

# 4TH OF MARCH 2021 PROGRAM BOOK



## SUMMARY



REPUBLIC OF ESTONIA  
MINISTRY OF SOCIAL AFFAIRS



Estonian  
Health Insurance  
Fund



Association of  
Pharmaceutical Manufacturers  
in Estonia



European Federation of Pharmaceutical  
Industries and Associations

# Commissioner for Health: **patients must be at the centre of a healthcare system**

Stella Kyriakides, the Commissioner of Health and Food Safety of the European Commission, stated in her address that COVID-19 has brought to the foreground the resilience of health policies and our healthcare systems. The pandemic has highlighted the weaknesses of the healthcare systems of our countries in a painfully clear manner and pointed out the most urgent issues that need addressing. It is extremely important for governments to use this lesson to develop their healthcare systems further to make them more efficient, more resilient, and more accessible.

When designing successful healthcare systems, it is essential that we focus on the patient experience. We must promote a more comprehensive healthcare system that includes patients in an active role and in which the cooperation between caregivers and medical staff is stronger. The European Union is also supporting its Member States with sharing best practices and funding the necessary reforms from the EU budget.

It is important to create opportunities for healthcare specialists to share and exchange their experiences. This conference – ‘Value Based Healthcare – Tallinn 2021’ – is exactly the kind of virtual forum where we can exchange our experiences and best practices.

For some time, the policy of the European Commission has focused on placing the patients at the centre of healthcare systems. We have emphasised the importance of patient satisfaction when evaluating the efficiency of healthcare systems. What could seem a satisfactory result from the point of view of a doctor might not be the same for a patient.

The perspective of patients is invaluable when we try to strengthen the existing healthcare systems and make them more effective. Knowing the expectations and hopes of patients is a significant source of knowledge that helps us to work better. It is a well-known fact that as a population ages, the number of chronically ill patients increases. At the same time, people suffering from various chronic conditions live longer than before. These are long-term conditions that turn patients and their relatives into primary-level caregivers.

“The pandemic has underlined the weaknesses of national health policies.”

This means that we need a new approach to providing healthcare services and must overhaul the system.

It is equally important to guarantee greater integration and closer cooperation between patients, non-professional caregivers, and healthcare providers.

Among all else, the EU Health Programme has funded initiatives for achieving this goal. Projects such as Jadecare, or the Joint Action (JA) on the implementation of digitally enabled integrated person-centred care, help integrate care with prevention, treatment, and rehabilitation. One of the crucial lessons of the pandemic is that we need to redirect the role of care in the treatment of patients as much as possible to preserve the capacity of hospitals for the treatment of the most severely ill patients. We need to work towards that goal and intensify relevant efforts. Our goal is to achieve the integration of healthcare and the promotion of primary-level and general services.

The digitalisation of healthcare is an important tool that helps make our healthcare systems stronger, more resilient, and more accessible. We need action on the EU level to promote such digital developments.

The main part of this process is establishing a European health data space. We are planning to submit a proposal for the creation of legislation that would help establish such a system by the end of this year.

There are two key objectives in this domain: to promote a safe and secure cross-border exchange of health data, and to support the research of new prevention strategies, treatment methods, medications, medical devices, and results. We need to guarantee



**MS. STELLA KYRIAKIDES**

*Commissioner, Health and Food Safety,  
European Commission*

that the shared use of health data is secure; it is of utmost importance to ensure that patients have full control of their data. We know that non-infectious diseases form up to 80% of healthcare costs. In many cases, these conditions are preventable, which is the key to better health as well as lower healthcare costs.

The Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases of the EU has called for an exchange of experiences to find the best practices and help use the funding options of the Member States for developing those practices in Europe.

Together, digitalisation, primary-level and integrated care, and community services guarantee that our population is healthier and our healthcare systems stronger, more resilient and accessible, more efficient, comprehensive, and future-oriented. We at the European Commission are ready for cooperation to achieve those goals. Healthcare is changing, as are our attitudes towards it and the related discourse. As they say – health might not be everything, but everything else is meaningless without it.

**TOOMAS HÖBEMÄGI**

# Tanel Kiik: **we must value patient-centred healthcare**

Protecting and supporting health and well-being through shaping the living environment and healthcare system is equally important. This requires cooperation between the public, the private, and the third sector, the inclusion of communities, and the application of an innovative approach.

Today, one of the largest challenges we face is reducing health inequality to increase the number of healthy life years for the population as a whole. To achieve this, we must focus on increasing the efficiency of interventions in the field of health, use measurable tools, and utilise those measures in shaping our healthcare system to make it more patient-centred and increase the health literacy of the general public.

The challenges that we face in Estonia when developing our healthcare system are not unique to us, and I am certain that similar trends affect many other countries.

Our population is declining and ageing. At the same time, our people are living longer and the number of cases of chronic and degenerative diseases is increasing. All these factors make the healthcare and social services all the more necessary. At the same time, the healthcare system has fewer resources because the number of working-age people who contribute to the system is decreasing.

Over the last decades, the healthcare system of our country has seen significant changes in the manner of providing services and funding, medical technology, and the technical capacity and quality of providing healthcare services.

The faster the changes are, the faster and more thoroughly the expectations and attitudes of the public towards healthcare shift. At the same time, this presents us with new challenges and opportunities for influencing health outcomes of individuals and the nation as a whole. The skill set of healthcare workers and the organisation of services must change – particularly in areas concerning prevention, communication, and the development of digital skills – so they would be more considerate of the expectations of the patients and families that deal with the needs of the patients.

Those goals and general health outcomes should become our main priorities.

“When creating any policy, we must take into account its effects on public health.”

Over the last few years, we have made remarkable efforts to strengthen our primary care system, we have invested funding provided by the EU in our primary care centres to establish conditions for multi-disciplinary cooperation by bringing prenatal care, home nursing, and physiotherapy services to the same centre as family physicians and nurses. These centres provide a wider range of services (for example, in the fields of mental health, nursing, and social welfare) to improve integration with social affairs.

In 2015, the World Bank conducted a study of the state of integrated care in Estonia. This report clearly indicated some of our weakest areas, including managing and coordinating chronically ill patients between various levels of care. Currently, we are discussing how to improve the coordination of care in the healthcare sector between the primary level, specialists, and social welfare services. Another great example of integrating healthcare providers from various levels with the social welfare system is the patient-centred recommended care pathway project for stroke patients.

An analysis of health care costs clearly indicates that hospital care is very expensive. The OECD has stated that healthcare systems mismanage funds very often, which could be avoided. Estonia has also seen that, on average, every fifth hospitalisation could be prevented in case of chronic illnesses. At the same time, a large number of patients with an acute condition or those admitted for surgery cannot get follow-up treatment within a reasonable time frame.

