle in seeking elective health care in Estonia lack of information.

Despite generally favorable environment and incentives in the system to attract foreign patients, the Estonian providers of health care are not actively pursuing foreign health care markets. Private providers who have tried out marketing themselves independently, all state having experienced non-cooperation among colleagues in those countries. Instead, these private providers now have entered into international networks of private providers, offering an alternative choice within the network. It is evident that due to increasing mobility of people overall and also increasing availability of internet based information, there will be increasing mobility of patients. Providers in the regions not accustomed to multilingual patients, such as are the providers in Estonia as well as in Finland, should consider possibilities of managing these increasing patient volumes.

Instead of trying out aggressive competitive health care markets within European Union, the member countries should concentrate on assuring availability of good quality health care on its territory for its citizens and visitors, when the need arises. More value can be added to health care availability through cooperation with Centers of Excellence and other cross-border cooperation initiatives, such as is the example of development of joint health care delivery system in twin-town Valga-Valka on the Estonian-Latvian border for the residents of the towns and neighbouring counties. The cooperation between Valga and Valka started from the need to effectively manage existing health care infrastructure and to increase quality of care provided. In August 2005, tender was launched for development of masterplan for regional health service provision in specialist care, long-term care and organization of ambulance services. The Valga-Valka case can serve as an important learning example for other regions both on successes as well as difficulties in cross-border cooperation.

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Introduction

With its natural harbours and inter-connected waterways, Estonia has for centuries been an important link in the trade routes between Europe and Russia. However, its geopolitical situation has also meant that its connections with the rest of Europe were disrupted by 50 years of isolation behind the Iron Curtain. Re-independence in 1991 opened up opportunities for re-establishing Estonia's historical relations with the west. The transition represented an opportunity for the Estonian health system to scale up its quality of care by adopting modern medicines and technologies that were not previously accessible, even though they had been available for 20 years in the west. With the opening of its borders, a wide variety of opportunities became possible through professional cooperation. Yet, so far, little is known about the extent to which Estonian patients have been able to use these opportunities to obtain health services abroad. Nor is there much knowledge about how Estonian health care providers have been able to cope with the rocketing number of multilingual and multicultural foreign visitors who require health services in Estonia. The close links to Scandinavian countries and the scale of price differential favour tourism to Estonia and could be an incentive for health tourism. On the other hand, the legacy of the Soviet Union and subsequent very low level of investment in the health sector during the period of transition mean that Estonia may not be seen as a high quality health care destination, either for foreign visitors or the resident population.

The objective of this case-study was to get an initial comprehensive understanding of the current extent of patient mobility to and from Estonia, of the motives and satisfaction level of these mobile patients, and also of the impact that this mobility has on the Estonian health system and its providers. On the other side we were interested in ascertaining Estonian providers' plans for treating foreign patients, identifying existing cross-border collaborations and assessing the willingness of the Estonian population to seek treatment abroad. Although the original aim was to concentrate on patient mobility between Estonia and Finland, in the course of the study it became apparent that new knowledge on patient mobility issues can be provided by broadening the scope to other neighbouring countries, especially the Estonian-Latvian border region.

The case-study consists of six parts. Firstly, contextual factors influencing patient mobility in Estonia will be described and analysed, such as Estonia's historical and cultural ties to neighbouring countries, the dynamics of in-bound tourism, as well as the structure of health care provision and financing.

The second part of the case-study gives an overview of the legal regulation of patient mobility in Estonia, and provides a detailed analysis of authorizations and denials for prior authorization for treatment abroad paid by the public insurer the Estonian Health Insurance Fund in recent years (January 2002-June 2005). This part also describes expectations and motivations of the Estonian population related to choices between local or foreign health service provision, based on representative opinion surveys carried out in the course of the project.

In the third part of the case-study, an attempt is made to describe foreign visitors' experience and expectations of Estonian health care, based on a survey carried out among foreign guests in Estonian spas.

The fourth part describes Estonian providers' experience of, and plans for, treating foreign patients and attracting foreign patients for elective treatments.

The fifth part gives an overview of policy makers' current thinking, mainly in Estonia, related to the perspective of patient mobility.

Lastly, main conclusions are drawn and some policy and further research proposals are made for future consideration.

The findings of the case-study are based on documentary analysis and analysis of data obtained from the Estonian Health Insurance Fund, the Estonian Statistical Office, the Estonian Spa Association, the North Estonian Regional Hospital in Tallinn, the Ministry of Social Affairs, Valga Hospital in south Estonia, and STAKES (National Research and Development Centre for Welfare and Health in Finland).

Two structured questionnaire surveys were conducted. The population opinion survey was an omnibus survey conducted among the 15-74 age group, using a multilevel probability random sample of 1000 (980 respondents) and face-to-face interviews. The spa guest survey was conducted using questionnaires in multiple languages, distributed by spa administration and room staff in a total of six spas in four different locations. It was held in two rounds, with the July-September 2004 round gathering 229 respondents, and the October-December 2004 round (with four spas in three locations) gathering 155 respondents.

Open semi-structured interviews were held with 25 stakeholders in the policy making process, including the Estonian Minister of Social Affairs, a representative of the Finnish Ministry of Social Affairs and Health, management from the Estonian Health Insurance Fund, the chief of the Estonian Medical Association and representatives from selected health care providers.

No data on health condition was collected on an individual, identifiably personal level. For the spa guest survey, approval was sought from the Estonian Medical Survey Ethics Committee at the National Institute for Health Development (Annex 1: Letter from the Committee).

The researchers would like to thank all persons in the organizations visited for their openness during interviews and helpfulness with providing existing data, especially the staff at the Health Department of the Estonian Health Insurance Fund.

1. Estonian contextual factors: geography, tourism and the health care system

1.1. Estonian geographical position and historical-cultural ties

Estonia, with its population of 1.3 million, is the northernmost of the three republics on the east coast of the Baltic Sea. Even though Estonia has a land border with Latvia in the south and Russia in the east, Estonia has historically closer cultural ties with its northern neighbour across the Baltic Sea, Finland, in part because of the similarity of the Estonian and Finnish languages. Helsinki, only 85 km away, can easily be reached by ferry, as can several destinations in Sweden, Estonia's neighbour across the Baltic Sea to the west. In contrast, the Latvian capital, Riga, is 307 km from Tallinn, and the Russian city of St Petersburg is 395 km away.

1.2. Tourism

According to the Estonian tourist board, the journey from Finland is the most frequently used means of access to Estonia, bringing about 70% of all visitors. During the summer there are 37 catamaran boats or ferries between Helsinki and Tallinn every day. By speedboat the journey takes only 1.5 hours, costing between €20 and 50 to "hop over" from Helsinki. The hourly helicopter crosses the sea in only 18 minutes, at an approximate cost of €100.

Following Estonian re-independence in 1992, and with the opening of borders to tourism[1], foreign visitor arrivals rocketed from a mere 175,000 visitors in 1985 to 1.3 million visitors in 1993. In 2003, Estonia was host to 3.4 million foreign tourists: 53% were Finnish and 12%

[1]During the period of Soviet occupation tourism was very restricted. Visitors had to stay in the capitals' very few Intourist hotels which had a total of 214 beds in 1965. Some day trips outside Tallinn were allowed under the supervision of a government official, including when visiting relatives in Estonia.

Latvian, with other sizeable groups from Russia, Sweden and Lithuania. With entry into the European Union in May 2004, tourism in Estonia has increased by about 20% in comparison to 2003 (Estonian Tourist Board, 2004). Currently, an increasing number of people are coming from Germany, Norway and the United Kingdom, in part fuelled by the emergence of budget airlines.

1.3. The Estonian health care system

Estonian health care is financed mainly from public sources (76% of total health expenditure in 2003), with a social health insurance system covering 67% of total health care expenditure. The health insurance system comprises a single national scheme and is almost universal, covering up to 94% of the population. It is administered by the Estonian Health Insurance Fund (EHIF), with no opt-out allowed. The entitlements are regulated in the Health Insurance Act and are quite broad, covering primary and specialist care, some dental care, long-term care, pharmaceuticals and illness cash benefits. In general, the system is based on the principles of territoriality[2] and in-kind benefits[3].

Health care providers are private (primary care and part of out-patient specialist care) or public, operating under private company law as foundations or joint-stock companies (hospitals). The EHIF has no obligation to contract with a provider and can exercise selective contracting, which is common with out-patient specialist care and dentistry for children. Providers are funded on a case-based or fee-for-service basis. All providers, public and private, can treat private patients and they retain all revenue received for health services provided to private or to foreign patients.

Total expenditure on health care was 5.4% of the GDP in 2002, Estonia being one of the lowest spenders on health care in the EU both as a percentage of the GDP and in absolute terms. While in 2002 average total spending on health care per person in the 15 "old" EU Member States was $2,364 (PPP-adjusted), the Estonian figure was $625, with only Latvia and Lithuania having lower levels (WHO, 2004).

Patient and population satisfaction levels with the Estonian health care system are monitored annually in population surveys. EHIF annual health care satisfaction surveys conducted among the Estonian population showed that nearly 90% of those who had used health services in Estonia were very or mostly satisfied with the care received, with satisfaction with dental services even higher, at 95%. However, there was a discordance between their personal experiences and their views about the system in general, with only 52% of the population considering access to care and 59% quality of health care as generally good[4] (EHIF/FAKTUM 2004). When compared internationally, the population's trust in their own

[2] Patient entitlements are in general conditional upon the health services being provided on territory of state of residence.

[3] Providers are directly reimbursed by the health insurance fund for the health services provided.

[4] Results need to be interpreted with some caution, as the survey coincided with difficult negotiations between the government and the physician association, while the media coverage emphasized long waiting lists and questioned the quality and sustainability of the system.

health sector ranked in the lower end of medium in the rankings of 44 countries around the world (EMOR 2004). However, compared to other societies that have undergone economic and political transition in Eastern Europe, the Estonian population had the highest rank for trust in and image of the health care sector.

1.4. Analysis of incentive environment for providers and patients

The structure of health care providers in Estonia, the prevalent fee-for-service or case-based payment method, as well as the providers' right to retain all revenue received for treating foreign patients, should be considered as a positive environment and incentive for Estonian health care providers to be interested in attracting foreign patients. The low general level of health care funding in Estonia, compared with most EU Member States, should create pressure for the providers to seek opportunities for extra revenue by treating patients in addition to the EHIF insured.

When considering the environment from the foreign patients' perspective, several scenarios can be considered. On the one hand, the scale of price differential favours tourism to Estonia and could be an incentive for in-bound health tourism. On the other hand, the legacy of the Soviet Union and the subsequent very low level of investment in the health sector during the period of transition mean that Estonia may not be seen as a high quality health care destination.

The image of the health sector, and the population's trust towards local health care providers, are important factors in determining the population's attitudes regarding rights and expectations in seeking treatment abroad. Repeated signals from health care providers about the health system being under-funded may create an undeservedly low image of the actual situation of health care provision, and may give incentives for local people to seek health care abroad. Based on the quite worrying satisfaction levels with the health system referred to above, one might expect a fairly high level of willingness among the Estonian population for considering treatment abroad.

Whether and to what extent these theoretical incentives materialize in the thinking and decisions of patients and providers will be described in the following parts of the report, based on the findings of the research conducted during the E4P project's first phase.

2. Patient mobility from the Estonian population's perspective: patients' rights, experiences and expectations

For the case-study, legal regulations and administrative procedures for patient mobility were analysed, as well as available official reports such as the EHIF annual reports. Data-files were obtained from the Estonian Health Insurance Fund, regarding applications for and approvals of prior authorization for treatment abroad for the period 1997-June 2005, with data from 2002-June 2005 enabling a detailed analysis of applicants' age structure, place of residence, home language and some other factors such as duration of the process, as well as medical specialities for which treatment abroad was sought, countries of destination and reasons for not granting prior authorization[5].

This data was complemented with a representative population survey, with the aim of capturing the extent and experience of privately paid medical care abroad, either in cases of emergency or of elective care. The second and larger objective of the survey was to gain an understanding of the attitudes and motives of the Estonian population regarding treatment abroad.

The survey was conducted using face-to-face structured interviews in respondents' homes, as part of an omnibus survey. The fieldwork period was from 15 to 27 September 2004. The interviews were conducted by a total of 67 trained interviewers who had been briefed on the specifics of the survey. 980 respondents were interviewed (see Annex C for the overview of the fieldwork, respondent structure, data processing and questionnaire). In order to enable the linking of the survey results with health care satisfaction rates and factors surveyed annually by the EHIF, the patient mobility survey was conducted concurrently with the annual EHIF health care satisfaction survey (EHIF/FAKTUM 2004).

2.1. Legal framework and procedure

The rights of Estonian insured persons for publicly paid treatment abroad are regulated in the Health Insurance Act (HIA). In general, non-urgent treatment received abroad will be reimbursed only if the insured Estonian resident has obtained prior authorization from the EHIF. Conditions for granting authorization have been established by the Health Insurance Act § 27 as follows: the care sought is not available in Estonia; the service is medically indicated; it is of proven medical efficacy, with a probability of success of at least 50 per cent. (Health Insurance Act, 2002). The regulation only covers treatment costs, however. As the Health Insurance Act does not foresee any reimbursement of transport costs, all costs related to transport abroad and back have to be borne by the patient's household.

[5] Although data allowed detailed analysis, patients remained anonymous and unidentifiable to the researchers

Waiting times have become a problem in Estonia, especially in some specialties. The reasons vary and include administrative, human resource as well as financial constraints. Waiting time targets have been set by the Supervisory Board of the EHIF. However, a long waiting time would not usually justify giving authorization for treatment abroad, as the wait is often associated with a specific provider while other providers can offer faster treatment.

The legal regulation is supplemented by a procedure for administering applications at the EHIF (EHIF, 2001b). The procedure has evolved over the years, giving more responsibility to EHIF in the administration and communication with the health care providers, and lightening the burden of bureaucracy for the patient (Tarien, Peetsalu, Interviews, 2004).

From 2001, the main steps in the procedure for applying for prior authorization are:

1. The insured person submits an application for prior authorization for treatment abroad to the EHIF, indicating his/her own contacts as well as the name and contact of the treating doctor in Estonia.
2. The EHIF contacts the treating doctor, asking for the case history of the illness and the reason for treatment abroad being necessary.
3. The medical necessity for treatment abroad is evaluated by a specialist panel/committee of this specific speciality based on the medical documentation. The panel may also ask to see the patient.
4. After the specialist panel has given its opinion on the necessity, the EHIF contacts health care providers abroad, asking for an assessment of treatment capacities, a time scale and also for a price-estimate in Euros.
5. A letter of guarantee is issued to the health care provider of the estimated amount.
6. The provider is paid after treatment according to an invoice sent to the EHIF, and after a short case history with description of the provided treatment and recommendations of follow-up has been received by the Estonian treating doctor.

In some cases, the procedure has also been used for a foreign consultant or a doctor to be invited to Estonia to provide the necessary treatment, instead of the patient having to travel.

The general rule of territoriality does not apply to health services that are reimbursed as cash-benefits in Estonia. Since 2003, adult dental care has been in such a category of reimbursement: the patient pays the full price of the service directly to the provider and later receives reimbursement from the EHIF, up to a predefined ceiling. For its part the fund is obliged to reimburse these services irrespective of the location of service provision, a regulation which is directly influenced by the Kohll and Decker rulings of the European Court of Justice (Tarien, Interview 2004).

