On the way to the integrated health and social care system

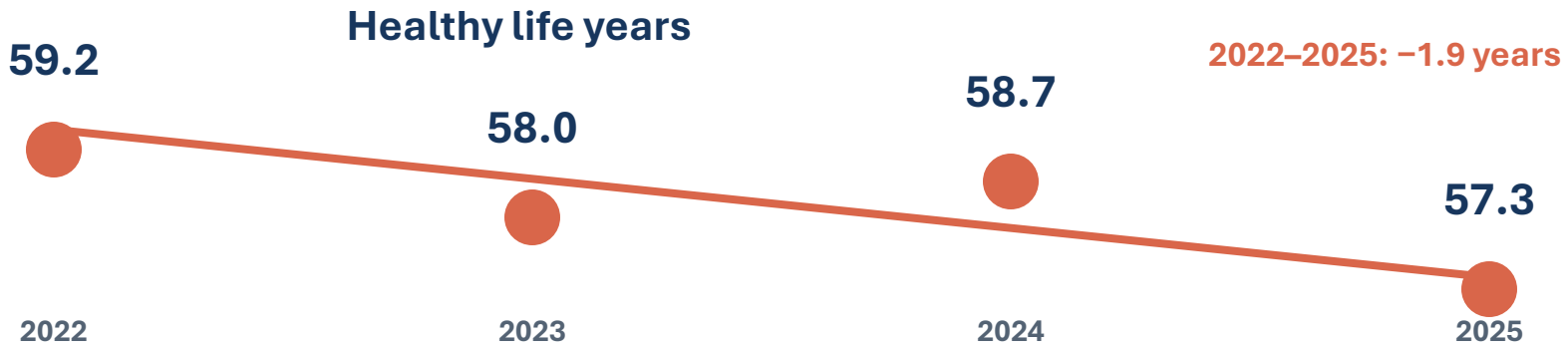
Estonia 2026

September 2026

SOTSIAALMINISTEERIUM

We live longer and spend more, but gain no healthy life years

Costs	2019	2025
Healthcare	**1,400m**	**2,500m**
Social protection	190m	360m



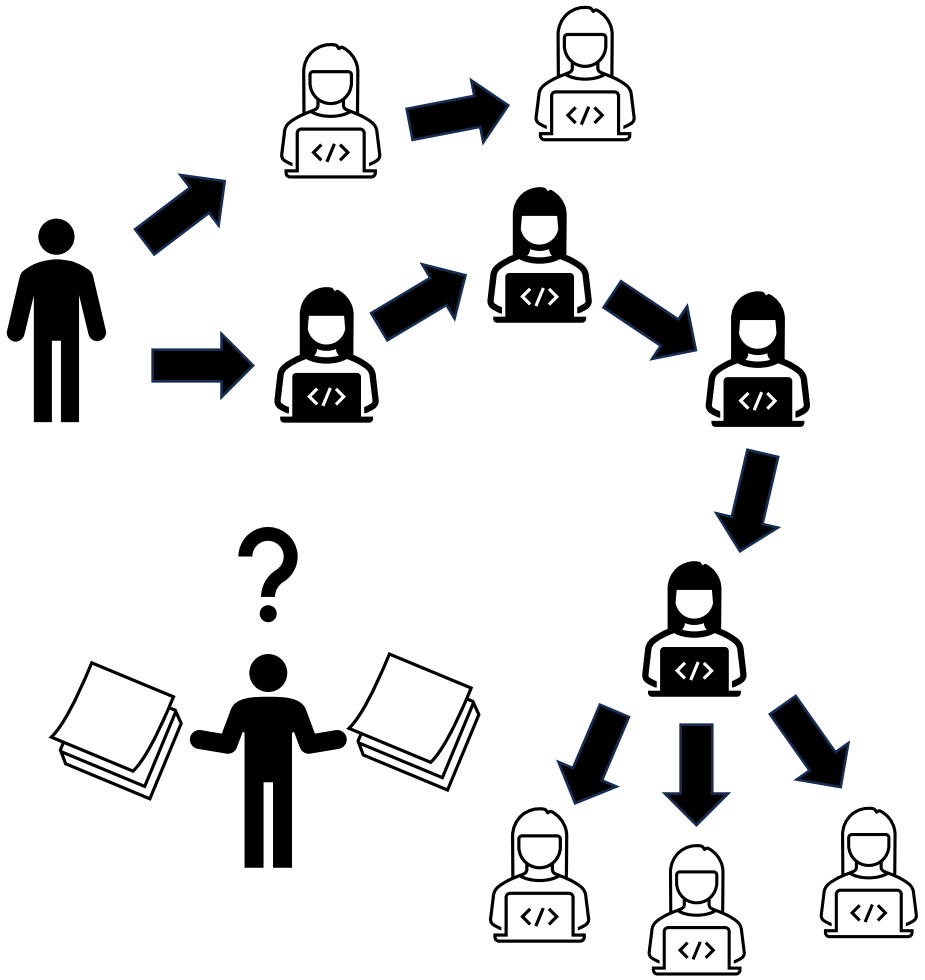
Annual figures fluctuate, with no sustained improvement. The 2025 figure is the lowest in four years.