In order to use our hospital resources better, we are preparing a project for developing a long-term evidence-based vision for the planning process of the hospitals of the future that takes into account changes in the living environment and public health, the needs of the nation, and naturally, the available resources.

We need to increase awareness of what a mod-



**TANEL KIIK**  
*the Minister of Health and Labour*

ern hospital should offer, what kind of financial and human resources are needed to maintain a hospital, and the ways to afford it.

As a society, we need to be aware that current digital technology already enables taking many healthcare services from hospitals to ambulatory and primary care facilities, and leaving only very specific health services for the hospitals. This requires an aggregation of resources because without it, we cannot meet the objectives for integrated and patient-centred care.

We should create a solidary health coverage for the Estonian population and guarantee the long-term sustainability of healthcare funding. It is important to diversify the funding model of healthcare because the current funding system relies too heavily on labour taxes and social tax. Therefore, we need to continue to search for and create opportunities to increase the revenue base that enables us to fund healthcare. We also need to ensure the continuity of care and services in a patient-centred and innovative manner.

In conclusion, a well-run healthcare system makes healthcare services available to everyone, it is financially sustainable, and healthcare is seen as an investment in a healthier and more productive population, making it possible to live life to the fullest and actively participate in public life into old age. When developing a healthcare system, important starting points are outcomes in healthcare, quality and accessibility, and the expectations of the population.

# Value Based Healthcare – Tallinn 2021

'Value Based Healthcare – Tallinn 2021' took place online on 4 March 2021 and had nearly 1000 participants from 60 countries. Colleagues from Germany, Belgium, the UK, the Netherlands, Portugal, Sweden, and Estonia spoke at the conference.

The conference was organised by the Ministry of Social Affairs of the Republic of Estonia, the Estonian Health Insurance Fund, MTÜ Eesti Vähiliit, the North Estonia Medical Centre, the Tartu University Hospital, the European Federation of Pharmaceutical Industries and Associations, and the Association of Pharmaceutical Manufacturers in Estonia; it was moderated by journalists Marjo Näkki from Finland and Johannes Tralla from Estonia.

The conference opened with addresses from Tanel Kiik, the Estonian Minister of Health and Labour, and Stella Kyriakides, the European Commissioner for Health and Food Safety. Both emphasised that we need new approaches to providing healthcare services that would be more inclusive of all parties because the world is changing – on the one hand, technology is rapidly developing, and on the other hand, the number of individuals with chronic conditions increases significantly with a growing life expectancy of the population.

The first session of the conference clarified the terminology of value-based and patient-centred healthcare, as well as possible methods for its evaluation and for better inclusion of the patients' point of view during the entire care pathway. While healthcare assessment used to focus only on the treatment volume and the cost as important factors, then now,

we talk about treatment quality, which is divided into the clinical benefits of treatment and the patients' quality of life indicators. The quality of life indicators are not only evaluated during the treatment, but also during the period following the treatment. In addition, Nicola Bedlington and Suzanne Gaunt from the UK and Anna van Poucke from the Netherlands also gave thought-provoking presentations.

During the second session, colleagues from abroad and from Estonia introduced various possibilities for implementing value-based and patient-centred care in daily practice and shared their personal experiences. In this regard, Professor Francisco Rocha Gonçalves from Portugal gave a fascinating presentation, as did his German colleague Dr Burkhard Beyer, who described his experiences with including prostate cancer patients in the development of value-based and patient-centred healthcare services at the Martini-Klinik in Hamburg.

Estonia was represented by Rain Laane, the Head of the Health Insurance Fund, and Dr Terje Peetso, a member of the Management Board of the North Estonia Medical Centre. They talked about the Estonian experience with using a risk-sharing model in the compensation of medications, and first experiences with the pilot projects of stroke and cancer patient care pathways.

The conference ended with a joint panel discussion; one of the main points was that, in the future, we will have to pay a lot more attention to the quality of life of patients during and after treatment in addition to the efficiency and cost-effec-



**VAHUR VALVERE**

*MD, PhD, Chair of the Council, Estonian Cancer Society*

tiveness of said treatment. A contribution from all parties to achieving treatment outcomes with the best quality and optimum costs is extremely important and will require a closer cooperation between the state, the medical and social welfare systems, and patients. The immediate inclusion of patients and their families in the decision-making process is of particular importance, as is constant consideration of the needs of the patients during the entire care pathway and the observation period following it.



# The role of patients in shaping value-based healthcare

In her presentation, Bedlington discussed the connection between outcomes-based approach and goal-oriented treatment and care, the importance of involving patients (both as a group and individually) in a value-based, i.e. patient-centred, healthcare system, the effect that involving the patients would have on the life cycles of medicines and healthcare services, and the digital transition.

Patients' role in shaping a value-based healthcare system and its indicators can be shown through three key terms: health literacy, a shared decision-making process with healthcare providers, and self-management.

Many evaluations of healthcare systems have come to the conclusion that patients should not be viewed as part of the problem, but instead as part of the solution. It has been proven that patients who are included and are goal-oriented can help achieve savings for the healthcare system, identify potential duplication and misuse of funds in the system, and assist in making wise choices.

In order to tackle this extremely important topic, we need to see value-based healthcare from the point of view of a patient and get a snapshot of which direction the prevalent discussions are heading.

Based on my experience of communicating with the 75 umbrella organisations of the European Patients' Forum, I have absolutely no doubt that value-based healthcare is the way forward. Increasing

“Value-based healthcare means a greater inclusion of patients.”

the influence of the patients and outcomes that are important for the patients are issues that many have tried to resolve for years with great tenacity, but without much success.

What kind of problems do patients identify? Firstly, current healthcare systems are often inefficient, wasteful, disadvantageous, expensive, and discouraging for patients. The COVID-19 pandemic has clearly highlighted the weaknesses and failings of current healthcare systems.

Today, solidarity in healthcare is a major challenge even in Europe, and various countries are facing large discrepancies in the availability and quality of their healthcare services.

Solidarity in healthcare is still a big challenge even in Europe, and large differences exist in accessing and providing quality healthcare services.

What stands out is that regardless of the well-known fact that including patients in shaping healthcare systems brings tangible results both in experiences and in outcomes, this option is still used minimally and rarely.



**NICOLA BEDLINGTON**

Former Secretary-General, European Patients Forum

*Nicola Bedlington, who was the Secretary General of the European Patients' Forum between 2006 and 2019, focused in her presentation on the inclusion of patients in value-based healthcare and possibilities for increasing the role of patients in shaping and managing the system to guarantee that the most relevant outcomes as determined with the patient are measured.*

Do the decision-makers in our healthcare systems actually know what is important for the patients? A group of experts convened by the European Commission searched for answers to this question among all else, focusing on the availability of healthcare services and pointing out the main problems in the extent, affordability, availability, and relevancy of the services.