In conclusion, when determining the rights of Estonian patients in seeking treatment abroad, two factors have been taken into account: Estonia's small population size on the one hand and availability of public resources on the other. The small population base makes cooperation with foreign providers necessary for rare diseases or treatments, and therefore legislation provides explicit rules for obtaining treatment abroad, paid from public revenues by the EHIF. The limited availability of public funds in the health care system has however forced legislators to place restrictions on patient mobility.

2.2. Practice of exercising prior authorization for treatment abroad

2.2.1. Numbers of applications and authorizations, applicants' age-structure and geographical distribution

The number of people receiving treatment abroad under this prior authorization procedure has been quite low over the years. Since 1998, between 12 and 30 patients have been treated abroad each year, from the 14 to 40 who apply. However, the number of applications, as well as authorizations, doubled last year, when Estonia became an EU Member State in May 2004 (Table 2.1.).

Table 2.1: Number of applications and approvals under prior authorization procedure, 1998-2004 and 2005 January-June

	1998	1999	2000	2001	2002	2003	2004	2005 January-June
Applications	14	25	22	19	23	27	46	52
Authorizations	12	18	20	13	19	16	28	31
%	86	72	91	68	83	59	61	60

Source: EHIF 2005a. Data obtained for E4P case-study

As can be seen, initially almost all applications were granted authorization. This indicates that in reality the application process was driven by health service providers, who pre-selected the cases for treatment abroad before an application was made. Over time, the number of applications has increased, as has the number of rejections. The increasing number of applications may be due to increased awareness of the procedure, increased availability of information, as well as being due to the simplification of the administrative procedure for the patient.

The total expenditure of the EHIF on treatment abroad remained under € 150 000 annually until 2005. Due to the jump in applications and authorizations, total expenditure on treatment abroad by the EHIF under the prior authorization procedure in the first half of 2005 already exceeded the total annual expenditure of previous years (Table 2.2).

Table 2.2: EHIF Annual expenditure on treatment abroad, 1998-June 2005.

Year	1998	1999	2000	2001	2002	2003	2004	2005: Jan-June
Total exp (€)	65 158	57 578	151 324	159 587	97 593	128 782	99 319	238 966

Source: EHIF annual report. 1998-2004. EHIF semi-annual report 2005.

An analysis of applications for and granting of prior authorization reveals that authorizations are skewed towards younger age groups (Table 2.3). Almost half (47%) of all applications during 2002-June 2005 were for treatment of children and young adults under 20 years of age, of which over 80% were granted authorization. For the over-40 age groups, the authorization rate is 50% and under.

Table 2.3: Age structure of applications and approvals, 2002-June 2005

Age group	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70 and over
No.of applications	44	26	18	16	17	14	8	5
Authorization granted (nr)	33	21	9	12	9	6	3	1
%	75	81	50	75	53	43	38	20
Authorization not granted (nr)	8	3	8	2	8	5	5	3
%	18	12	44	13	47	36	63	60
Application withdrawn (nr)	3	2		1		3		1
Not decided yet (nr)			1	1				

Source: EHIF 2005a. Data obtained for E4P case study

Looking at the geographical equitability of using the application procedure, applications were analysed in terms of the applicants' place of residence. We were interested to find out if it was only people from the bigger towns where the tertiary health care providers are who were applying. The analysis showed that applications had been made from all regions in Estonia, which leads to the conclusion that geographically there was quite an equitable distribution of use of the opportunity for treatment abroad.

2.2.2. Reasons for not granting authorization

The reasons for not granting prior authorization, however, reveal unequal access to information for different population groups. Overall, the three most common reasons for not granting authorization were: availability of treatment in Estonia (31% of denials), specialist panel did not consider sought treatment evidence-based, and did not therefore support it (24%) and that the authorization was applied *post factum* after treatment had already been received (17%) (See Annex B.2 for more data). A few cases of denial were of a technical nature – that the person actually needed a European Health Insurance Card, but applied by mistake via this procedure.

There were a few cases when the patient had applied for treatment or a second opinion abroad, but for some reason not had not proceeded with the process, failing to turn up at the specialist panel or not returning EHIF e-mails and letters. Only one application in the period 2002-June 2005 was made due to a long waiting list. However, as the waiting list was due to a shortage of donor organs (a cornea for cornea transplant), rather than due to capacity or financial constraints, and because the transplant service is available in Estonia, the application was denied (Peetsalu.Interview 2004).

There is a difference in the reasons for denial due to the *post-factum* applications relating to the home language spoken by the applicant[6]. While only one application was made by an Estonian-speaking insured person *post-factum* during the period, six Russian-speaking insured persons had first obtained the treatment (mostly in a centre in Russia), and had applied for reimbursement only upon return to Estonia. This may be a sign of insufficient information about the procedure to the Russian-speaking population. Also, a marked difference appeared in applications for treatments that had been considered non-evidence-based by the Estonian medical specialists: while no Estonian-speaking persons had been denied authorization for this reason, there were four such denials in the case of Russian-speaking insured persons.

From the 10 cases where the application was withdrawn by the patient or guardian during the administration process, four of these cases involved the person applying being unaware that the treatment also existed in Estonia. After such information was conveyed, the patients in question instead chose local providers and withdrew the applications. On the other hand, there was also one case when authorization was granted despite there being treatment availability in Estonia. In this case treatment abroad was granted due to a conflict that had developed between the patient and the local provider.

2.2.3. Main specialities and initiation of application

The top-10 specialities by number of applications in 2002-June 2005 were: ophthalmology (20 applications)[7], oncology (14), neuro-surgery (12), facial surgery (12) and orthopedics (13), haematology (10), genetic testing (8), cardiac surgery (6), gastric surgery (8), neurology (6) (Annex B.1.).

By share of authorizations granted, however, only 25% of the applications for ophthalmic treatment were granted authorization, with most of the denials due to either the treatment being available in Estonia or the sought treatment not being considered evidence-based by the specialist panel. For some specialities or treatments, authorization had been granted to all patients, as for genetic testing (8 applications), vascular surgery (5), ear-surgery (3), endocrinological testing (2), and pre-natal care procedures (2).

The researchers also asked the EHIF to try and evaluate the main initiator of the application procedure, when the EHIF entered the application data into the case-study data-file – did the application seem to be mainly the patient's own initiative, the patient or the family being the most active part in the process, or were the treatment options actively proposed by the provider? Although noting that such an evaluation based on documentation is to a certain degree subjective, 39% of applications were evaluated as purely initiated by the patient or family. Fewer than half of these applications were granted authorization (36%), and four applications (7%) were withdrawn in the process, as the patient had found out that the treatment was also provided in Estonia and had preferred a local provider. In these cases

6 Home language judged based on language of the application and name of the insured person.

7 It has to be noted that categorization of treatment specialities may have been misleading in some cases (for example reconstructive surgery after ophtalmic cancer may have been put under oncology or facial surgery)

where referral abroad seemed to have been suggested or indicated actively by the Estonian provider, the share of authorizations granted was the highest, at 95-100%. However, it also has to be noted that in 12% of cases the evaluators did not dare to state an opinion of who was the most active initiator based on the documentation at the EHIF.

2.2.4. Countries of destination and continuity of care

The countries and providers receiving Estonian patients have mostly been selected by Estonian providers on a case-by-case basis, based on existing professional contacts (Peetsalu, Interview 2004). As can be expected, due to geographical and linguistic proximity as well as close contacts between health care professionals in the countries, Finland has received the highest share of Estonian patients (36% of the total authorized cases in 2002-June 2005), followed by Germany (17%), Sweden (15%) and Russia (13%) (Table 2.4 and Annex B.1). Providers from other countries are mostly European, and have been treating only a few cases.

Looking at the total number of applications, Finland is still the country with highest number of applications (approximately one third of all applications, 48), of which 71% were granted authorizations. The second country of destination by number of applications is Russia with 34 applications, of which only 35% were granted authorizations. Rejections were mostly due to applications being made after the treatment had been received or if the treatment sought was not found to be evidence-based by the specialist panel.

Table 2.4: Number of applications for authorizations for treatment abroad granted by country. January 2002-June 2005.

	Granted	Not granted	Undecided	Withdrawn	Total	% Authorized	% of total authorized cases
Finland	34	10		4	48	71	36
Russia	12	19		3	34	35	13
Germany	16	5			21	76	17
Sweden	14	2			16	88	15
Unspecified		4		2	6	0	0
Denmark	3	1			4	75	3
Czech Rep	3				3	100	3
Foreign doctor to Estonia	3				3	100	3
Belgium	1	1			2	50	1
Netherlands	2				2	100	2
UK	2				2	100	2
Ukraine	1		1		2	50	1
Austria	1				1	100	1
Lithuania	1				1	100	1
Latvia	1				1	100	1
Norway	1				1	100	1
USA				1	1	0	0
Total	94	42	1	10	148	64	101

Source: EHIF 2005a. Data obtained for E4P case study

Although referral abroad is mostly based on existing professional contacts, in some cases the EHIF has assumed a more active role, comparing prices from different providers in several countries before agreeing a destination with the patient. In one case, for example, a patient with an ophthalmic malignancy went to Prague rather than to a UK provider, which had been the original preference. In another case, the referring hospital took comparative medical evaluations of the case, descriptions of proposed treatment and price-references from three hospitals in different countries before the patient made the application to the EHIF (Peetsalu, Tarien. Interviews 2004).

Regarding continuity of care, patients with complicated cases (such as some child patients having had major cardiac surgery) have continued to be followed up annually by the foreign provider. The majority of cases, however, return to the care of Estonian providers. Continuation of care and transfer of medical information between the Estonian and foreign care provider have been facilitated by the EHIF requirement in the billing process – the invoice is paid to the foreign provider by the EHIF only when a short case history has been received by the Estonian referring provider.

2.2.5. Evaluation of the administration of the procedure

To evaluate the administration of the prior authorization procedure by the EHIF, we started with the availability of information about the procedure to insured persons and health care providers. The information is generally easily accessible on the internet website of the Estonian Health Insurance Fund[8], as evidenced by the growing number of applications every year. As identified earlier, the internet-based information seems to be less used by Russian-speaking residents. Applications can be submitted to any local office of the EHIF, or sent by mail. The administration is held centrally by designated EHIF staff working with the procedure, who are the main contacts for the insured as well as for the providers of care.

The target time for administering applications set by the EHIF is one month. During 2002-June 2005, 41% of decisions had been made within one month. 14% of decisions had taken less than two weeks (some even within a few days), and overall 63% of cases had been decided within two months. In 2004 and the first half of 2005, the process has speeded up. Although the total number of applications has increased sharply, most decisions had been made within a one-month period from the application being received by the EHIF (EHIF 2005a).

The EHIF has taken quite an active approach in the administration, requiring the opinion of the Estonian specialist panel and also by asking for price references from possible foreign providers before issuing the letters of guarantee. While on the one hand these requirements certainly contribute to the administrative burden, they do serve as a measure of cost containment.

[8] http://www.haigekassa.ee/kindlustatule/arstiabi_val/erandkord/

The requirement of the specialist panel's opinion on medical effectiveness included in the process could be seen as a hurdle for a patient seeking care abroad. However, in view of the effectiveness of public spending on treatments abroad as well as for protecting the patient from bearing travel-costs while seeking non-evidence-based care, the requirement of the panel's opinion has justified itself. For some of the patients the panel has turned out to be a source of information on existing treatment possibilities in Estonia, and patients have preferred treatment by local providers. In two cases, the application for treatment abroad turned into the foreign doctor coming to Estonia, and providing treatment locally in cooperation with a local medical team. In one case, the panel also advised treatment abroad, although similar treatment existed in Estonia. This was due to a conflict situation between the patient and the provider, followed by a loss of trust. In this situation, the specialist panel and the EHIF decided that it was in the interest of the patient to continue treatment abroad.

Looking at the administration on the provider side, in previous years the main contacts for the EHIF were treating doctors in the foreign hospitals. In recent years some of the providers (Karolinska University Hospital in Sweden and Helsinki University Hospital in Finland) have appointed foreign patient coordinators as contact persons for the treatment of foreign patients, and they administer the process from the provider side. The EHIF assesses that this considerably facilitates the administration of the procedure, and having a concrete contact in the hospital gives the provider a preferential position compared to other possible providers (Tarien, Interview 2004).

2.2.6. Experience with dental cash benefits

Allowing patients to freely select their dental care provider should, in theory, lead to more competition between the providers and to increased patient mobility in border regions where prices of Estonian health services are higher than in neighbouring countries (such as Russia and Latvia). There is some evidence that in urban border areas people are obtaining care in another country (Tapfer, Interview 2005). However, there is no information on the scale of this activity and it seems that those patients involved may not be claiming reimbursement. The EHIF has received only two invoices for dental care, from Russia and Latvia, in 2003 and 2004 (EHIF2005a). This could indicate a lack of information among the insured about their rights. As an aside, the number of foreign patients seeking dental care in Estonia is increasing steadily.

2.3. Use of health services abroad by the Estonian population

The EHIF data on mobile patients was complemented a population survey carried out in September 2004. The main aim was to try and discover the extent of emergency and elective health care abroad that was privately paid, and to learn about population attitudes, expectations and motivational factors regarding seeking treatment abroad (see Annex C for the overview of fieldwork, respondent structure, data processing and Estonian language questionnaire).

The results should shed light on the future potential for people seeking medical care abroad, the destinations they favour and why and how they would like to obtain information on

health services provided in foreign countries. As the survey was carried out concurrently with the annual health service satisfaction survey by the EHIF, using the same interviewers, further analysis was possible in correlating satisfaction with the health care system in Estonia and probability factors for seeking treatment abroad.

2.3.1 Overall experience with health care services abroad

It was expected that people would have little experience of treatment abroad, therefore the respondents were asked for their personal as well as family members' experience over the last three-year period. Findings confirmed that Estonian experience of health services abroad is very limited – only 2% of those aged 17 to 74 have experienced health services in a foreign country over the past three years and an additional 2% have a family member who has done so (35 respondents of total 980). In 25% of cases, the health care had been provided in Finland. The majority of cases had been due to a medical emergency. Most of those with experience abroad were young and educated, such as entrepreneurs or managers, and in most cases they either paid for the services themselves, or their company did (in a third of cases). Only in a quarter of cases did a private insurance company pay.

Surprisingly, no problems with language, access to information, speed of assistance or payment for services were reported by respondents. Fewer than 50% of respondents considered the treatment provided better than in Estonia, 21% found the quality of care similar and 17% were dissatisfied with the care provided.

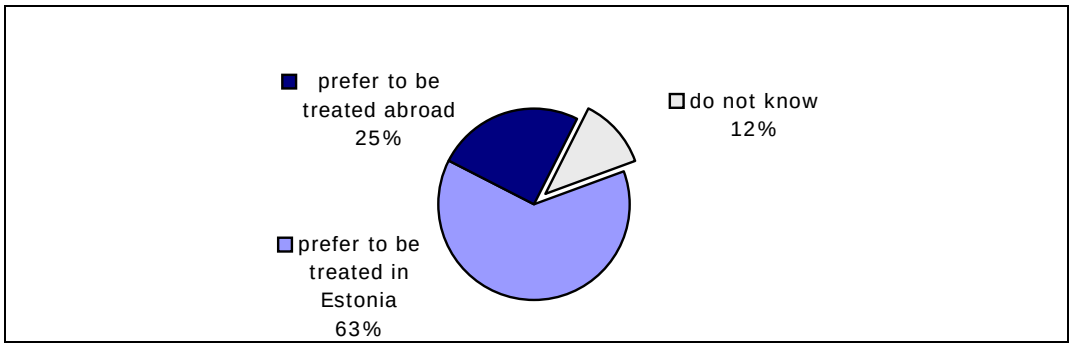
The small number of respondents did not allow for more analysis regarding existing experience.

2.3.2. Population attitudes towards seeking health services abroad.

The second part of the study dealt with the attitudes of the total population towards health services provided in a foreign country.

The respondents were asked if they could choose between health services provided in Estonia and in a foreign country (i.e. the payment procedure is similar, and Estonian co-payment rates would apply), which option they would prefer.
If the principles of payment were the same, 63% of respondents preferred to be treated in Estonia, and one quarter of the respondents would prefer to be treated abroad (Figure 2.1.). 12% had no definite opinion.

Figure 2.1.: Preference for the place of health services
% of all respondents, n=980



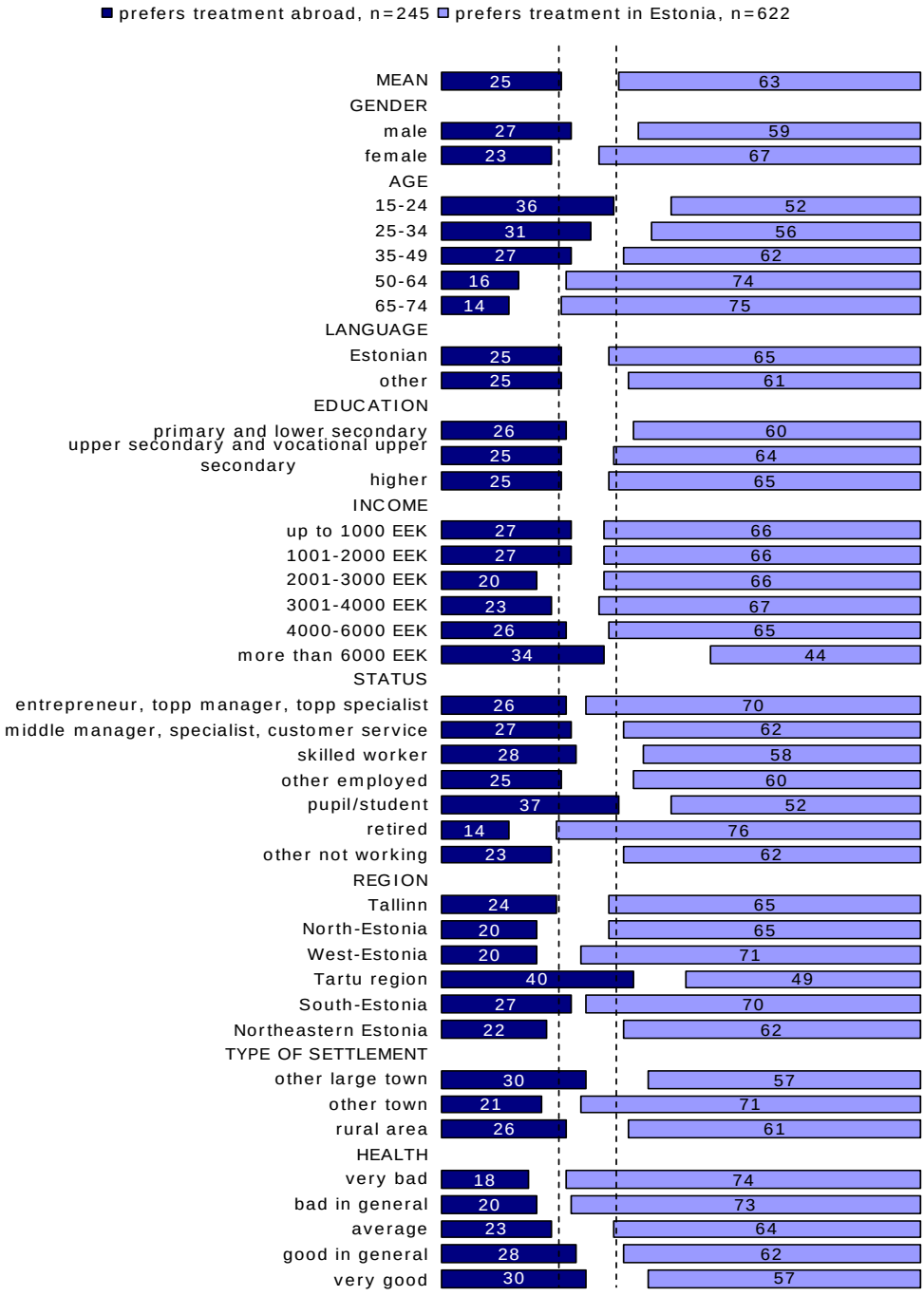
There is a difference in the preferences in the population groups' breakdown by socio-demographic indicators. As Figure 2.2. on page 23 illustrates, the preference for or against local service provision is mainly affected by the age of respondents – younger people have an above average preference for health services provided abroad, while the older population prefers local health services. While 36% of the respondents aged 15 to 24 prefer foreign services, only 14% of the population aged 65 to 74 would choose to be treated abroad. Also, men have an above average preference for receiving treatment abroad and women have an above average preference for the Estonian health services.

When these preferences were linked with the EHIF survey data on satisfaction with access and quality of the Estonian health care system, the results were not surprising: preference for place of treatment depends a good deal on how access to and quality of the Estonian health services are perceived. Those who preferred to be treated abroad believed the quality of the Estonian health services to be lower and the services less accessible.

In the case of extreme assessments of the quality of the Estonian health services, the gap between those who prefer foreign services is 12%. There are more people preferring treatment in a foreign country among those who believe that local health services are not always easily accessible. While 20% of those who are of the opinion that access to local health services is good or fairly good prefer to be treated abroad, 31% of the respondents who assessed the availability of local services negatively prefer foreign services.

Thus the share of those who prefer foreign services depends mainly on the image of local health services, which according to the results of the EHIF/FAKTUM 2004 population health care satisfaction survey is influenced mostly by people's satisfaction with the local specialist doctor system (EHIF/FAKTUM 2004). Differences in other background variables arise mainly from the age structure and satisfaction with the local health care system.

Figure 2.2: Preferences between local and foreign health services provision [9]
% of all respondents, n=980



[9] 1 EURO=15.6466 EEK

2.3.3.Reasons for seeking medical services abroad

To discover the reasons why people would consider treatment abroad and in which cases, the respondents were asked to pick five statements in order of importance from a set list of 10 possible reasons, starting with treatment not available in Estonia and different aspects that can be related to perceived quality of care.

Figure 2.3. on page 24 presents the results according to the two most frequently stated reasons. The overwhelmingly most common reason behind seeking treatment abroad is treatment not being available in Estonia, with 81% of respondents mentioning it among the five selected reasons, and half of respondents (54%) stating this as the first or second reason.

The next two reasons can be considered as influenced by perceptions of quality of local health care services: 69% of respondents stated better level of equipment as a reason to seek care abroad and 49% better care and more trust in foreign providers.

The fourth reason is the opportunity to receive an independent second opinion on the diagnosis or treatment plan (43%). As Estonia is a small country, this reason will persist, irrespective of perceptions on local quality. Other reasons (such as shorter waiting lists, more caring attitude towards patients, unreliability of the Estonian providers, wanting choice) received considerably fewer mentions.

Analyzing the results and statements by different population groups, there were marked differences.

Better equipment was mentioned as a reason for seeking medical help from abroad more often by Estonians than by non-Estonians (72% vs 63%); more often by women than by men (73% vs 65%), and more often by people with higher education than by people with primary and lower secondary education (76% vs 67%). Equipment received fewer mentions from people of retirement age (59%).

Better and more reliable treatment was mentioned more often by the younger population: by 61% in the youngest age group and by 38% in the oldest age group. The gap between the opinions of those who consider their health better and those who consider their health worse was 16-17%. Also, the non-Estonians mentioned this reason more often than the Estonians (55% vs 47%). This reason was also mentioned an above average number of times by students/pupils (76%), inhabitants of the north-east of Estonia (66%) and larger cities (except Tallinn -58%).

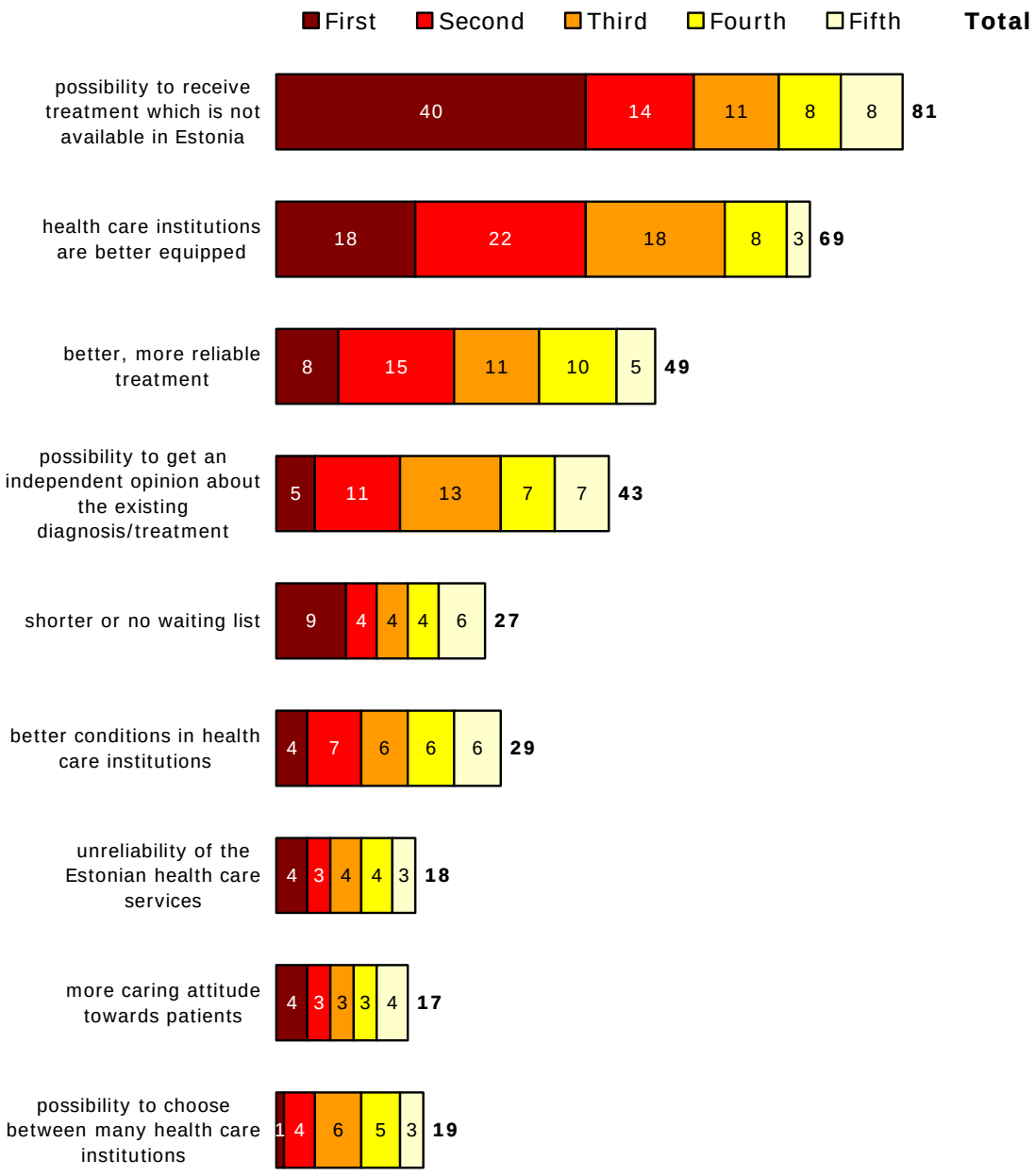
Unreliability of the treatment provided in Estonia received an above average number of mentions as a reason for seeking medical help abroad from younger respondents (the gap between the youngest and the oldest age groups being 17%), by those who considered their health very good (+13%), students/pupils (+8%), inhabitants of larger cities (except Tallinn)

(+8%), and inhabitants of western Estonia and north-eastern Estonia (+7% and +6%). The inhabitants of the north of Estonia mentioned this reason less often (-10%).

An opportunity to get an independent assessment of the existing diagnosis or treatment was mentioned more often by Estonians (Estonians 45%, non-Estonians 37%), and by respondents with higher education (55%).

Shorter or no waiting list was mentioned more often by inhabitants of smaller settlements (34% in the country vs 15% in the capital) and by Estonians (Estonians 30% vs non-Estonians 19%).

Figure 2.3. Reasons for seeking medical help abroad
% of all respondents, n=980



Better conditions in medical facilities as a reason for seeking medical help from abroad were mentioned more often than average by the inhabitants of north-eastern Estonia (+10%) and larger cities (except Tallinn) (+9%).

A more caring attitude towards patients was mentioned more times by non-Estonians than by Estonians (23% vs 14%), and more often by students/pupils (+10%), inhabitants of north-eastern Estonia (+10%), the respondents in the youngest age group (15-24) (+8%), and by people with primary and lower secondary education (22% vs 14% of people with higher education).

An opportunity to choose between many medical institutions was mentioned an above average number of times by younger respondents (the gap between the youngest and the oldest age groups being 10%); entrepreneurs, top managers and specialists (+8%); inhabitants of north Estonia (+7%) and men (+5%). The inhabitants of north-eastern Estonia mentioned this reason less often (-7%).

2.3.4. Preferred destination country to obtain treatment

Respondents were asked to name spontaneously their preferred country for getting health care outside Estonia. Almost half of respondents (46%) do not have any spontaneous preference, 9% would expect a suggestion from doctors, and 9% would not prefer any country to Estonia. From countries named, Finland was the most frequent (21% of spontaneous responses).

When asked again, there was an expected difference in preferences between language groups: while those speaking Estonian as a mother-tongue preferred Finland (50%), Sweden (31%) and Russia (4%), among the Russian-speaking population the respective preferences were 18%, 15% and 32%.

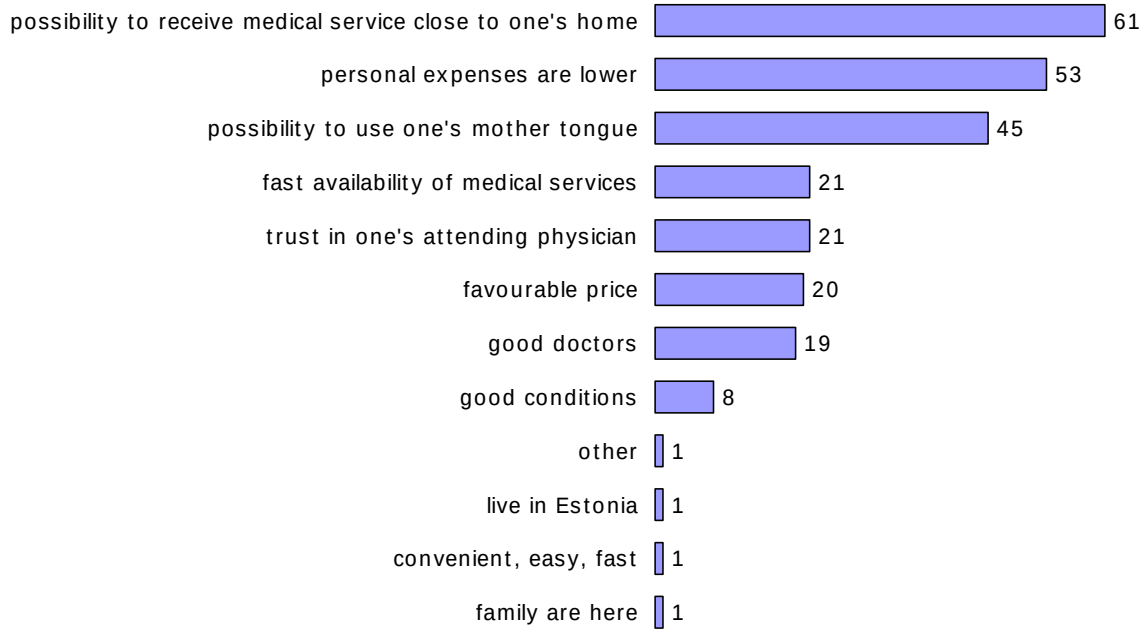
Those who had a concrete preference as a first spontaneous response were asked to explain their preference according to different criteria. While the most common reason given for preferring Finland was closeness, for Sweden and other EU countries it was the general high level of health care. The main reason for those preferring Russia as a country of destination for treatment was ability to cope with the language.