When discussing helping and empowering patients, it is essential that involving patients should be future-oriented, qual-



Speaker Rain Laane



Panel Discussion: Moderators Marjo Näkki, Johannes Tralla with Speakers Terje Peetso and Rain Laane

ity-oriented, and one of the pillars of sustainable healthcare systems, as backed by studies conducted by numerous patient organisations.

On an individual level, this issue can be approached from three angles: access to quality information and health literacy that enables patients to navigate the system; a dialogue based on trust between patients and healthcare providers; and a shared decision-making process and self-management which also includes digital technology and changes in behaviour and societal attitudes.

Europe has several positive examples in its recent past about a better involvement of patient representative organisations in the implementation of healthcare policies.

A great example is the vaccination campaign in Bulgaria that was conducted at the initiative of the local umbrella organisation for patients in a close and constructive cooperation with government authorities, specialist organisations, and healthcare providers. The campaign's objective was to dissipate doubts regarding vaccines, emphasise positive examples, and communicate with the general public and various ethnic groups.

This was an excellent example of the contributory capacity of patient organisations; unfortunately, such examples are few and far between. The European Patients' Forum pointed out as early as in November 2009 at its congress, which focused on the main obstacles and opportunities for a greater involvement of pa-

tients in shaping healthcare policies, that we need an urgent shift in attitudes.

We already saw back then that healthcare systems are not patient-centric, the opinions of patients are systematically dismissed, and this area lacks training and development opportunities.

This pandemic has forced us to change our thinking about the digital transition and the responsible use and sharing of anonymous health data. Digital development that is based on the interests of the patients is essential for better healthcare outcomes and a more positive user experience for both patients and healthcare providers.

In order to develop digital solutions and innovation that is aimed at solving existing issues, we must urgently establish a culture of trust that would allow the responsible sharing of anonymous health data. We need to promote the free movement of big data that respects the privacy and security of patients.

We have a lot of work to do in this regard. Health data is fragmented; cross-border obstacles for this data are hindering the collective efforts to fight the epidemic. Aggregating anonymous data and various tools would benefit the entire society. So far, Europe has been a follower in this regard.

In this domain, an interesting European initiative has been the introduction of the Data Saves Lives platform, which is currently being implemented in Europe. This is an initiative created by several

parties with an objective to raise awareness of the importance of health data and its use as well as to provide an environment of trust where various parties can discuss this subject and share relevant experiences and best practices in Europe. The initiative is led by the European Patients' Forum and the European Institute for Innovation through Health Data. In the course of the initiative, the European Health Data Portal will be created. The initiative is part of the global #DataSavesLives movement.

One major issue is strengthening the link between value-based healthcare and personalised healthcare. Personalised healthcare must guarantee an equal and better access and quality; this approach has been developed in the last 20 years. Personalised healthcare helps to develop personalised medical solutions which lead to better prevention, increasingly accurate diagnostics, and new treatment opportunities.

In case of personalised healthcare, the system centres on an individual, not their condition. It also ensures that the patients are involved in determining the outcomes that are important for them at their current stage of life. We have cooperated with universities in this field to conduct research and establish global expert groups to integrate the field of value-based healthcare with the field of personalised healthcare.

# Towards Value-Based Healthcare 2.0

In her presentation, van Poucke, who leads the KPMG Global Healthcare unit that employs 4,500 healthcare specialists from 45 countries and has a total turnover of 1.25 billion dollars, discussed factors that prevent the vision of value-based healthcare from becoming a reality.

To put it succinctly, switching to value-based healthcare needs an agreement which links costs to the quality of treatment, a leadership model that is characterised by responsibility and an emphasis on quality, and technological innovation to coordinate treatment that is aligned with patient outcomes.

Generally speaking, it is possible to claim that almost all current developments in healthcare are aimed at bringing more value to the sector. Unfortunately, the quality of healthcare systems is still often overshadowed by other factors. To a very large extent, the so-called traditional healthcare systems use a leadership model that concentrates on volumes. However, this model is cheap and inefficient; it does not reward the creation of value and raising quality, but instead increasing volumes.

How can we change the existing healthcare systems to achieve better health outcomes and quality? According to our vision, which we call Value-Based Healthcare 2.0, we need to adopt a new model that links quality, i.e. treatment outcomes, patient satisfaction, and access to services, with expenses that can be both direct and indirect.

How would this approach impact different parties? First of all, patients would have better treatment outcomes and greater satisfaction; payers would get something efficient for their funding; and

“We need to implement a new model where treatment outcomes, patient satisfaction, and access to services is linked with direct and indirect expenses.

service providers could offer a service that brings results.

This would also flip the current system that centres on the service provider so that it becomes centred on the client: separate treatment models would be replaced by complex care that is seamlessly integrated; a modern, clear, and user-friendly e-healthcare system would be used instead of single digital solutions; and the focus would shift from treatment to prevention and achieving the well-being of patients. It also entails developing management models that link leadership with responsibility and quality culture.

Transition to the new model requires a new approach. I will give you a simple example: hip replacement in an elderly patient does not create value unless the treatment is integrated with a shared rehabilitation system, the patient receives the required support from their community, and they have access to the necessary services. We must create integrated value networks to meet those needs.

The role of technology and digital solutions is also extremely important. The healthcare of the future is thoroughly digital in the way that data is processed and treatment and care are combined into a single system; it offers solutions that are mainly aimed at prevention and



## ANNA VAN POUCKE

*the Global Head of Healthcare at KPMG International*

*Anna van Poucke, the Global Head of Healthcare at KPMG International, stated in her presentation that transitioning to value-based healthcare is in no way a new concept; unfortunately, there are very few global examples of its successful implementation.*

diagnosis rather than treatment. Digital or e-healthcare must offer its clients, i.e. the patients, a possibility to access all services through a single outlet by supporting various platforms and integrating at-home monitoring and a functionality for controlling medical devices, for example.

I believe that the most important thing to remember is that creating value is a team sport, i.e. it is a result of a joint effort. Therefore, in order to implement Value-Based Healthcare 2.0, we need to cooperate with various parties, coordinate our activities, and guarantee that all parties of the value chain are committed to achieving the same goal.

# Why measure health outcomes and cost?

A healthcare system that aims to achieve great health outcomes also creates possibilities for savings because measurement allows monitoring the effect of changes. Unfortunately, input and process are still mainly measured in healthcare, e.g. the number of procedures and visits, but not outcomes.

This has created a situation where we have healthcare systems characterised by high costs, uneven treatment quality, frequent medical errors, and limited access to treatment. Healthcare systems that are becoming increasingly expensive without a serious jump in service quality are fast becoming a global problem.

In value-based healthcare, this contradiction has been solved with transitioning to the measurement of health outcomes and costs. Instead of measuring inputs such as the number of procedures and visits, we measure health outcomes or, for example, patients' evaluation of their experiences with healthcare services.