2.3.5. Reasons for preferring locally provided services

In order to find out to what extent people prefer the health services provided in Estonia, the group of respondents who preferred the Estonian services (63% of all respondents, Figure 2.2 earlier) was asked to mention spontaneously up to three of the most important reasons why they preferred the Estonian services.

The reason mentioned most often (in 61% of cases) was the opportunity to receive treatment close to home (Figure 2.4). Lower personal costs (53%) and the possibility to speak in one's own mother tongue (45%) were also mentioned more often than average. Other reasons were mentioned less often.

Figure 2.4. Reasons for preferring the Estonian health services
% of those who prefer to be treated in Estonia, n=622



Analyzing by different socio-demographic groups, the opportunity of using health services close to home is considered more important by younger respondents: this factor was mentioned by 69% of 25 to 34 year old respondents and 55% of 50 to 64 year old respondents. This reason was mentioned an above average number of times by people with higher income (3000-4000 EEK[10] per household member in a month) (71%) and by the inhabitants of Tallinn (66%). These may be the people with busier lifestyles.

Lower personal costs were mentioned most often by the inhabitants of north-eastern Estonia (+18% as compared to the average), non-Estonians (+12%), people with lower income (1001-2000 EEK per household member) (+11%), other employed persons (+11%), retired persons (+9%), and inhabitants of smaller towns (+7%).

More favourable price was mentioned more by non-Estonians (26% vs 18% of the Estonians). In addition, this reason was mentioned by people who were not employed (28%).
The opportunity of speaking in one's mother tongue was more important for Estonians than for non-Estonians (50% vs 32%), for older respondents (the difference between age groups being 12%) and people who considered their health condition worse (51% vs 37% of those

[10] 1 EURO=15.6466 EEK

who considered their health to be good). Also, this factor was mentioned an above average number of times by retired people (55%), inhabitants of smaller towns (56%), and inhabitants of Tartu and south Estonia (59 ja 63%). In the capital and in other larger cities the respective shares were 37 and 36%.

Quick access to health services was mentioned as a reason for preferring to be treated in Estonia more by women, by people with a monthly income per household member of 3000 to 4000 EEK (23% compared to 12% in the group with the lowest income) and by people whose health condition was better (difference 23%).

The professionalism of Estonian doctors was mentioned an above average number of times by the older population: of 50 to 64 year-old respondents a quarter and of 65 to 74 year-old people 22% mentioned this factor. Younger people who said an above average number of times that one of the reasons why they preferred to be treated abroad was because they trusted local doctors less, also made fewer mentions of the professionalism of local doctors as one of the reasons for preferring the Estonian services. Local doctors are preferred for their professionalism by the rural population (26%), inhabitants of west Estonia (39%), and by entrepreneurs, top managers and specialists (27%). This factor was less often mentioned by inhabitants of south Estonia (7%) and north-eastern Estonia (10%), and by other unemployed persons (12%).

2.3.6. Probability of seeking medical help abroad

All respondents were asked to assess the probability of seeking (or considering seeking) medical help abroad on a 7-point scale where 1 = definitely not and 7 = definitely. The respondents were asked to assess their behaviour in four different situations:

A: Health service is not available in Estonia and the Estonian Health Insurance Fund pays for using the service abroad.
B: Health service is provided in Estonia, but the Estonian Health Insurance Fund also pays for using the service abroad.
C: Health service is not available in Estonia and the patient pays out-of-pocket for using the service abroad.
D: Health service is provided in Estonia and the patient pays out-of-pocket for using the service abroad.

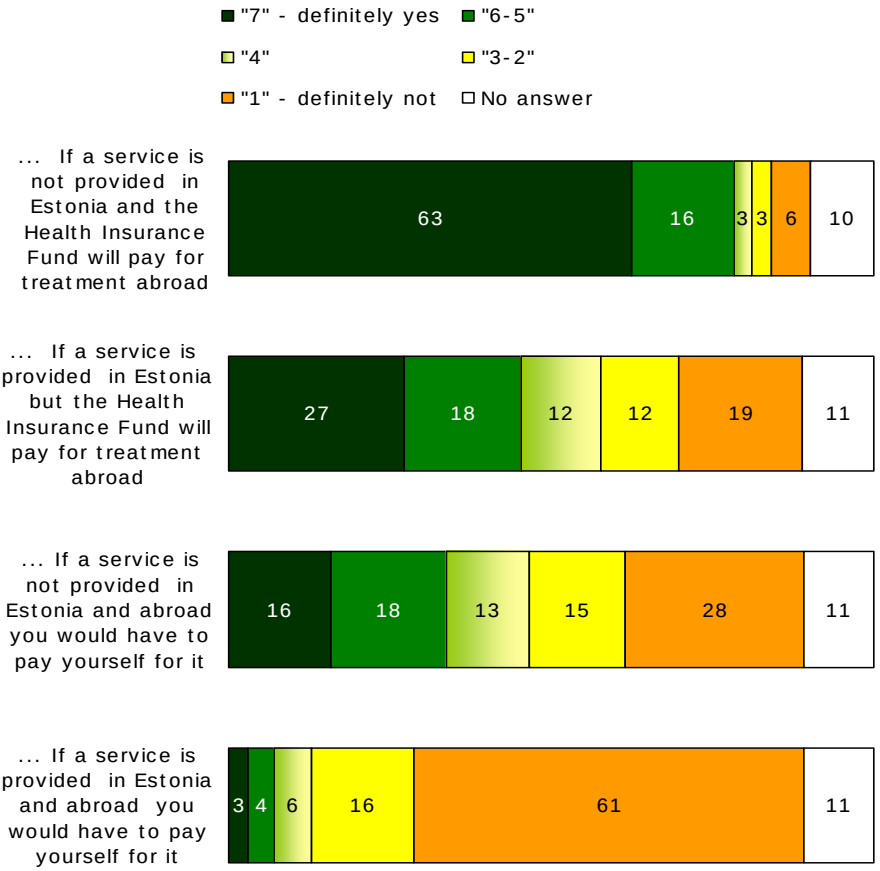
Thereby two possible motives for seeking medical health abroad are combined in different versions. This allows an assessment of how much a decision to seek medical help abroad is affected by whether the service is paid by the patient or by the Health Insurance Fund - the payment or reimbursement factor; and how much the decision to seek medical help abroad would be affected by whether or not the service was provided in Estonia – the factor of health service availability.

The results, broken down by question, are provided in Figure 2.5. As expected, the likelihood of seeking medical help aboard was the highest in a situation where on the one hand a service was not available in Estonia (which puts people in a forced situation) and on the other hand

where people have minimal personal expenditure because the service is paid by the Estonian Health Insurance Fund. In this situation, 79% of the respondents considered it fairly likely that they would seek medical help abroad (7-5 on the scale).

If a service was available in Estonia, yet the Health Insurance Fund still paid for using the service abroad, 45% of the respondents would be more likely to consider seeking medical help abroad.
If a service was not available in Estonia and the patient would have to pay himself/herself for using the service abroad, 34% of the respondents would be more likely to consider seeking medical help abroad.

Figure 2.5. Probability of seeking medical help abroad
% of all respondents, n=980



The difference between the two first columns on Figure 2.5 indicates that a big part of the population would not seek medical help from abroad if the service was available in Estonia and the payment terms were the same. Based on the assessment's 5 to 7 points, 34% of the respondents would not seek medical help from abroad if the service was available in Estonia.

The difference between the first and the third option is in payment for services. If a patient had to pay himself/herself, 46% of the respondents would give up the plan to seek medical help abroad.

Thus, the likelihood of seeking medical help from abroad is somewhat more affected by the factor of reimbursement or public payment than by the availability of the service in the local health care system.

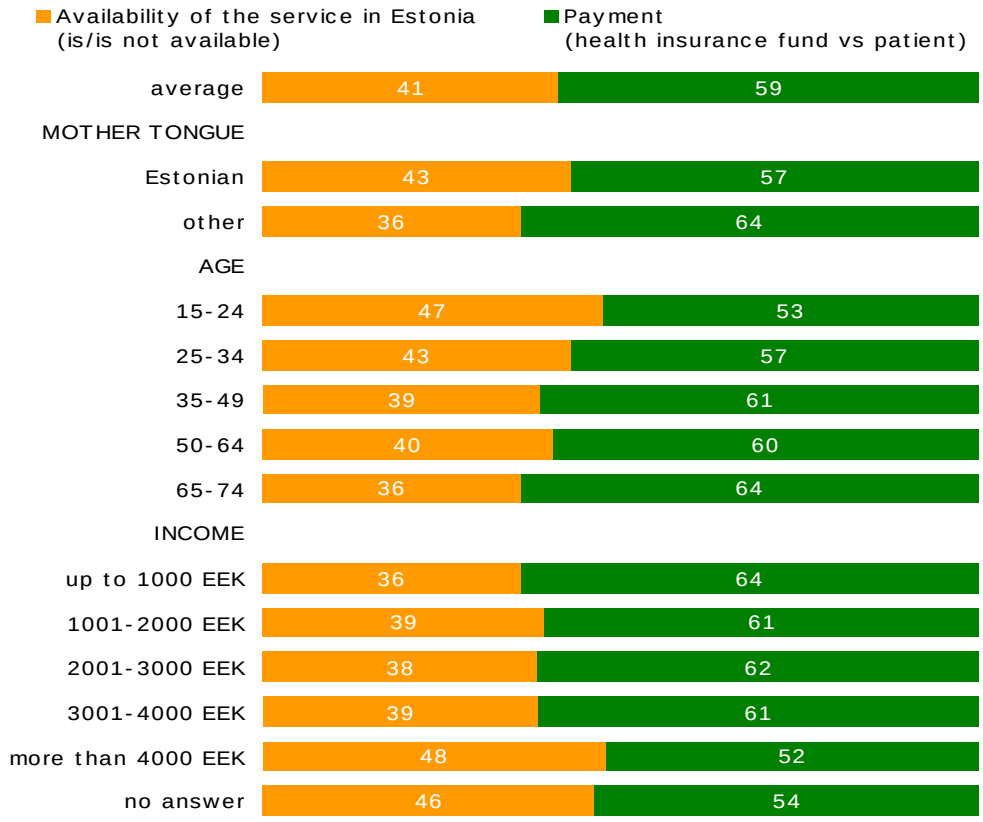
In order to explore the effect of these elements, we measured their relative importance by a conjoint analysis. In the analysis, we compared the combinations of all important factors (four versions). The aim of the analysis was to find out what the relative importance of the used factors (payment and availability of service) is in the decision making process.

The conjoint analysis revealed that a decision on whether or not to seek medical help abroad is affected most by who is paying for the service, the patient or the Health Insurance Fund. The values of the conjoint analysis are 59 concerning payment and 41 concerning availability. Figure 2.6 illustrates the results of the conjoint analysis broken down by respondent groups.

As compared to the average, the factor of payment affects non-Estonians and older respondents more and Estonians and younger people and people whose monthly income per household member is more than 4000 EEK (€ 255)[11] less. In the breakdown of income groups up to 4000 EEK the deviation is fairly stable. Changes are more significant in the highest income group. Thus, starting from this income group, the possibility of seeking medical help abroad and paying for it himself/herself is perceived as more realistic.

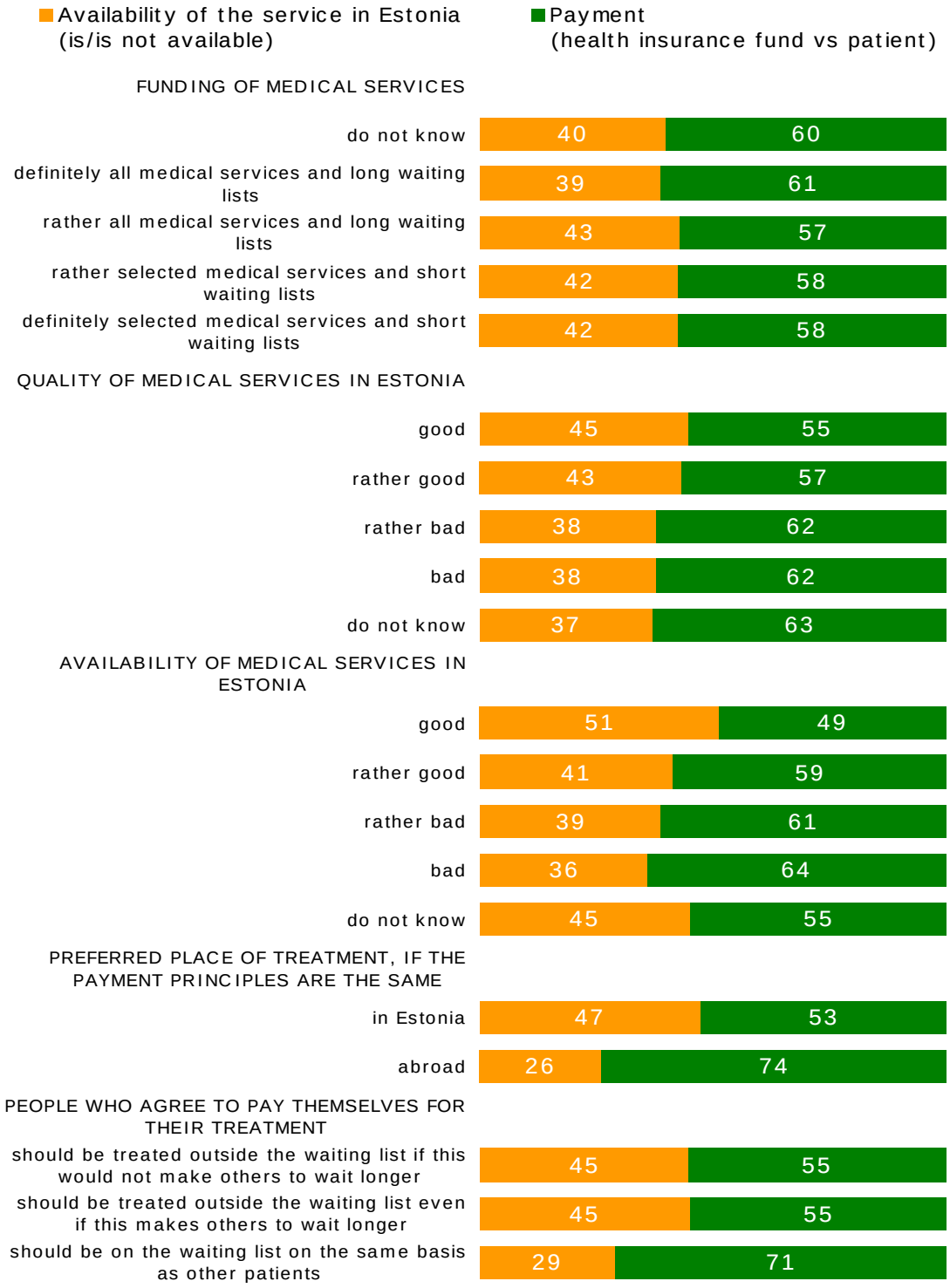
Figure 2.6. Relative importance of factors determining the probability of seeking medical abroad (broken down by socio-demographic indicators), values of conjoint analysis, all respondents, n=980

[11] 1 EURO= 15.6466 EEK



The results of the conjoint analysis are also provided by groups who offered different assessments of the quality and availability of health services provided in Estonia; by preferred destinations; and attitudes towards jumping the waiting list when paying privately. The results of the analysis as compared to the average are provided on Figure 2.7.

Figure 2.7 Relative importance of factors determining the probability of seeking medical help abroad (broken down by attitudes), values of conjoint analysis,



Whether a decision to seek medical help abroad is affected more by the availability of the service (the service is provided or not provided in Estonia) or by payment terms (paid by the patient or by the Health Insurance Fund), depends also on the assessment of access to health services in the local health care system.

For those respondents who consider access to health services in Estonia good, the factor of availability is even more important than the payment. At the same time, for those who consider access to health services in Estonia poor, the factor of payment is more important. Here we can see the attitude that as health services are not available in Estonia, seeking medical help from abroad becomes more important. However, the issue of payment remains, and this is the most important relative factor among other factors affecting people's behaviour.

Thus, with regard to those respondents who are less satisfied with access to health services in Estonia, the factor of availability affects a decision to seek medical help abroad less. The situation is similar regarding the quality of local health services. However, the relationship is less visibly expressed.

2.3.7. Sources of information

Respondents were asked to select up to three preferences out of a given list of 10 possible sources from where they would like to obtain information on treatment opportunities abroad. An overwhelming majority of respondents (47%) named their family practitioner as the first preference, and 67% of respondents named family practitioner among their three preferences. This was followed by specialist doctor as a source of information, and the Health Insurance Fund (35% named among three sources of information). Internet search was mentioned by 31% of respondents.

The internet as a source of information had the biggest differences when analysed by population groups. The difference between younger age groups mentioning the internet to older ones was 37%, and difference between students and pensioners was 40%. The internet was also preferred more among higher income groups (income over 3000 EEK per family member).

2.4. Conclusions

In conclusion, it can be said that patient mobility has been regulated in Estonian legislation, and the procedure for granting prior authorization for treatment abroad is a well established procedure administered by the Estonian Health Insurance Fund.

Year-by-year a growing number of applications show that information about the procedure is known to the providers and is also easily accessible to the insured persons. The same cannot be said, however, for mobility related to dental care, which is reimbursed to insured persons as cash benefits. The marginal number of reimbursement requests when dental care has been provided in Russia or Latvia may indicate that insured persons are not aware of the reimbursement possibility, and more information on their legal entitlements is needed.

The growth in application numbers also shows that patients are now taking more initiative in seeking alternative treatment options, even when the treatment is available in Estonia. With the aim that evidence-based treatments should be provided, Estonia has introduced a requirement of the opinion of specialist panel as part of the procedure for granting prior authorizations, which has not supported applications for treatments for which medical evidence has not been available.

Although the EHIF has also taken price references to compare treatment costs in different destinations, mostly the provider of care is selected based on existing professional contacts between providers or due to earlier good experience.

The study indicated that interest in seeking health care abroad is likely to increase in the future. Should services abroad be fully reimbursed, applying Estonian rates of co-payment, as many as 25% of the population would prefer, in a hypothetical situation, treatment abroad. These were mostly young, educated, and healthy. Even in the town of Tartu, which has the only university medical faculty in Estonia, 40% of respondents state a preference for medical treatment abroad. Those people who were less satisfied with the Estonian health system were more likely to want to move.

The three main reasons for seeking treatment abroad were for treatment that was not available in Estonia, to attend facilities abroad that were perceived to be better equipped than those in Estonia, and to obtain a second opinion from an independent institution or doctor. Waiting lists, which are a factor in other countries, are less important in Estonia as they are not very long.

The findings from this survey paint a depressing picture of the popular perception of hospital equipment and quality and they also show that people are aware of differences in other countries. This should act as an incentive for national hospitals to strive for excellence and to work for greater local acceptance.

Even when people go abroad for care, they usually prefer the treatment to be carried out close to their home country. Finland and Sweden are the most popular destinations, Finland for its location and good connections and Sweden for both the high quality of its health services and

its good connections to Estonia. With respect to other EU countries, the high quality of health services was the factor most often cited. The hypothetically given preferred coincide with current experience of destination countries for treatment abroad.

When considering why people decide whether they would be willing to seek treatment abroad, the unavailability of particular services in Estonia is a significant factor, but even more so is coverage of the costs by the Health Insurance Fund. Thus, if current restrictions on public reimbursement of health services obtained abroad were to be lightened or lifted, the number of patients considering treatment in Sweden or Finland could increase significantly, with a loss of revenue to the Estonian health system. On the other hand, such contestability could in principle also provide additional motivation to Estonian providers to increase quality, efficiency and responsiveness.

The way people would like to receive information about health services abroad is largely from their personal doctor, either a family practitioner or specialist, or from the Health Insurance Fund.

3. Assessment of foreign guests' experience of, satisfaction with and expectations of Estonian health care

It has been difficult to obtain detailed information from health service providers on how much and which health services foreign visitors to Estonia have used. The existing data shows that this is quite rare as compared to the Estonian local population, as will be discussed in more detail in part 4 of the study.

A survey was designed to gain some insight into the frequency of foreign visitors using health services in Estonia, into their satisfaction with the services and into how much Estonian health care meets the foreign guests' expectations. Carrying out a foreign patient survey in hospitals and out-patient clinics is complicated, due to the rarity of cases, therefore experiences and opinions of foreigners staying in Estonian spas were sought. The spa guests were chosen for the survey for the following reasons: a) foreign guests in spas have a higher probability of using health services due to their pre-existing health condition; b) it is known that spas rent space to several out-patient clinics in dental care, ophthalmology and some others, making these services easily accessible to foreign spa guests; c) spa guests are more accessible for surveying than hotel guests, due to their longer average stays.

3.1. Spa sector development and use of spa services in Estonia

Spa tourism in Estonia is on the rise and is particularly popular among foreign tourists. The spa tradition goes back to 1865 when therapeutic mud was discovered in the west cost of Estonia and several health resorts, highly popular among the Russian aristocracy and Baltic Germans, were established in Haapsalu, Pärnu, the Island of Saaremaa and in the north of Estonia at Narva Jõesuu. The spas are situated mostly along the coastline of the Baltic Sea and on the biggest island.

The number of spas and spa accommodation capacity has increased in the last 10 years, as has the number of foreign tourists to spas, from 12,000 in 1994 to almost 200,000 in 2004. During the same period, most of the spas have expanded their product mix to complement pure health treatment with relaxation and wellbeing-oriented services. The bed capacity of spas in the Estonian Spa Association was 3900 in 2004, and the average occupancy was 71.4% (Estonian Spa Association, 2005).

Today, approximately 70% of Estonia's spa visitors are foreign tourists, who account for 27% of all foreign tourist overnight stays, staying on average six nights. According to a survey by the Turismimaailm Plc in 2005, 1.37 million foreign tourists stayed in accommodation establishments and spas in Estonia in 2004 (preliminary figures). Compared to 2003, the overall number of tourists increased by 262,000 (+24%). Tourists staying in the hotels of Tallinn account for almost two thirds of the increase, while spa tourists (mainly in Pärnu and near Tallinn) account for a quarter of the increase in Finnish

in-bound tourism. In total, spas accounted for 19% of Finnish tourists and 44% of Finnish overnight stays at all accommodation establishments in 2004. In 2004, spas accounted for 35% of Swedish overnight stays in Estonian accommodation establishments (compared with 26% in the respective period of 2003). Spas accounted for 15% of foreign tourists and 32% of their overnight stays in accommodation establishments. In terms of purpose of travel, tourism flows have increased mainly due to the expanding demand in holiday and wellbeing (SPA) segments (+34%) (Turismimaailm Plc 2005).

3.2. Objectives and methodology of foreign spa guest survey

The main study questions researched by PRAXIS in 2004 among foreign spa guests were use of health services in Estonia by spa guests, their satisfaction with the services, and general attitudes towards the Estonian health system as a potential provider of elective care. To increase the spas' interest in participating in the survey, questions related to choice of spa and satisfaction with spa services were added to the main research questions.

The survey was carried out using a respondent-filled questionnaire, which was distributed to the guests by spa reception and room staff. A quantitative survey method was used, and only a couple of questions allow any qualitative analysis. Unfortunately, open-ended questions were poorly answered.

To balance the possible difference between people staying in spas in different seasons of the year, the survey was carried out and data was collected in two rounds – in summer and in autumn 2004. Participating spas were selected based on their shown interest, while making sure that all main spa locations were covered. The questionnaire was prepared in Finnish, Swedish, English, German and Russian. For round two, the same languages were used, but the questionnaire was a bit shorter and its wording of some of the questions was clarified (English version of questionnaires in Annex D.3. and D.4.).

Round one was carried out from July to September 15, 2004. Six spas from four locations participated. Only customers (patients) outside Estonia were invited to participate. The number of respondents in round one was 229 (description of sample in Annex D.1), and out of these 77% were from Finland and 21% from Sweden. The response rate was 20%, calculated from the total number of foreign visitors staying in the participating spas during the period. The report refers to this round as opinions and experiences of summer guests (SG).

Round two was carried out in November-December 2004, and respondents are referred to as fall guests (FG). The questionnaire was slightly shortened, with some of the questions about customer satisfaction with spas removed. Four spas from three location participated. The number of respondents in round two was 155 (description of sample in Annex D.1.). The response rate was 30%.

The following map gives an overview of the locations of the pa as of the numbers of respondents by spa and season.

Pirita TOP:
SG: 52
FG: 32

Viimsi SPA:
SG: 32

Haapsalu
LAINE:
SG 34

Saaremaa
SPA Hotels:
SG: 39
FG: 24

Pärnu
Sõprus:
SG: 42
FG: 57

Pärnu Estonia:
SG: 27
FG: 42

The r vey rou d tw gether, but presented separa above st s in th sed.

3.2.1. Profile of Respondents

The share of women and men visiting spas and participating in the survey was quite similar in both rounds (Table 3.1.), with women dominating at nearly 70%.

Table 3.1. Respondents by sex

	Round 1-SG		Round 2-FG	
Male	54	23.6%	36	23.2%
Female	**158**	**69%**	**107**	**69%**
Missing	17	7.4%	12	7.8%

In the summer round, almost half of respondents (46.7%) belonged to the age group 56-70, and in the fall round the share was even higher at 57.4%. The mean age of respondents was 58 and 62 respectively. The median age in the two rounds was 60 and 64 years respectively.

Regarding employment status, corresponding to the age distribution of guests, in both rounds the majority of the respondents were retirees (46.7% of SG and 65.7% of the FG). By level of education, half of the SG (50.2%) stated having vocational secondary education, with the basic education group following with 24%. In the second round, the education distribution was more equal, with 33.8% having basic education, 29.7% having vocational education and 23.2% higher education.

The majority of the respondents in both rounds were from Finland and Sweden. In the summer period 75% of respondents were from Finland and 20% from Sweden. Patients from Sweden were represented with a bigger share in the fall period: during the fall period approximately two thirds of respondents were from Finland and slightly more than one third from Sweden (37%).

Table3.2. Respondents by country of origin

	Round 1- SG		Round 2-FG	
Country of origin	Frequency	%	Frequency	%
Finland	177	77.3	93	60.0
Sweden	47	20.5	57	36.8
Germany	1	0.4	-	
Russia	2	0.9	-	
Ukraine	1	0.4	-	
Total out of those responded	228	99.6	150	96.8
Missing	1	0.4	5	3.2
Total	229	100.0	155	100.0

The duration of stays in spas was similar during the summer and fall season, with the fall stays slightly longer compared with stays in the summer season (Tables in Annex D.2.). During the summer round, stays of four and seven days were most common (23.2% and 26.8% of respondents). During the fall, the most common length of a spa stay was seven

days (48.6%). 77% of respondents stayed in the spa for four to seven days. Every fifth person stayed in a spa for eight days and only four respondents (3%) stayed for two weeks.

The majority of foreign customers (89%) paid for the whole stay in the spa themselves. 9% of respondents were partially paying themselves for the whole stay in the spa. Only 3% (four out of 155, FGs) found someone else to pay for their stay in the spa.

3.2.2. Reasons for choosing to stay in the spa

Questions related to reasons for staying in the spa were asked to get information on whether the guests percieved the spa treatment more as a holiday or for seeking a health service recommended by a doctor.

In both rounds, the two main reasons for staying in spas were for vacation and general health improvement (Figure 3.1.for SG and Figure 3.2. for FG). For the FG, general health improvement as an aim was more important than having a vacation, which was the main aim of the SG. About every second guest stated having been recommended spa treatment by a doctor.

Figure 3.1. SG Respondents by the aim of stay in spa, % (n=229)

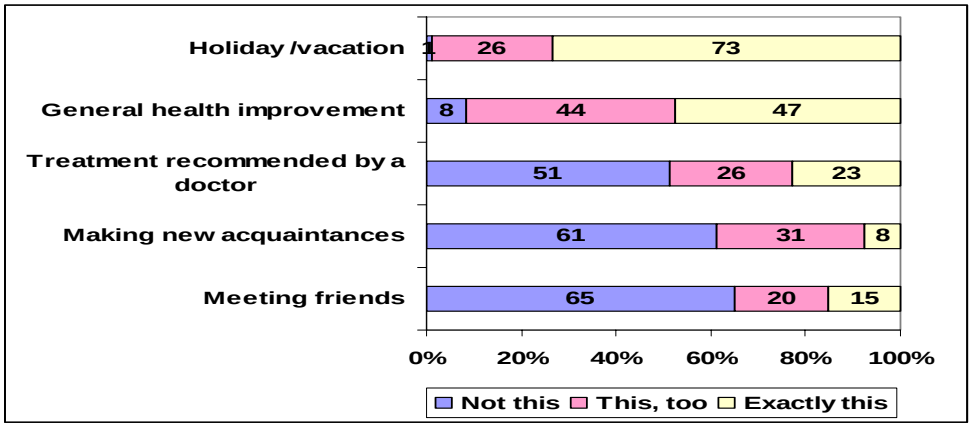
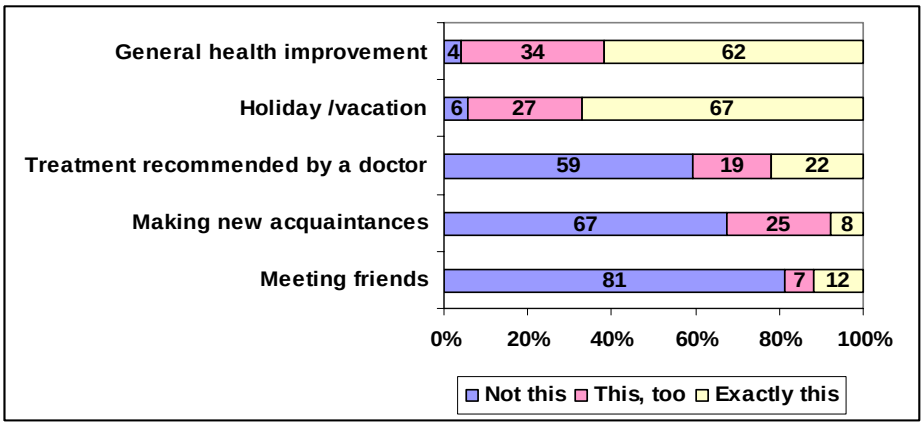


Figure 3.2. FG Respondents by the aim of stay in spa, % (n=155)



3.2.3. Choosing the spa

Questions related to selection criteria and sources of information were asked in order to discover which sources of information the guests used.