However, not only the quality of health outcomes varies in different countries, but states also use diverse methods and levels of precision to measure that.

Standardised measuring principles would solve this problem by creating a common basis for comparison.

Standard Sets developed by ICHOM are such a solution. ICHOM standards are based on health conditions, they are freely available, and can be downloaded from the Internet. Currently, we have completed 39 Standard Sets, more than 25 of which have been published in peer-reviewed science journals. We are working on five new Standard Sets, which will be hopefully finished this year.

“ Instead of counting procedures and the number of doctor's visits, we should measure health outcomes or patients' assessments of their experiences with healthcare services.

The Standard Sets help gather standardised information about treatment outcomes based on the condition of the patient and by using indicators that best describe the aspects important to the patient.

Most importantly, we proceed from the priorities of the patient when developing a Standard Set. As a global non-profit, ICHOM is an independent organisation with an objective to put patients at the centre of the process. The Sets are developed in cooperation with various teams that include healthcare providers, patient representatives, and other stakeholders. When creating a Standard Set, we cooperate with over a thousand leading experts from all over the world.

Currently, our focus is shifting to the implementation of the Standard Sets. This requires the removal of existing barriers.

Note from the editor: In Estonia, the first systematic measurement of health outcomes is implemented by the Health Insurance Fund as a Stroke Patient Pathway Pilot which the Fund coordinates. During the pilot project, the care pathway of stroke patients was mapped; the project determined that the post-stroke care pathway was com-



**SUZANNE GAUNT**

*the CEO of ICHOM*

*Suzanne Gaunt, the CEO of ICHOM (the International Consortium for Healthcare Outcomes Measurement), explained in her presentation that one of the greatest advantages of value-based healthcare is its main objective – the value created, or health outcomes (i.e. the health status of a person and any changes in their condition).*

plicated and fragmented for the patients and did not consider the needs of the patients and their families. Four development projects were initiated to find solutions which were prepared by and are currently ongoing in four Estonian hospitals. The development projects continue until the end of 2021.





Speaker Terje Peetso with Moderator Marjo Näkki

# Terje Peetso: **the importance of data in value-based healthcare**

Taking into consideration a recent study, according to which the amount of health data that we have collected has increased by 878% during the last four years, we are talking about a remarkable volume of data.

Health data is critical for empowering patients and transitioning towards personalised medicine and person-centred and value-based healthcare. It is like a coin with three sides.

The health data received from the patient is becoming more and more essential, such as information about their experience with the level of service.

As the largest hospital in the country, the North Estonia Medical Centre collects data from about 150,000 individual patients. If we add all doctor's appointments and other contacts with the hospital, then that data covers about half a million doctor's appointments and consultations.

By having three subsidiary hospitals and by providing specialist care in all areas except obstetrics, the North Estonia Medical Centre has gained an excellent overview of various patient needs and care pathways due to this information.

I would like to emphasise the importance of patient-centred care among our work principles, as it is an extremely relevant factor that needs to inform various aspects of our work.

This brings us to the next important subject, which is the health records that we possess.

“Health records have a very important role in empowering patients and moving towards value-based healthcare.”

I do not mean all health records, but only those that we collect or process daily.

Imagine this data map as a clock; at 12 o'clock, you have a person who creates a large quantity of data through their daily activities, which has important health considerations.

At 1 o'clock, you have various information that is collected through simple ordinary remote-sensing tools and mobile apps which monitor the health or well-being of an individual, for example.

At 2 o'clock, you have information from the loyalty and client programmes of various stores or sports clubs.

At 3 o'clock, you find information from the Patient Portal that stores the health records of each citizen which has been entered by healthcare providers and which the patient can control.

At 4 o'clock, you see the health data gathered by the Estonian Health Insurance Fund; this entails such details as prescription medication and information on public health studies and other health studies conducted by other entities.

After this, you find visual data, such as X-ray images, MRI images, dermatological images, ECG results, etc.

At 8 and 9 o'clock, you see the so-called academic data, which is gathered through clinical studies but also through research conducted by the Medical Centre alone or in cooperation with other hospitals in Estonia and abroad. This includes clinical research, pharmaceutical studies, etc.

Finally, we have information from genetic research that is becoming absolutely crucial. We are looking forward to the time when we can implement the findings of genetic research in our daily practice.

In conclusion, there is a lot of information pertaining to health; however, are we using this wealth of data in our work? Unfortunately, the answer to this is 'No'. There are various reasons for this.

For example, the information is not stored in a single location, a single database; it is not accessible simultaneously, making a search for information a drawn-out and inconvenient process. Sometimes, we need a separate agreement for accessing certain information.

At other times, we need a conscious permission from the patient to access their personalised data at the hospital.

Now and again, we need an agreement with a specific service provider who has gathered the data and is managing it.

Due to all that, I think that we are at the starting point of a long journey of using big data in healthcare. However, we are working on it and doing everything we can to make the electronic health records more comprehensive and increase their quality.

Here, the information provided by the patient about their experience with our services plays an important role and is an important source of feedback about the quality of the healthcare services. Information that is gathered from the patients about the effect of treatment on their quality of life can be added to this. This data is gathered with international standardised questionnaires during and after the treatment.

We are moving towards linking the information about the patient experience with our services with genetic data; this would open up new avenues for using and processing data and could be linked to the health records.

Ideally, all data about a patient – both data unrelated to their health and information gathered in the healthcare system about them – should be available through a single access point and comparable with similar information collected in other countries.

I really hope that the new open data space that the Commissioner mentioned in her speech will be a reality soon and will open up new possibilities for using health data.

While discussing our experiences, I would like to introduce some pilot projects of the North Estonia Medical Centre.

The common denominator of these projects is the care pathway of the patient. The starting point of this pathway is not always the same; for example, a cancer patient's pathway usually begins outside the hospital and a stroke patient's pathway with an ambulance ride or a hospital.

A care pathway includes very different parties, mainly healthcare providers (both hospitals and rehabilitation facilities), but also primary care providers and social workers who have an important role in the recovery process.

In this pilot project that lasts until the end of the year, our task is to develop and test a

solution that would provide the patient with an opportunity to access all information regarding their treatment from the same place.

This contact person is a patient coordinator, who manages and issues all information regarding a patient's treatment and communicates with the patient and their family. In some cases, the coordinator is a digital case coordinator.

A very important stage of the project is testing the tool that we created so we could verify its suitability and usefulness to patients and their families – the so-called unofficial care providers. Patient input is essential here; it includes descriptions of the expectations, needs, and goals of a patient, and providing all information through a single outlet, as well as giving a comprehensive overview of the developments in the care to all parties of the care pathway.

In the course of all this, we are also testing a shared information space that healthcare providers and social workers can use for obtaining information about the condition and needs of a patient.

Such a single integrated system should provide a much better result and create more value to the society at large.