Among the SG, two out of three respondents got their information from a tourist agency, with about every second respondent in the spa using someone's recommendation, an advertisement, or being inspired by a positive experience from a previous visit (Table 3.3.). Out of SG no one was recommended this specific spa by a doctor.

Table 3.3. SG Respondents by the choice of the particular spa (% of the "yes", n=229)

Information from a tourist agency	65%
Someone's personal recommendation	58%
An advertising brochure	57%
Positive experience of previous stay	49%
Other, please specify	33%
Information from the internet	27%

Among the FG, slightly more than half of respondents had someone's personal recommendation or had read an advertising brochure. Nearly half had had a positive experience in their previous stay or had got information from a tourist agency. The internet as source of information was not significant, with only 6% having chosen the spa based on information on the net. Out of the FG only five percent of respondents were in the spa due to a doctor's recommendation (Table 3.4.).

Table 3.4. FG Respondents by the choice of the particular spa (% of the "yes", n=155)

Someone's personal recommendation	57%
An advertising brochure	54%
Positive experience from previous stay	44%
Information from a tourist agency	43%
Information from the internet	6%
Doctor's recommendation	5%

The data shows that personal recommendation is a very important factor for choosing a specific spa, and that seasonal variation was not important. Use of a tourism agency is expectedly low in the fall. Those out of the FG with a doctor's recommendation (only four respondents – three women and one man) stayed in the spa for four to seven days. One of them has already been to the same spa six times. Of these four two were from Finland and two from Sweden. Three of them have considered the possibility of coming to Estonia in order to receive elective or planned treatment and have made some preparations. One had used such an opportunity already.

In choosing the spa, the price/quality ratio is the most important criterion, followed by factors such as quality of service and location and surroundings (Table 3.5.).

Table.3.5. FG Respondents by the three most important criteria if choosing a spa (n=155)

Suitable price/quality ratio	131
Quality of service	96
Location/surrounding	91
Safety	56
Catering standard	45
Entertainment and recreation opportunities	32
Privacy	15

3.2.4. Use of spa health services

To get an understanding of health services offered by the spas and to make a distinction between the spa services and other health care services that the guests had experienced while staying in the spa, questions were first asked relating to the health services used as part of the spa treatment. This part of the questionnaire was shortened for the fall round of the survey.

As illustrated in the following Figures 3.3. and 3.4., water therapy was the most popular service among the SGs and guests remained satisfied with the service.

Figure 3.3. SG Respondents by the frequency of using different services in the spa, %
(n=229)

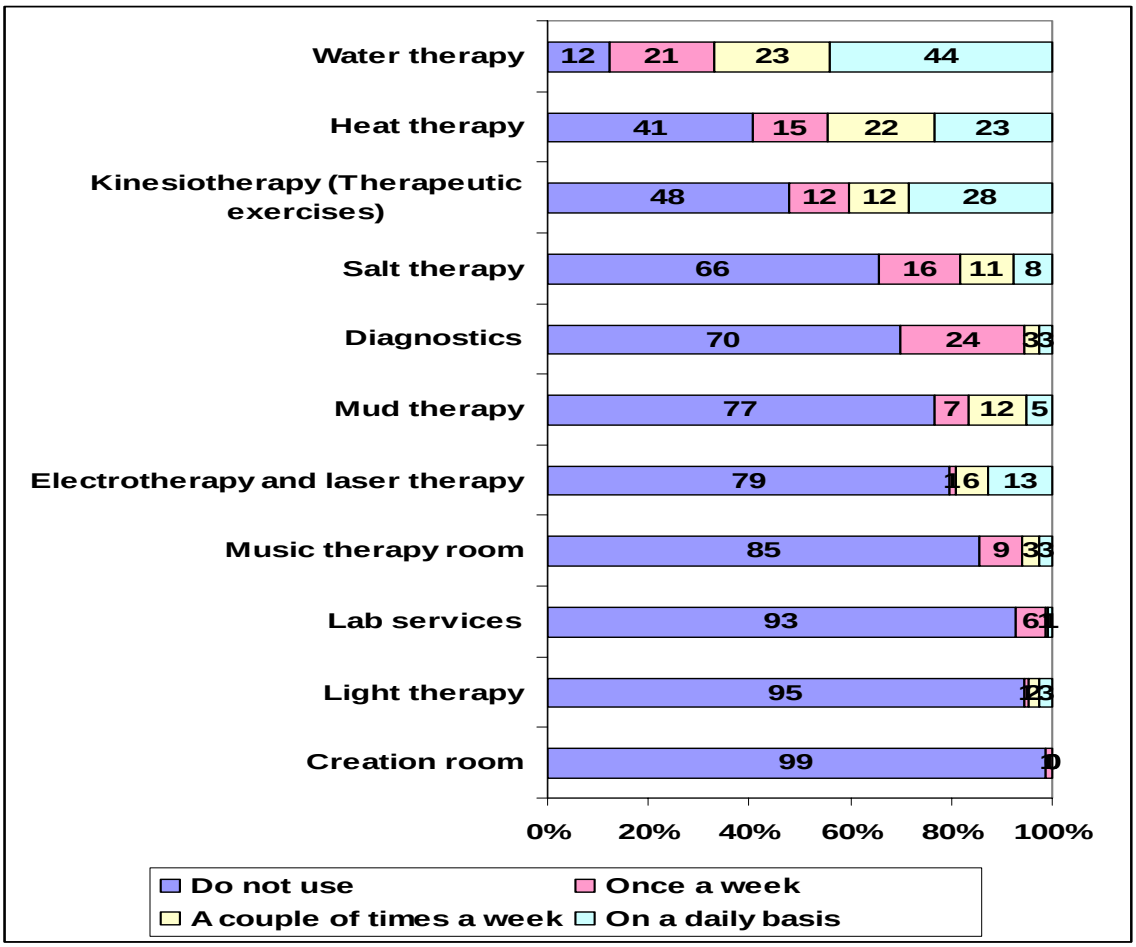
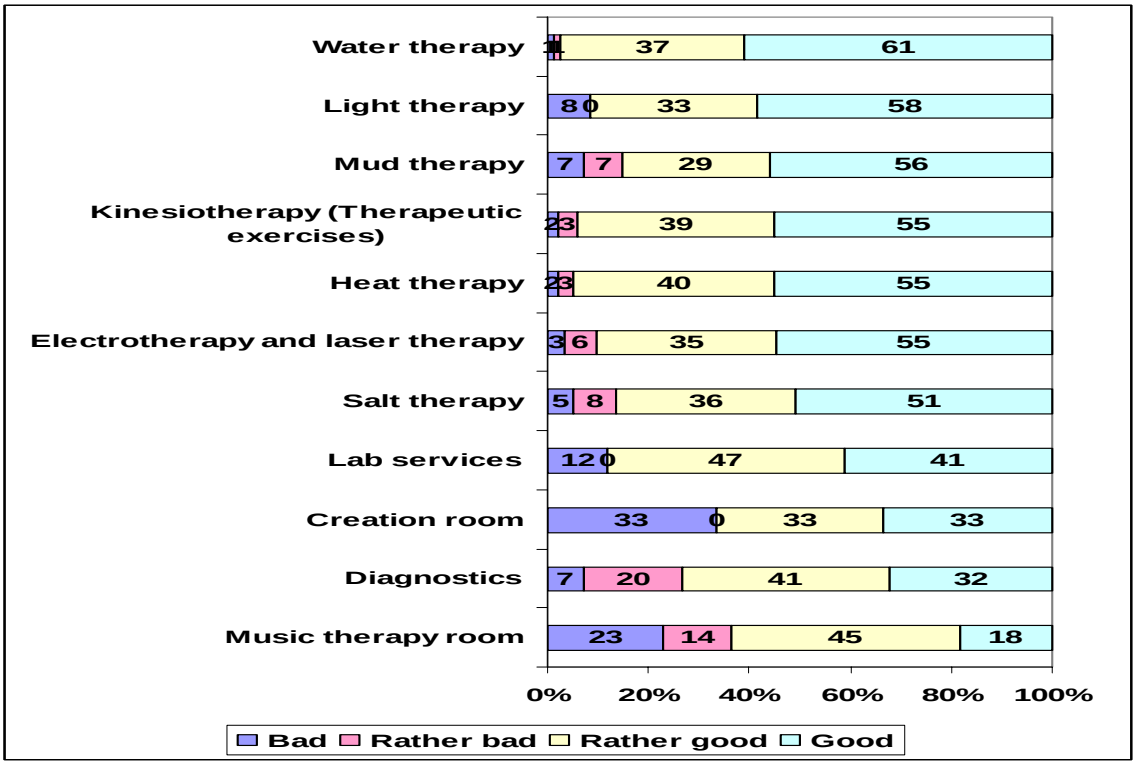


Figure 3.4.. SG Respondents by the satisfaction with the service , % (n=229)



3.2.5. Use of other health care services

Questions were asked relating to experience with other health care services not included in the spa package, and satisfaction with the service, in order to get information on the extent of use of the services in case of emergency, and possibly use of planned care such as dental care and other services. During the analysis of the first round results, some doubts were raised over whether the question had been properly understood by respondents, and the question was simplified for the second round of the survey.

During the summer season the most frequent treatment was for muscular-skeletal diseases (n=22). Emergency care was needed by eight summer guests (3.4%), and 12 people (5.2%) reported having had dental care in Estonia (Table 3.6.).

Table 3.6. Respondents by the kind of health care services and frequency used in Estonia, (n=229)

	generally not	seldom	once a year	more than once a year	Total
First aid	167	7	1		175
Dental care	166	7	5		178
Treatment of gynaecological diseases	168	2			170
Treatment of cardiovascular diseases	167	2		2	171
Treatment of bone and joint diseases	152	7	7	8	174
Plastic surgery	165	3	3	2	173
Other service	148	4	3	3	158

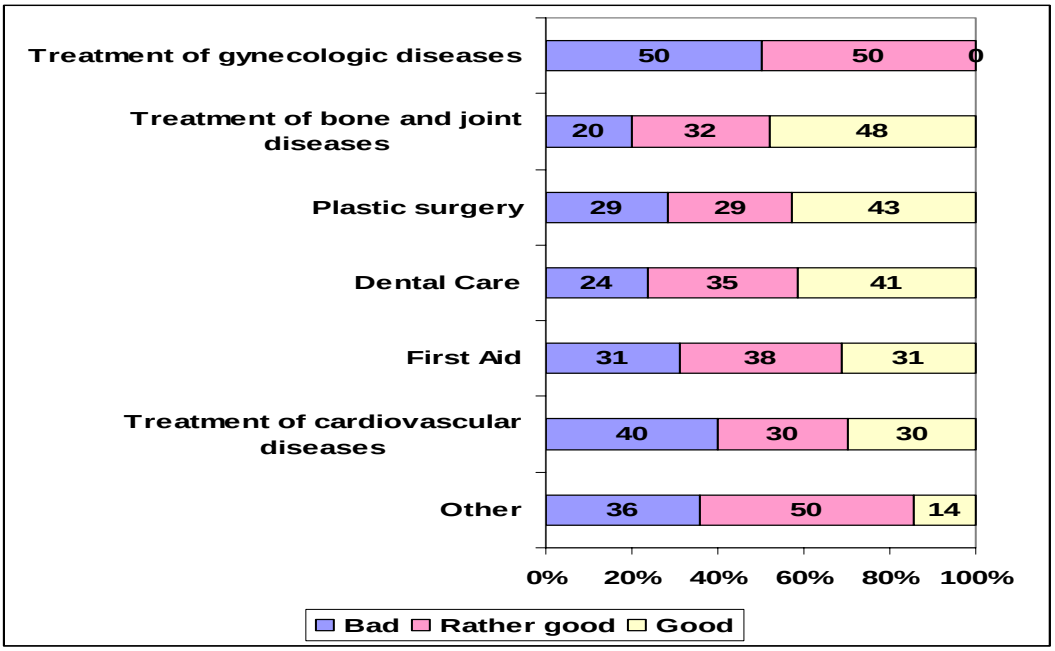
From the second round of the survey, 12% reported having seen a doctor for muscular-skeletal diseases, and 5% had had dental care. First aid was needed by 3% of the FG (Table 3.7.) One quarter of respondents of round two (FGs) had previous experience of medical treatment in Estonia.

Table 3.7. Respondents by the kind of health care services used in Estonia, % (n=155)

	Have used	Have not used
First aid	3	97
Dental care	5	95
Treatment of gynaecological diseases	0	100
Treatment of cardiovascular diseases	1	99
Treatment of muscular-skeletal system and arthritic diseases	12	88
Plastic surgery	2	98
Other	20	80

Regarding satisfaction with the services, unfortunately about every third patient of the small number of those with experience of health care services in Estonia was not satisfied with the service (Figure 3.5).

Figure 3.5. SG Respondents by the satisfaction with the service, % of those having experience.



3.2.6. Estonian potential as a patient-receiving country

Estonian potential as a patient-receiving country for elective treatments was explored with questions related to general perceptions of or attitudes towards different aspects of the Estonian health care system. The respondents were asked whether they had thought about coming to Estonia for elective care, and what the perceived obstacles were for doing so.

When the spa guests were asked whether they had considered the Estonian health care system as a potential provider of planned or elective care, half of the guests had never thought about it, and 20-40% in the different rounds had thought about coming to Estonia for scheduled treatment. Respondents from the fall period had thought about coming to Estonia for scheduled treatment less than respondents from the summer period. Respondents who definitely do not plan to come for scheduled treatment are also more prominent among the fall period patients (Table 3.8.).

Table 3.8. Respondents by consideration of the opportunity of coming to Estonia in order to receive scheduled treatment

	Round 1 - SG		Round 2 - FG	
	Frequency	%	Frequency	%
Certainly not	7	2.9	29	**18.7**
I have not thought about it	117	**49.2**	75	**48.4**
I have thought about it	94	**39.5**	32	**20.6**
I have made preparations	5	2.1	1	0.6
I have used the opportunity	3	1.3	4	2.6
I have thought about it and I have used the opportunity			1	0.6
I have thought about it, I have made preparations, I have used the opportunity			1	0.6
Missing	12	5	12	7.7

Levels of trust in the Estonian health care system were explored using questions regarding percieved quality of different aspects related to the input of health care delivery. There was no significant difference between the results in the two survey rounds, with 66-67% of respondents considering the comptetence of doctors “good” or “rather good”, and half of the respondents considering the other factors such as condition of institution, quality of medical equipment and materials “good” or “rather good”. 30-40% of respondents did not have either an opinion or experience and they responded with “don’t know” (Figure 3.6. and Table 3.9.).