Together with other hospitals that are participating in the pilot project of the care pathway, we created a website that the patients and their families can use for obtaining relevant information which also displays the patient's evaluation of their experience with the services and of their well-being.

In addition, it functions as a calendar for the patient: it lists all future treatment procedures, which medication must to be taken at what time, and symptoms to monitor.

All of this makes for a very useful information portal that offers relevant information to all parties involved and enables the patient to participate in their treatment process to a much larger degree than previously possible. We are also planning to add a web-based consultation function and an AI module which helps the patient weigh all existing choices and make decisions.



## TERJE PEETSO

Member of the Management Board,  
North Estonia Medical Centre

*Terje Peetso, a member of the Management Board of the North Estonia Medical Centre, emphasised in her presentation that if we want to make healthcare services more efficient and improve them, we need to gather pertinent, well-organised data based on standardised questionnaires and make that data more readily available to all parties.*

Due to this, the patient will receive a singular pathway plan that is specific, comprehensive, organised, and systematic, and that explains in clear terms the end goals and the time when these are hopefully reached.

This journey might have obstacles; however, the important thing is having all parties in the loop, providing a common information space, and ensuring everyone is using the same data – the aim of this is to involve the patient in the treatment process more.

This requires the patients to have the so-called health literacy, or even digital health literacy, because without the necessary knowledge, the patients will find it difficult to participate in this process and to provide input. It is essential to include patients in this process already in the planning stages.

# The role and governance of a provider of funding in value-based healthcare

In his presentation, Rain Laane, the Head of the Estonian Health Insurance Fund, talked about the huge responsibility that the Estonian Health Insurance Fund as an agency that governs the financing of the healthcare system bears in deciding how to use the funds dedicated to healthcare in a way that would offer the greatest value to the patients and the society.

Estonia has 1.3 million residents and the annual budget of the Health Insurance Fund is 1.7 billion euros. A simple calculation shows that this means 1,300 euros per person a year; this is three and a half times less than the average expenditure in Western Europe.

This is why the negotiations between the Health Insurance Fund and pharmaceutical companies sometimes take longer – we want to be certain that what we buy creates value and has an affordable price.

Innovation is definitely one of the main options for using the existing means in the most efficient way possible and for achieving a result that satisfies all parties. As a provider of funding for the healthcare system, the Health Insurance Fund must be as innovative as possible and use the existing and new digital solutions, health data, and machine learning better.

I would like to give you two examples of what we have developed and implemented at the Health Insurance Fund.

The first example is the risk sharing model that we use for funding medicines.

This model was developed in cooperation with pharmaceutical companies and is an excellent way to finance medications if we

“Patients do not have to be aware of the practical issues a provider of funding faces; instead, patients need a solution that helps them.

are not certain that a new, rare, or expensive drug is effective or when a significant number of patients do not respond to treatment based on clinical studies.

The Health Insurance Fund first implemented this expense-sharing (or risk-sharing) scheme in 2014. Today, we use this risk-sharing model with about ten medications.

The principle of this model is very simple – the Health Insurance Fund pays the entire price of the drug to its manufacturer only if the drug has a previously agreed effect on the patients; otherwise, only the costs of research are compensated to the manufacturer.

At first, the implementation of the new model caused a lot of confusion and created a lot of additional work for manufacturers, doctors, and pharmacies. Free medications used in trials had a separate accounting system, and we had no clear idea of how many patients participated in the clinical trials and what kind of clinical efficacy the pharmaceuticals had.

When weighing various digital solutions, we had an idea – as the state had developed and implemented a digital system for e-prescrip-

tions, then perhaps we could use it for managing our risk-sharing model. So we created a solution for monitoring the clinical effect of a drug during the trials and gathering patient feedback. If the drug has the expected effect, then an agreement is signed with the manufacturer; otherwise, the treatment is terminated and any expenses incurred by the manufacturer are compensated.

This solution helped the Health Insurance Fund and pharmaceutical companies monitor the process digitally, obtain reports, have an overview of the actual effect of the drug, released the pharmacologists from the duty of a separate accounting and the doctors from the need to work with free trial drugs. A clinical assessment was generated automatically, because e-prescriptions were linked to the health information system, and it was approved by a doctor.

In case of such solutions, it is important to ensure that the patients would not feel like their care pathways become more complex as a result. Patients do not need to know the administrative side of our work; they want a solution that would help them and provide treatment for their conditions. In addition, we are now planning to link hospital pharmacies with the same system and make the patients' pathways even smoother.

The second example is the Stroke Patient Pathway Pilot, which the Health Insurance Fund started in 2019.

Stroke is a serious condition that affects about 4,000 people a year in Estonia. It also places a large burden on the society because about 20 per cent of the stroke patients die within a year of the stroke, 50 per cent make a full or sufficient recovery to cope with

their daily lives, and 30 per cent will be dependent on a caregiver.

The objective of the project is to improve the quality of life of people who have had a stroke through a care pathway that is more patient-centred and integrated; this should ensure a comprehensive pathway that empowers the patient and their family, takes responsibility for the coordination of the care pathway, and guarantees the availability of the necessary services for the patient.

In order to bring about changes, we had to see and understand the care pathway through the patient's eyes first because this differs greatly from the perceptions of a doctor or a nurse. In addition, understanding the patients' point of view lets us make the healthcare system more patient-centred.

A patient meets many involved parties during their care, starting from the ambulance staff and a neurologist and ending with rehabilitation specialists and social workers; they will also receive care and treatment in various establishments, be it at a hospital, at home, or at a nursing home.

We started developing the project from placing ourselves in the same situation as a stroke patient and mapping the entire care pathway of a patient with all parties. As a result, we found that the post-stroke care pathway is rough for patients and their families. Often, the needs of a patient and their family are dismissed; some services are provided to an insufficient extent, and others are missing completely; there are problems in the way information is exchanged and in cooperation between the parties of the care pathway.

Although the acute care of Estonian stroke patients is world-class, the following care pathway is often complicated and fragmented. Patients and their families, who bear a very large burden of caregiving, have no clear understanding of the care pathway, available services and medical aids, and the criteria for obtaining those.

A very important shortcoming was having no information about the quality of life of a stroke patient because the healthcare system does not measure the health outcomes of the patients.

We asked service design experts to help us tackle these challenges. With the help of students from the Estonian Academy of Arts, we visualised the care pathway and launched the project.

As I said, the ultimate objective was to improve the quality of life of patients following a stroke. A stroke is an acute and severe condition with serious life-changing consequences for patients and their families.

We have selected four hospitals and concluded agreements with them for the implementation of development projects. In the course of these development projects, novel solutions for a care pathway are created, which will be tested on users; their objective is to create a comprehensive care pathway for patients and provide timely and necessary information to patients and their families in an understandable manner, as well as to include them as equal partners in decision-making. An integrated treatment plan is used for determining the roles of various parties, ensuring a smooth transition from one treatment stage to the next, and appointing a coordinator whom the patient and their family can contact for assistance and who will guide them through the different stages.