Figure 3.6. SG Perceived quality of Estonian health care services, % (n=229)

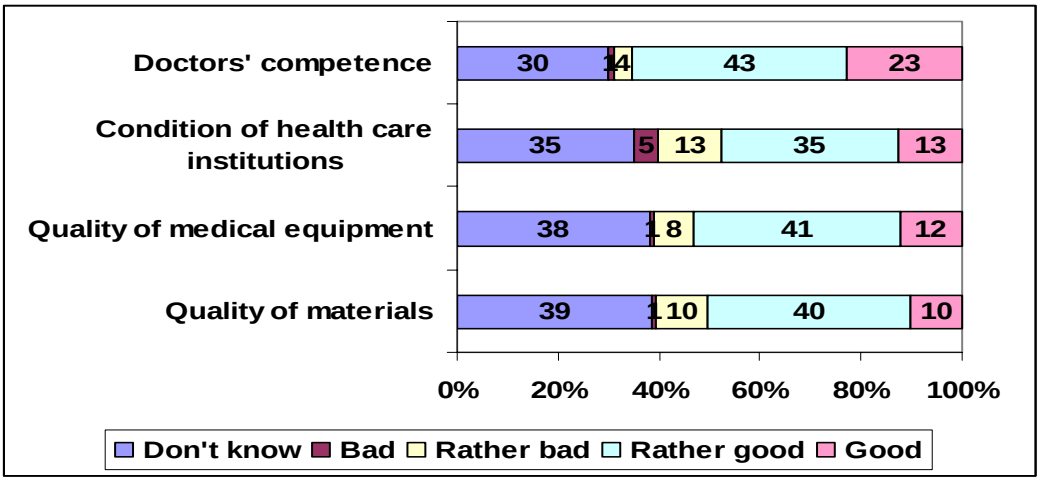


Table 3.9.Perceived quality of Estonian health care services "good" and "rather good", %

	Round 1-SG	Round 2-FG
Doctors' competence	66	67
Quality of medical equipment	48	50
Quality of materials	53	48
Condition of health care institutions	50	53

When asked about possible inhibiting factors for considering coming to Estonia for treatment, lack of adequate information was the most important factor (Figures 3.7. and 3.8.). Language barrier and a fear of doctors' inconsistent competence are the next ones. Language barrier was rather similar in both rounds. Language and communication cause problems for every third respondent. Factor analysis shows that the problem with the language barrier is bigger for the Swedish guests, because among the older generations English usage is poorer and among the spa staff service, people with knowledge of Swedish are rarer than staff speaking English and Finnish.

Figure 3.7. SG Respondents' estimation of the biggest obstacles for coming to Estonia for scheduled treatment, % (n=229)

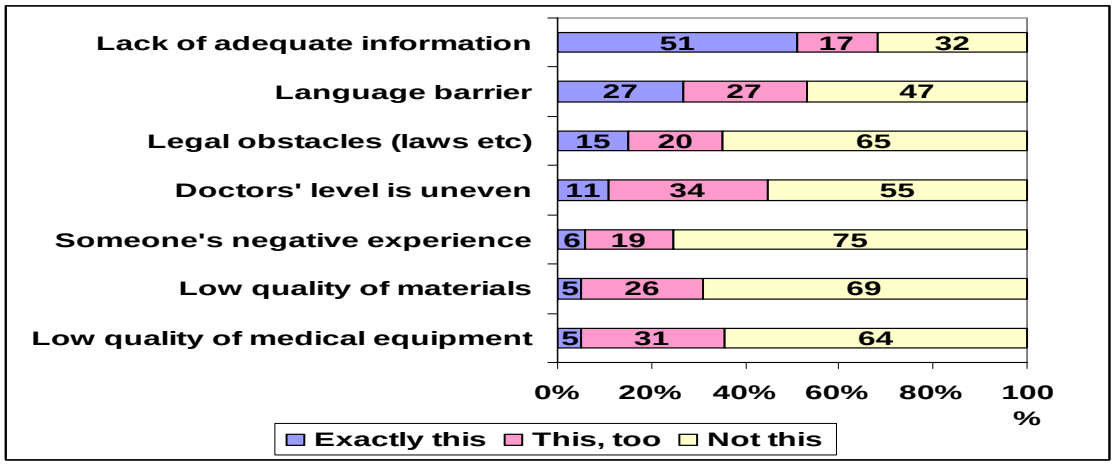


Figure 3.8. FG Respondents by the main obstacles for coming to Estonia for scheduled treatment, % nr (n=155)

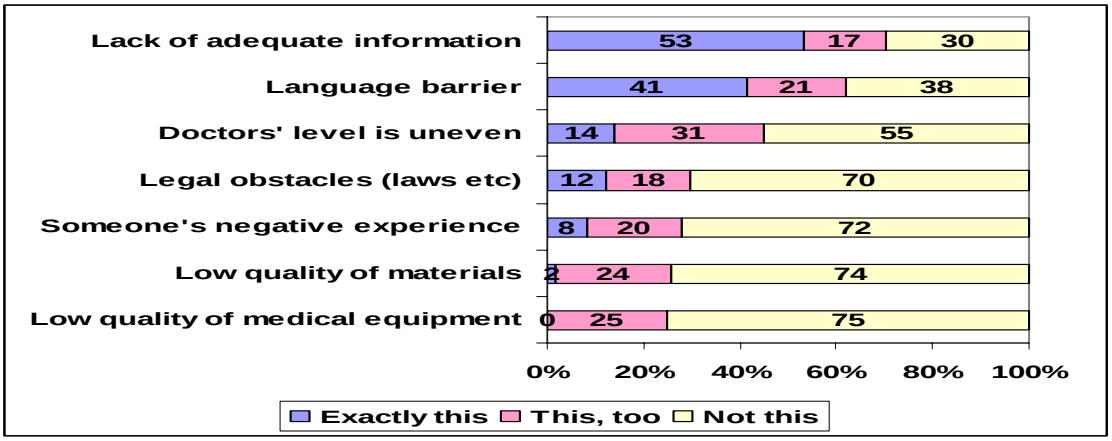


Table 3.10. Main obtsacles for coming to Estonia for scheduled treatment ("exactly this" and "this, too"), %

	Round 1-SG	Round 2-FG
Lack of adequate information	**38.4**	**36.7**
Doctors' inconsistent competence	20.1	16.8
Low quality of medical equipment	15.3	9.0
Low quality of materials	13.1	9.6
Legal obstacles (laws etc)	15.3	11.0
Someone's negative experience	10.9	10.9
Language barrier	**31.4**	**32.9**

3.3. Discussion and conclusions

The survey was a first attempt in Estonia to discover the extent of health service mobility, satisfaction levels with the services and Estonian potential as a patient-receiving country from a foreign guest's point of view.

The spa guests were chosen as a study group due to the higher probability of these people also using other health services, and because of longer stays when compared to hotel guests. The survey was carried out in two rounds in 2004 and provided valuable information on the study questions. Our research team was fully aware of the high proportion of leisure guests in spas, but it was expected that people who needed medical treatment would also be among them. From the other side, a guest's satisfaction levels with the spa services can also serve as an indication of a patient's satisfaction and readiness to come to an Estonian hospital for planned treatment. However, clearly the frequency of using health services in Estonia among the spa guests is higher than among foreign visitors in general, and the frequency of using health services by other tourists to Estonia is less than in the study being reported hereby.

The overwhelming majority of foreign guests were from Estonia's northern neighbour Finland (77% of respondents in the first round and 60% in the second), the second most important country of origin being its western neighbour Sweden (20% and 36% respectively). This shows that spa tourism to Estonia is regional, drawing in-bound tourism mainly from the Baltic Sea region. Among both summer and autumn guests, the main aim of the stay in the spas was for a holiday, with general health improvement a second aim.

As was expected, over half of respondents were in the age group 56-75, a group likely to require health services – both acute services as well as in management of chronic diseases during a longer stay abroad. However, the use of health services other than those offered as spa services remained quite low among the respondents. In both rounds, dental care stood out, with 5% of respondents having used it in Estonia. Although a higher frequency of use came out for orthopaedic services, this may include both elective orthopaedic consultations as part of spa treatment as well as with other health care providers. Health services had been needed in cases of emergency by 5% and 3% of respondents. Fall period patients have more experience of medical services in the spa. One quarter of respondents from the fall season had previous experience of medical treatment in Estonia. During the fall period guests gave more positive feedback compared to those who stayed in the summer period.

Levels of trust in the Estonian health care system were explored using questions related to percieved quality of input into health service delivery, such as training levels or the competence of doctors, equipment, materials and condition of institutions. While the doctors' comptence was seen as good by 66-67% of respondents, other aspects were seen as good or rather good by approximately 50% of respondents. However, 30-39% of respondents did not want to give an opinion, not having had any personal experience.

When asked about Estonian potential as a patient-recieving country for elective or planned care, most respondents had not thought about this possibility. The willingness to consider Estonian health care providers was higher among the summer guests, which may be related to the slightly lower age of respondents and the higher proprtion of Finns among respondents, who experience fewer language difficulties in Estonia than do Swedes.

The main obstacles for coming to Estonia for scheduled treatment were considered to be lack of adequate information and language barriers.

Based on this data, it can be said that although some mobility of health services is happening, it is on quite a low level. The biggest obstacle in considering treatment in Estonia is lack of information, with language barriers coming second. Aspects related to quality of input were not seen as potential obstacles in considerations.

Therefore, if Estonian providers were active in creating cooperation arrangements with public funders or provider networks in neighbouring countries, Estonia could have some potential for receiving patients from abroad.

The level of preparedness and current thinking of Estonian providers will be described in the following part of the report.

4. Experience of Estonian health care providers with foreigners

Estonia inherited an oversized hospital infrastructure from the Soviet Union. It had a total of 120 hospitals and far too many beds for the population, reflecting that hospital capacities were also planned for military purposes. The hospital reforms during the 1990s reduced capacity, renovated the existing infrastructure and created incentives for greater efficiency linked to increased decision rights by hospital managers. At the same time, licensing procedures were reinforced and the purchasing power of the EHIF strengthened, particularly through the introduction of diagnosis-related groups (DRGs) for hospital reimbursement (Jesse et al., 2004).

The persisting hospital overcapacity (to some degree), the constrained domestic revenues, coupled with the autonomy possessed by hospital managers, the ability of providers to retain earned revenue and the scope for competing on price with Scandinavian providers, could in theory motivate Estonian providers into attracting foreign patients. We were interested to learn about the existing experiences of Estonian providers in attracting foreign patients and if and how the foreign patients fitted into the strategic development plans of Estonian hospitals.

4.1. Methodology and data availability

As there are no previous studies or analyses/reports available on patient mobility between Estonia and other border regions, the first attempt was then to identify all possible sources of information, lists of providers with known experience of treating foreign patients, or providers with known plans for focusing on foreign patients. Lists were made of senior level hospital managers, members of professional associations and other relevant bodies for interviews in Estonia as well as in Finland.

In the very early stages of the research it was evident that there was no data available on foreign patients in the areas where patient mobility was expected to be most intensive, such as dentistry and cosmetic surgery, largely because data is not collected based on country of origin, but also because these providers were somewhat resistant to sharing information. The limitation of data also became evident in hospital discharge records where there is no information on the country of origin of the patient. The current hospital information systems contain data on the method of payment (private or EHIF), medical information (such as type of services, emergency or ambulatory, diagnoses based on ICD 10, codes of health services) and financial data. The best existing information source was the Estonian Health Insurance Fund, which receives invoices for reimbursement of care provided to foreign patients under regulation 71/1408 (including out-patient and in-patient care) from the health care providers.

In Finland there are several ways of identifying foreigners in Finnish health registers. Medical birth and abortion registers and hospital discharge registers will in future allow the recording of data on country of birth, language, nationality, and migration to Finland, with specific decision rules on how to identify foreign residents. However, there is no information currently available for identifying immigrants, asylum seekers or refugees, nor to indicate whether the patient is a visitor, health service seeker or is referred from another hospital that has a contract with the Finnish provider (Gissler 2005).

Interviews were conducted focusing on the following providers:
- Larger hospitals providing emergency and elective care with known experience of treating foreign patients (North Estonian Regional Hospital Foundation)[12],
- Hospitals in border regions (Pärnu Hospital Foundation[13], Valga Hospital Ltd[14], Ida Viru Central Hospital Foundation[15], East Tallinn Central Hospital Ltd)
- Smaller private clinics in Tallinn and Pärnu with known cross-border collaboration experience or future plans for it (Taastava Kirurgia Kliinik, Viruplatsi Medical Center, Dental Clinic Citymed in Tallinn and Villa Medica, Pärnu Dental Polyclinic in Pärnu)

The location of the main focuses for the case-study is illustrated on the following map.

We conducted 13 open semi-structured interviews with senior hospital managers, executives and members of the hospital management boards from the selected health care providers during December 2004 and May 2005. In order to minimize interviewers' bias, two researchers were present at the interviews.

[12] 1390 beds and serving northern part of Estonia; Estonian-Finnish border region

[13] New hospital, built in spring 2005 in popular spa and tourist area in Western Estonia

[14] Estonian-Latvian border region

[15] Estonian-Russian border region

4.2. Results. Limited in-and out-bound mobility was discovered

Data from 2004 reveals that the overall numbers of foreign patients treated in Estonia were relatively modest. For example, 157 patients were treated in Pärnu Hospital in south-western Estonia, with 755 in the regional hospital in Tallinn (Pärnu Hospital,2005; PERH,2005). Most were emergency cases, mainly from Finland and other Nordic countries comprising approximately 0.01 percent of the hospital budgets. The EHIF received 734 invoices for reimbursement of care provided to foreign patients under regulation 71/1408 (including out-patient and in-patient care) from the health care providers in 2004 (EHIF, 2004).

As reported by the hospital managers who were interviewed, public providers in Estonia seem to have no plans to actively seek elective patients from abroad. Their strategies seemed more reactive, stating that if a contract for hip replacements was offered, they would of course consider it, but they were not actively seeking it. Some cross-border cooperation initiatives in the areas of radiology and telemedicine were, however, underway.

A few private providers in orthopaedic and vascular surgery had actively been seeking patients and contracts for patients from abroad, especially from neighbouring Scandinavian countries. All those interviewed admitted having experienced difficulties

and resistance while trying to enter foreign markets, despite having worked themselves as specialists abroad. A certain lack of trust was noted among foreign colleagues. As a result, these providers have changed their strategies for attracting foreign patients from trying to market themselves directly to patients to instead adopting a strategy for building up relations with networks of private providers and "middle-men" in those countries.

The highest levels of patient mobility take place in price-sensitive areas such as dentistry and cosmetic surgery. Unfortunately, these were also the specialties where information on foreign patients was the most difficult to obtain, largely because data is not collected based on country of origin, but also because these providers were somewhat resistant to sharing information. In interviews, the managers of dental clinics in Tallinn and Pärnu estimated that the share of foreign dental patients treated in Estonian clinics is relatively modest, varying in their clinics from 5-30% of the total number of patients. The same prices are charged to foreign and local patients. Patients pay out-of-pocket and, in rare cases, use private insurance. Reportedly, the price of dental care in other Scandinavian and EU countries is 50-200% higher, with the greatest difference for prosthetics, orthodontic appliances and advanced dental surgical procedures (Postimees, 2005). Although most foreign patients come from Scandinavian countries (mostly from Finland and Sweden), increasing numbers of patients seeking dental care come from Norway and Russia (Mõttus, Interview 2005; Voll, Interview, 2005).