The implementation of the project is still ongoing; however, before the project, 23 per cent of Estonian patients died within a year after a stroke, and now, this rate has dropped to 16.7 per cent, according to the calculations based on last year's data, so we have seen significant improvement.

The Stroke Patient Pathway Pilot is the first time that we are using the systematic measurement of health outcomes in Estonia. Another factor that we measured thoroughly was patients who had a poor care pathway or whose family felt that they did not receive as much help from the healthcare system as they would have liked. These observations can be used to better monitor the recovery of patients and find ways to improve their quality of life. New solutions are tested until 2023, and if we are successful, then these will be implemented in the entire system.

Based on the information that we have collected, we can monitor changes in how well patients cope with their daily lives, how they



**RAIN LAANE**

CEO, Estonian Health Insurance Fund (EHIF)

perceive their quality of life, etc. When gathering information on health outcomes, we are using the Standard Set for Stroke of the International Consortium for Health Outcomes Measurement (ICHOM), which has been adapted to the situation in Estonia.

All in all, we have room for growth and the beginning has not been easy, but the first results are promising. We have had to resolve so many important issues due to this project – where to start, how to begin, what are the greatest challenges? This could be called a cultural shift, and making such changes a reality always takes a long time.

In conclusion, when discussing the governance of a value-based healthcare system, I am convinced that using innovation and innovative ideas inevitably brings positive results. I have absolutely no doubt that we will see more new digital solutions being developed in the future, including in personalised medicine.

However, we cannot put all of our trust in technology, because our health depends largely on our choices and preferred lifestyle – according to some studies, up to 80% of it. Our activities for the prevention and detection of diseases have the same objective. All our efforts are aimed at the creation of the maximum amount of value for our clients and the society at large with the available funding.

**TOOMAS HÖBEMÄGI**



# Payment should be tied to outcomes

Karl Arnberg represents a pharmaceutical company called Novartis and one of his main interests and tasks is developing payment models that correspond to the buyer's demands.

Arnberg's presentation focused on examples which explain outcome-based payment models and are related to value-based healthcare.

In value-based healthcare, the main emphasis is on health outcomes, not the number of procedures and visits. It is important to consider what the achieved health outcome means to the patient because poor health is expensive to the healthcare system, the patient, and the entire society. To put it in simple terms, outcome-based agreements mean that paying for the products is related to outcomes.

Outcome-based methods for medications could be useful in a situation where there is no certainty about who in the target group will react well to the treatment or where the

permanence of the benefits of the treatment are largely unknown.

There are various situations where using outcome-based agreements would be beneficial: for example, biological treatment for a chronic illness (it is possible to assess early response to treatment and predict long-term benefits), solutions created for monitoring and finding patients (telemedicine, prevention efforts), and agreements where payments for medical services depend on the treatment outcomes of patients.

When focusing on value-based healthcare and health outcomes, cooperation is the most important factor. It is important that many different interest groups be included in the development process of models and methods. It is also essential to reduce the administrative gauntlet as much as possible and to begin with determining whether the expected health outcomes are important for patients and healthcare systems. Focusing on health outcomes could be a triple win for



**KARL ARNBERG**

*Access Model Director Region Europe, Novartis*

*The presentation of Karl Arnberg focused on examples of outcome-based payment models.*

patients, healthcare systems, and the pharmaceutical industry.

**TRIIN VENTMANN**  
resident of family medicine

# We need to offer valuable medical care and a friendly environment

In her presentation 'The Future of Health', Dr Bettina Ryll explained the patients' perspective in a value-based medical system.

Dr Ryll founded the Melanoma Patient Network Europe after her husband died, so patient-centred medicine is extremely important to her. After creating the organisation, Dr Ryll became very interested in patient-centred clinical research. She started her presentation with an explanation of the meaning of value-based healthcare and explained her thoughts as a spokesperson for patient interests.

It is important to focus on the meaning of value and think about the following questions: how to measure value, who will measure it, whose values should be achieved, how to include those in decisions, and what is value from the point of view of health?

Dr Ryll is convinced that it is important to use the correct techniques and methods for the assessment of patient well-being in value-based healthcare. As an example, she used an article which described a situation where, regardless of the

*In order to research the well-being of patients and their satisfaction with healthcare on a scientific basis, we need to take a very critical approach to the methods used.*

toxicity of the chemotherapy, the quality of life of individuals was the same as in a control group receiving a placebo. Dr Ryll emphasised that using the wrong methodology lets the researcher be easily convinced of outcomes that are not true but which the scientist wants to believe. In order to conduct science-based research of the well-being of patients and their satisfaction with healthcare, a very critical approach must be taken towards the methods used.

According to Dr Ryll, patients mostly need valuable medical care and a friendly and pleasant environment, because they primarily remember their feelings regarding the experience. In addition, a value-based healthcare system needs a



**BETTINA RYLL**

*Founder, Melanoma Patient Network Europe*

concrete perspective. For each individual, value means a different thing; therefore, it is easier to agree on a general concept for value-based healthcare but much more complicated to find common ground in the details of it. When mapping values, we need to remember that everything measurable is not necessarily important, and everything important is not necessarily measurable.

**TRIIN VENTMANN**  
resident of family medicine



Discussion with Karl Arnberg and Burkhard Beyer

# A good feedback system is essential

The Martini-Klinik specialises in diagnosing and treating prostate cancer and is a unique hospital in Europe and the entire world. Over 5,000 prostate cancer patients are treated there per year; they tackle a wide variety of challenges that could occur with prostate cancer.

Dr Beyer emphasised that it is extremely difficult to know the outcomes of treatment and learn from them unless you gather enough information about the patients after they leave the hospital. In the beginning, their hospital also lacked a regular feedback system, but starting from 1992, the hospital started collecting information about the medical history of patients. Currently, their database contains the histories of over 30,000 patients, which allow new patients to find answers to questions about their treatment and health outcomes in addition to its scientific value and its usefulness in quality control. Dr Beyer stressed that a patient is an expert on their own disease and is primarily interested in the post-treatment health outcomes. Due to an excellent feedback system and the patients' assessments of their health outcomes, it is significantly easier to move towards value-based health-care.

“A patient is an expert on their own illness who is mostly interested in the post-treatment health outcomes.”

Martini-Klinik uses the PROM method (Patient-Reported Outcome Measures) for analysing feedback and quantifying health outcomes; the method measures the patients' assessment of their health outcomes. Beyer said that a working environment without hierarchies and with everyone knowing their specific tasks is needed for a well-functioning system. According to him, mapping health outcomes is an important investment in the future, and their evaluation should be systematic, standardised, transparent, and internationally comparable.

**TRIIN VENTMANN**  
resident of family medicine



## BURKHARD BEYER

Consultant Urologist and CMIO, The Martini Klinik

*In his presentation 'What is important for patients?', Dr Burkhard Beyer, a urologist at the Martini-Klinik in Hamburg, focused on the importance of patient feedback and the challenges of measuring health outcomes by using the development of a feedback system at the Martini-Klinik in Hamburg as an example.*

# Expectations to the healthcare system and the medical community are growing

'Untreatable' is not a word that people like to hear. However, it is clear that innovation, including new medications, and the increasing expectations of patients will bring about changes.

Value-based healthcare and a patient-centred approach to healthcare is a direction that Europe, including Estonia, has taken. The 'Value Based Healthcare – Tallinn 2021' conference takes place due to the desire of many Estonian organisations to contribute towards a better future for healthcare. How can we make healthcare services more accessible to the public while increasing the effectiveness of the healthcare system and proofing it against future crises?

Anything that is value-based is based on innovation. Innovation in medicine means either technological e-solutions or innovative diagnostic and treatment methods, and definitely new medications. There has been a lot of talk about how innovative and novel medications are expensive – meaning biological medications, gene and cell therapy. Solutions of precision medicine that enable the treatment of diseases which were untreatable in the past are extremely costly because these are often highly specific, meant for a tiny group of patients, or even only suitable for a single patient.

Developing novel medications also causes us to be more flexible in the models of

Value-based healthcare is based on innovation.

compensation for medicinal products for the patients. As Rain Laane, the Head of the Management Board of the Health Insurance Fund, stated at the conference: Estonians are direct. To put it succinctly, 'they would prefer to pay for only those treatments that add value and are beneficial to both the patients and the society.' This is also one of the solutions that we could create together with the Health Insurance Fund, hospital pharmacies, and pharmaceutical manufacturers. The goal of outcome-based funding is the assessment of treatment outcomes based on a defined set of criteria and the financing of innovative medications based on the results. In brief, pharmaceutical companies are paid for medications only if the treatment is effective and improves the health of the patients. This would be a part of the value-based measurement of outcomes provided by medications.

A leader in the field of value-based healthcare and one of the organisers of this conference, the European Federation of Pharmaceutical Industries and Associations, along with the Association of Pharmaceutical Manufacturers in Estonia, is a supporter of a high-level initiative of the EU Health



**RIHO TAPFER**

*Head of the Association of Pharmaceutical Manufacturers in Estonia*

Coalition – the High-Level Forum on Access to Innovation – which aims to emphasise the importance of health-related and medical issues in the political agenda of Europe, and through that, bring state-of-the-art solutions to the patients. One of the main objectives of creating the High-Level Forum is to provide a faster and more uniform access to innovative medications and other medical technologies for the patients in various Member States.





Speaker Terje Peetso with Moderator Johannes Tralla



Speaker Karl Arnberg

# PANEL DISCUSSIONS

## NICOLA BEDLINGTON:

I think that we should begin with looking at the bigger picture of value-based healthcare, in a more general context, as a part of changes taking place in the global community. We all want our health to be as good as possible so we could live healthily into old age. The state of someone's health depends largely on social factors. Therefore, value-based healthcare, its methods, goals, and implementation must be a part of a wider social dialogue.

When discussing changes, the COVID-19 pandemic has caused quite a shift. It has put a tremendous amount of pressure on healthcare systems and also forced us to implement new digital technology in an accelerated manner and change the way we live and work. This has affected patients, particularly those with chronic illnesses, who have not received the necessary care due to the pandemic.

## RAIN LAANE:

When discussing the international dimension of value-based healthcare, I would like to use the exchange of health records between Estonia and Finland as an example. In Finland, a doctor can write a prescription to a Finnish national, who can get it from an Estonian pharmacy. And the other way around – an Estonian can receive their prescription from a Finnish pharmacy.

The negotiations for this project took several years. At first, there was a lot of talk and little action; in the end, it was the other way around. The issue was with political will. As they say, where there is a will, there is a way. We need political will to see more examples like that.

However, everything around us is changing and we need to take that into account and keep up with the developments. For example, when we started to plan this conference, we booked a hall and made all the preparations, and now we are alone on the stage of this venue. The entire event takes place online and we have close to 1,000 people attending. Some will also watch it later. Moreover, this is perfectly normal.

Phone and video calls were seldom used in the medical field before the pandemic. Now, these are a standard part of life. It has also created new problems, such as how to protect and maintain mental health.

Estonia as a developed digital state has several advantages both in the technological sense and in the way people think. This has simplified the transition to remote working and medicine, for example. Now, we have to start using machine learning and data analysis more efficiently so we could make better decisions based on the available data. Using information rationally and effectively is important. We can provide comparative data for hospitals, show their relative positions in a category, and thus facilitate healthy competition between hos-

pitals by generalising data, for example. Ultimately, patients will only gain from this.

## ANNA VAN POUCKE:

When discussing the definition of value in value-based healthcare, then I think that it is shaped by measuring the health and treatment outcomes on the one hand, and how the patients evaluate their experience with the received treatment on the other. Naturally, we need to place all that in the context of finances and efficiency, and ask ourselves whether we are achieving the goals we have set and ensuring the best possible treatment for the patients. Is our healthcare system truly integrated? Is it patient-centred enough; or, in other words, when creating the system, is it sufficiently based on the patients' vision of what they value?

## KARL ARNBERG:

When talking about whether all states have a uniform understanding of value-based healthcare, then I believe there is no such vision considering the discussion in this field. However, this is fine because I think the most important thing to do now is to agree on the general principles and set the goals that we want to achieve with value-based healthcare. Do we want to save money, receive better care for the same amount, or provide the best possible service to the patients? On top of that, we need to answer the question of what the best way is to achieve these goals in real life.





### BURKHARD BEYER:

When I think of Germany, then I cannot see a shared vision or an agreement on the principles of implementing value-based healthcare. This concept is viewed from several different angles and execution depends on the goals, available means, and the vision of the parties involved. Here, it is extremely important to remember that the common denominator of value-based healthcare is patient-centred care, involving the patient, and making choices based on the best interests of the patient.

### RAIN LAANE:

When we say that transitioning to value-based healthcare is a cultural shift, then it is understandable that patients are scared of this transition. It is unavoidable due to the changes occurring in the society, so the patients ask whether healthcare will receive less money because of it, whether their treatment is jeopardised, etc.

We need to discuss these concerns with the patients in a clear and understandable manner. For example, things were not running smoothly in the beginning of the Stroke Patient Pathway Pilot. When we analysed the main obstacles, we found that the different groups of project participants did not understand it the same way; they could be thinking too much about a potential reduction in financing, additional work volume, or the complexity of achieving the goals that were set. Then, we realised that we need to approach things through the patients' point of view – we need to step in their shoes and design their care pathway accordingly. At that moment, things fell in place.