Very low foreign patient flows were also observed from the Finnish hospital discharges records, where only 0.09% from the total number of patients were foreigners (1173 patients) in 2003 and the majority of them from Sweden and only 5% from Estonia. Finns are also very likely to return back to Finland for care while temporarily residing or working abroad. The proportion is quite similar in foreign patients seeking care in Finland, comprising 0.05 % of the total number of patients in 2003.

4.3. Information availability to foreign patients and communication with foreign patients

All of Estonia's biggest health care providers have their own websites. Information directed at foreign patients or English or Russian language information on those is however limited.[16] Smaller providers such as Taastava Kirurgia Kliinik and Villa Medica, who have been more active in marketing their services to foreign patients, have more multilingual websites. However, even though the website for Villa Medica[17] is in five languages, all the prices for health services are in the Estonian currency EEK, with no equivalent in EUROs, which would give an easier price comparison basis to possible foreign patients. None of the interviewed representatives of providers said that they

[16] www.regionaalhaigla.ee; www.kliinikum.ee; www.itk.ee

[17] www.villamedica.ee

employed, or were planning to employ, interpreters. All providers rely on the language abilities of the current medical staff.

As a valuable initiative towards providing information to foreign temporary residents in Estonia, the Estonian Health Insurance Fund has published on its website, additional to family practitioners' contact details, their self-assessed language proficiencies. Overall, the EHIF website provides comprehensive information on the Estonian health and health insurance system in English.[18]

4.4. Cooperation between twin towns Valga-Valka on the Estonian-Latvian border

The most interesting and advanced plan for cross-border care is however not related to tourist flows, but to the twin towns of Valga and Valka on the Estonian-Latvian border. These adjacent towns are seeking ways to optimize facilities and health care staff across the border that divides them. The process offers a good example of both favourable and hindering elements for cross-border collaboration.

The Estonian-Latvian twin towns Valga-Valka, on the borders of the two countries, are on the way to developing true cooperation in cross-border health care delivery. The area of Valga is 16.5 km² and Valka 14.2 km². Populations are 15,330 and 7,100 respectively. Both towns are surrounded by counties with populations of about 30,000.

Historically, until the 19th century, the area now divided by an international border was just a small town, populated by Germans, Latvians, Estonians and Russians. The building of the railway in 1889 led to a doubling of the town's population over 20 years, and by the beginning of the 20th century Estonians represented the biggest nationality in the town. With the declaration of independence in 1918, both Latvia and Estonia claimed Valga as their own territory. The dispute was finally settled by international arbitration involving a British special envoy, who established the border between the two countries. The larger part of Valga, including the railway station, remained in Estonian territory. Unlike similar twin towns, Valga-Valka has no natural division such as river.

During the Soviet occupation, both towns developed their own social infrastructure, including two hospitals separated by a distance of about two kilometres.

After re-independence, both countries faced the same challenges of transition and reorganization of their health care systems, with a need for increasing efficiency of hospital-based care delivery. The problem is exacerbated in an area such as this that has experienced depopulation and internal migration to the capitals. In the mid 1990s, new premises for the Estonian Valga hospital were built, but about one fifth of the hospital

[18] www.haigekassa.ee

space still remains unused in 2005. At the same time, the facilities in the Latvian Valka remain outdated and in urgent need of renovation.

In the last few years, development of cooperation in hospital services has been on the agenda of regional cooperation committees in both countries. The main reason for this is the financial impossibility of maintaining two parallel on-call medical teams for this relatively small area, as well as the need to increase the efficiency of capital investments. Obstetrics was identified as the most suitable area for cooperation; the Estonian Valga hospital already employs a part-time bilingual Latvian specialist in gynaecology. Another area being discussed was a joint ambulance service: the Estonian side would provide emergency care for the whole area during the evenings and nights. The hospital expressed an interest in employing medical doctors and nurses from the Latvian side and, with 30% higher salaries on the Estonian side, there are ample financial incentives for the medical staff to agree to this cooperation (Valga Haigla, 2005). A big step forward in making the plans more specific was made on August 30, 2005, when Valga City Government opened a tender for working out a 10-year masterplan for the development of a joint plan for specialist, nursing and ambulance care provision (Valga Linnavalitsus, 2005). The development of the masterplan is financed by the EU Baltic Sea region Interreg III A programme.

Yet some administrative hurdles must still be overcome before the joint delivery of services can be implemented. Unresolved issues by the beginning of 2005 included questions of where birth certificates should be issued and what the country of birth should be for Latvian babies born on Estonian territory. Other issues include reimbursement mechanisms and the application of co-payment rates, both of which differ between Latvia and Estonia, a problem that still needs to be resolved (Tapfer, Interview 2005).

Although local newspapers on both sides of the border have reported on the developments, the public's views on this process are not yet clear. The general response appears to be one of "wait and see". This is probably because the process is not yet seen as concrete, with no firm proposals having been made.

4.5. Plans and perspectives for the near future

Many interviewed hospital managers suggested that collaboration between the providers and regions is a more effective strategy for building trust in competences than the single entry to the foreign health care market.

Providers consider patient mobility an opportunity, but are not developing strategies to explore the opportunities actively. Although the incentives provided by the autonomous status of public hospitals, payment mechanism and price differences could all favour in-bound patient mobility, few providers are actually pursuing these opportunities. Even private providers see the future of cross-border health service provision more as increased

choice for patients within a network of providers from many countries, than as entering into a competitive international health service market.

Several providers addressed the limitations of the existing capacity in terms of infrastructure and human resources, in order to focus more on foreign patients.

Surprisingly no major problems (language, access, quality of care) in treating foreign patients were mentioned. The biggest problem with foreign patients seems to be that people are not aware of their health or travel insurance status or limitations.

5. Patient mobility on the policy agenda: attitudes of policy makers & relevant stakeholders

Although patient mobility is relatively modest between Estonia and Finland, EU enlargement, ECJ decisions and the EU service directive have brought the issue onto the agenda of policy makers at national level. Our objective was to find out about the importance of the issue on the policy agenda and the compatibility of existing national legislation with EU regulations, in order to assess whether increased patient mobility is seen as an opportunity or a threat to the health system, and if future developments are planned in this regard. We interviewed eight policy makers, including the Estonian Minister of Social Affairs and top level managers from Estonian and Finnish Ministries of Social Affairs and Health, the Health Insurance Fund in Estonia and the Professional Medial Association.

Attitudes towards a patient's right to seek treatment abroad were cautious and mixed. All respondents interviewed referred to the lack of, and difficulties in obtaining, the relevant information about the issue and therefore the extent of the phenomena. The media in both countries has also shown very little interest in the topic so far, except for a few articles referring to single cases. However, these articles did not induce a subsequent wider public debate.

From the policy makers' perspectives, patient mobility is considered positive in many ways: it opens up new opportunities for patients, allows the best available resources to be combined in centres of excellence at a European level, helps to clarify what is meant by a European standard of quality of care, and provides insights into pricing policies elsewhere in Europe. As one of the respondents stated: "*People should get appropriate, high quality treatment with fewer bureaucratic obstacles"*. Some of the Estonian policy makers found discussions on patient mobility to be an opportunity for focusing on the financial sustainability of the current health care system and on the need to direct more resources into health care. Overall there was a consensus that patient mobility will very likely increase in the future, and policy makers are concerned about the financial

sustainability of the national health system once more patients start to seek health services in other countries.

Overall it could be said the approach taken by policy makers was more one of "let's not rock the boat but just wait and see" than actively pursuing enhanced mobility. Cross-border collaboration was strongly encouraged and supported. "*We support sensible cooperation like health technology assessment and e-health, keeping it on a realistic level where real added value at the European level can be achieved.*"

A point was made by two of the interviewed policy makers that before seeking to enhance patients' opportunities, EU Member States should make efforts for EU citizens to be able to use the already existing rights properly. Namely, in the first year after the introduction of the European Health Insurance Card (EHIC), there had been many instances when doctors in "old" Member States had not accepted the EHIC, not being aware that it is replacing previous E-forms, and also that the EHIC is issued in national languages.

All interviewed people stressed the need to know more about this phenomenon and to learn more about people's preferences, attitudes and experiences of using health services abroad.

From the professional associations' perspective, patient mobility was not considered an issue of concern and they were relatively confident that it will remain limited in the future as well. Health tourism on a mass scale was not considered realistic, although increasing mobility could be a result of better collaboration between professionals in different countries, allowing better access to advanced technologies, exchange of professionals and the treatment of rare diseases and cases in centres of excellence. Unfortunately this confidence could become ice-thin once people become more dissatisfied with national health systems, especially regarding the access and quality of care and being better informed about patient rights, quality of care and opportunities in other countries. According to the annual patient satisfaction survey in 2005 conducted by the Estonian Health Insurance Fund, nearly 90% of those who had used health services in Estonia were very or mostly satisfied with the care received. However there was a discordance between their personal experiences and their views about the system in general, with only 52% of the population considering access to care and 59% quality of health care as generally good[19] (EHIF/FAKTUM, 2004). The survey referred to in part 2 indicated that interest in seeking health care abroad is likely to increase in the future. Should services abroad to be fully reimbursed, at Estonian rates of co-payment, 25% of

[19] Results need to be interpreted with some caution, as the survey coincided with difficult negotiations between the insurance fund and the physician association, while the media coverage emphasized long waiting lists and questioned the quality and sustainability of the system

the population would prefer treatment abroad. These were mostly the young, educated, and healthy. Even in the town of Tartu, which has the only university medical faculty in Estonia, 40% would prefer medical treatment abroad. Those people who were less satisfied with the Estonian health system were more likely to want to move.

In contrast, the Finnish health care system enjoys one of the highest satisfaction and confidence levels in Europe by Finns (EMOR 2004), and Finns prefer treatment in Finland even while residing abroad. Medical professionals are more supportive of increased patient mobility, as this opens up new opportunities for doctors and other medical professionals, whereas the Ministry of Trade and Industry and the Ministry of Social Affairs and Health should defend the sustainability of the overall health systems where local municipalities are responsible for the organization and financing of health care services.

In conclusion, we can say that the issue of patient mobility is on the policy agenda, although the issue is not a top priority. Although patient mobility was considered positive in many ways as it opens new opportunities for patients and allows the best available resources to be combined, the financial sustainability of the overall health system remains the major concern for policy makers. Somewhat surprising was ignorance of some providers and professional associations towards increased mobility in the future, whereas the observed trends in existing patient satisfaction surveys and additional external pressures on the sustainability system are showing the opposite. By having better access to information, people will become more aware of the possibilities and differences in other countries and of European citizens' rights to access a high quality of health care services whenever and wherever the need arises. Reduced confidence in one's own health system may create significant out-bound mobility in seeking health services, if these are fully reimbursed by the public sector, as indicated by the earlier described survey of the Estonian population. This may, however, create a vicious circle that directs health care resources away from, and creates further under-funding of, the local health system.

6. Discussion, conclusions and policy proposals

Patient mobility as a topic is not yet an important item on the Estonian health policy agenda, but there is clearly a growing awareness on different levels of the health system, where it is seen as both an opportunity and a threat. Clearly, both features are present in patient mobility, and it is up to governments of EU Member States to find a balance that would truly serve the interests of patients without jeopardizing the quality of health services and the financial sustainability of the health system.

The aim of the case-study was to gain an overview of the current extent of patient mobility in and from Estonia, motives and problems related to it, as well as to learn about the attitudes of the population and plans of health care providers in making projections for the future.

The research conducted from February 2004 to August 2005 consisted of documentary analysis, analysis of data from the Estonian Health Insurance Fund and of providers of health care, a representative population survey and a patient survey in Estonian spas, supplemented by interviews with representatives of providers, and stakeholders in health policy in Estonia and Finland, including the Estonian Minister for Social Affairs.

Being a small country, it is only to be expected that Estonia relies on foreign health care providers to provide treatment in rare cases. On the other hand, the structure of health care providers in Estonia, the prevalent fee-for-service or case-based payment method, as well as providers' right to retain all revenue received for treating foreign patients, should motivate Estonian health care providers to attract foreign patients. The low general level of health care funding in Estonia, compared with most EU Member States, should put pressure on the providers to seek opportunities for extra revenues by treating patients in addition to those insured by the Estonian Health Insurance Fund.

The research confirmed that Estonia has a transparent working legal regulation of out-bound patient mobility, targeted at those needing treatment not available in Estonia. The total number of applications for prior authorization for treatment abroad used to be low – fewer than 30 in total annually. However, both the number of applications, as well as authorizations, have doubled since Estonia became a member of the EU in 2004. The growth in number of applications can signal two issues: firstly, that the patients and their families are taking more initiative to explore treatment options outside their home country, and secondly, that awareness of the right to apply for publicly paid treatment abroad has increased.

The population survey confirmed that although the current extent of having had treatment abroad is very limited, and mostly due to emergencies, there is an interest in having the choice of treatment abroad as well. 25% of respondents stated that they would even prefer treatment abroad to local health care provision, if it was paid for by the EHIF.

Although in an actual situation of illness, most of the respondents stating a preference for foreign providers would probably not act on their preference given in a hypothetical interview situation, the high share of such respondents deserves attention. Even if only 10% of the people were to seek treatment abroad, it would mean a considerable loss of revenue for the Estonian health care system due to the price differential between Estonia and Finland with other Scandinavian countries, which were the preferred destination countries.

Estonian providers of health care do not see patients seeking treatment abroad as a realistic scenario, and neither do they really count on in-bound patient mobility as an opportunity for increasing their revenues. The share of foreign patients is marginal, and is in general due to emergency care needs. Spas, with their wellbeing services, have 70% of clients coming from abroad. The share of foreign patients is higher than for general care in plastic surgery and dentistry too, but the exact data for this is difficult to obtain. This is due to the providers not keeping a record of the country of origin of the patient, but only of medical and financial data. Finland, on the contrary, collects data according to country of residence. Private providers who have tried to market themselves to foreign patients acknowledged having faced resistance from providers of these countries, and see the future of cross-border health service provision more as an increased choice for patients within a network of providers from many countries, rather than entering into a competitive international health service market.

It is to be expected that patient mobility will increase in the coming years. On the one hand, it will be influenced by increasing tourism in the region, with visitors needing both emergency care as well as management of chronic diseases. Although clinically capable, the communication abilities of Estonian health care providers with foreign non-Finnish or English speaking patients may not be up to the future needs of the patients.

The biggest inhibiting factor for considering treatment abroad that both local people as well as foreign visitors reported was lack of information. With the internet becoming more and more part of everyday life for people, information opportunities increase, as well as for independently finding out about treatment opportunities outside one's own country. This is especially relevant for younger people, who show higher dissatisfaction with the local health system and have at the same time a higher ability to pay.

Considering the conservative nature of health systems, there are many information asymmetries involved and there is a need to use public revenues efficiently. The answer to people's expectations would certainly not lie in opening up a publicly paid European-wide market of health services.

Patients' interest in having a choice of provider and a timely referral would be taken into account by creating provider networks and facilitating cross-border cooperation. Networks which are used to working together would also help to keep down the

administrative costs involved in enhanced cross-border service provision. One such cooperation case is the recent development on the Estonian-Latvian border between twin-towns Valga and Valka. The towns have agreed to develop a joint plan for specialist care, nursing care and ambulance service provision for the next 10 years.

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