### NICOLA BEDLINGTON:

I am extremely happy that the dialogue with patients is becoming more important when designing and transitioning to value-based healthcare. Communication with the patients and receiving feedback from them through various questionnaires, for example, is the best way to discover what they value the most, how they see the situation as insiders, what the most positive and negative aspects are based on their experience, and what kind of goals value-based healthcare should meet in their opinion. The quality of the system governance and determining areas of responsibility are extremely important factors so that all parties would know their precise roles, rights, and obligations.

In case of patients, we should also discuss responsibility. It is easy to accuse a patient



Panel Discussion: Speakers Nathalie Moll, Bettina Ryll and Andrzej Jan Rys

of being lazy, but if a patient does not keep their doctor's appointment for some reason, we should find out why. Perhaps the patient is facing some obstacles in their daily life? Maybe the patient does not have enough information? It could be that the patient does not know how to interpret that information – this would be an issue of health literacy. Have we done enough to provide honest answers to these questions to the patients; have we empowered the patients enough or included them in the dialogue and the decision-making process? Let us not forget to see the patients as part of the solution, not as a problem.

### SUZANNE GAUNT:

I would like to add that we ask patients to fill in questionnaires for feedback, but have we explained to them the benefits of answering those questions sufficiently? Are the patients even motivated to fill in a questionnaire? We ask patients to dedicate their time to providing input and improving their care pathway, but are we actually using that input or are we simply gathering data without taking full advantage of its value? We need to demonstrate to the patients how their input has helped improve the system. This is what we mean by empowering the patients. I think this is one of the biggest problems when transitioning to value-based healthcare.

### TERJE PEETSO:

One important aspect of patient information and privacy is that we need to view the issue of data protection from two angles. One is meeting the requirements of data protection rules, and another is cybersecurity. We need to pay equal attention to both because when patients know that their information is safe and protected and

only used for medical purposes, then they are willing to let us use their data.

We have the information and we must utilise it. We need patient data for determining the correct diagnosis and treatment, monitoring the treatment, and choosing a rehabilitation method, for example. However, patient records should also be considered a part of big data that enables us to make better choices in protecting public health. We gather information and measure indicators better, which gives us higher-quality data. Now, the main question is how to integrate the existing information more efficiently. We need to explain to patients that their information will become anonymous at the moment of generalisation, so it becomes a part of big data, because this helps us understand the treatment of a particular condition better. The main goal of value-based healthcare is not better care for less money – it is more care for the same amount.

### KARL ARNBERG:

Value-based healthcare needs data to measure what we offer through the system. Here, we have a great opportunity to compare how different countries have transitioned to value-based healthcare and what measures have been effective in these countries. There are states that have done more in this field and thus achieved more. What kind of lessons have they learned not only when gathering data, but also when using it? What have they discovered and how well have the patients and healthcare providers accepted the change? The same goes for the general public and politicians. Has the administrative load increased because of it, and how much? If we heard more success stories and useful advice from the states that are ahead of the rest in this regard, then perhaps we could also convince those countries where the transition to value-based healthcare has not been particularly successful.

## ANNEX

## Value Based Healthcare - Tallinn 2021 Programme

04.03.2021 Tallinn, Estonia

09:45 - 10:00

**Virtual Meeting Room / Virtual arrival**

10:00 - 12:00

Plenary session, Virtual Meeting Room

**I session - Value Based Healthcare – Common Understandings - Why We Need to Measure Outcomes****Moderators: Marjo Näkki**, Journalist, YLE - Finnish broadcasting company (Finland)**Johannes Tralla**, Journalist, Estonian Public Broadcasting (Estonia)**Opening Address - Setting the Scene****Tanel Kiik, Minister**, Estonian Ministry of Social Affairs (Estonia)**Stella Kyriakides**, Commissioner, Health and Food Safety, European Commission**Value Based Healthcare – Common Understandings Why We Need Measured Outcomes****Nicola Bedlington**, Former Secretary-General, European Patients Forum (United Kingdom)**Value Based Healthcare: Getting There****Anna van Poucke**, Global Head of healthcare, KPMG International (Netherlands)**Value Based Health Care - Why Measure Outcomes and Cost?****Suzanne Gaunt**, CEO, ICHOM (United Kingdom)

12:00 - 13:00

Virtual Meeting Room

**Lunch**

13:00 - 15:00

Plenary session, Virtual Meeting Room

**II session - Good Practices and Real-world Examples****Moderators: Marjo Näkki**, Journalist, YLE - Finnish broadcasting company (Finland)**Johannes Tralla**, Journalist, Estonian Public Broadcasting (Estonia)**VBHC in Practice****Francisco Rocha Gonçalves**, Professor at Faculty of Medicine, University of Porto (Portugal)**Payer's Role and Governance for VBHC****Rain Laane**, CEO, Estonian Health Insurance Fund (EHIF) (Estonia)**Case Study: What Benefits Does Measurement Give to a Provider? Real Life Examples of VBHC and PPP****Karl Arnberg**, Access Model Director Region Europe, Novartis (Sweden)**Development and Challenges of Outcome Measurement at Martini-Klinik, Prostate Cancer Center, Hamburg****Burkhard Beyer**, Consultant Urologist and CMIO, The Martini Klinik (Germany)**Regional Hospitals****Terje Peetso**, Member of the Management Board, North Estonia Medical Centre (Estonia)

15:00 - 15:30

Virtual Meeting Room

**Coffee break**

15:30 - 17:00

Plenary session, Virtual Meeting Room

**III session - Discussion Panel****Moderators: Marjo Näkki**, Journalist, YLE - Finnish broadcasting company (Finland)**Johannes Tralla**, Journalist, Estonian Public Broadcasting (Estonia)**The Future of Health****Bettina Ryll**, Founder, Melanoma Patient Network Europe (Sweden)**Discussion Panel****Andrzej Jan Rys**, Director responsible for Health Systems, Medical Products and Innovation, Directorate-General for Health and Food Safety, EU**Rain Laane**, CEO, Estonian Health Insurance Fund (EHIF) (Estonia)**Nathalie Moll**, Director General, EFPIA (Belgium)**Terje Peetso**, Member of the Management Board, North Estonia Medical Centre (Estonia)**Bettina Ryll**, Founder, Melanoma Patient Network Europe (Sweden)**Wrap-up of our event**

Authors: Mr. Vahur Valvere, MD, PhD, Chair of the Council, Estonian Cancer Society

Mr. Riho Tapfer, MD, Managing Director, Association of Pharmaceutical Manufacturers in Estonia (APME)

Ms. Triin Ventmann, Physician-Resident, Family Medicine

Mr. Toomas Hõbemägi, Journalist-Interpreter

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