We have developed separate, clinically effective services while neglecting comprehensive care

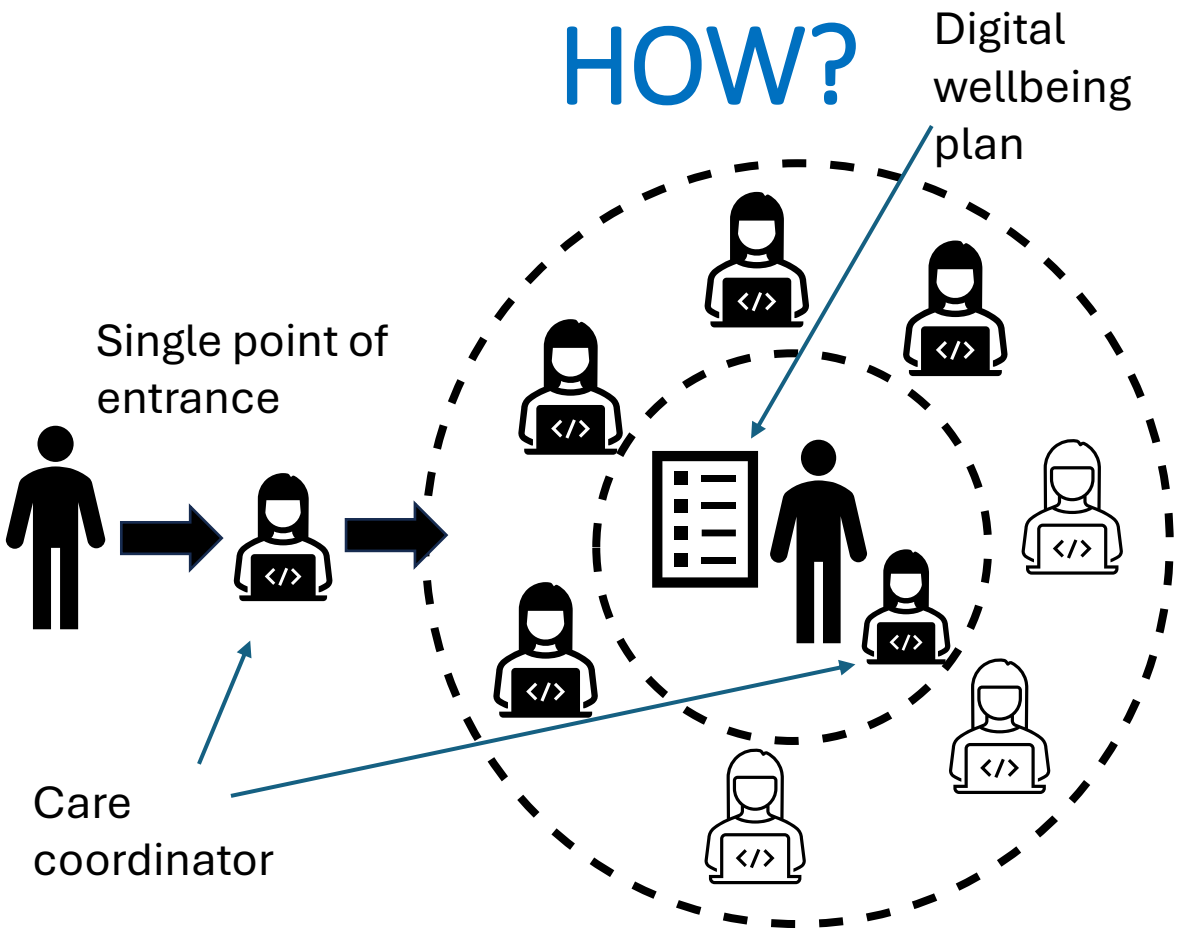
We need a shift from reactive, individual services to proactive, comprehensive care pathways coordinated by primary care.

Care integration – why, how, to who?

WHY ?



HOW?



TO WHO?

1. Multiple chronic conditions + social problems
2. People with needs of social rehabilitation

Strategy for implementation integrated care

SHARED VISION+ strategic management

GOAL ORIENTED FINANCING

POPULATION HEALTH MANAGEMENT

WELLBEING REGIONS and formal networks

SUPPORTIVE LEGISLATION

DIGITAL PERSONAL PLAN+ access to data

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Collaboration management mechanisms

TODAY	PLAN
Health care arranged and financed by state. Social care by municipalities. Very few collaboration in strategic management.	Collaboration level will be county (ca 40 000 people) – an wellbeing region. Representatives of state and municipalities meet on regular bases to agree in common vision, common goals and joint implementation + outcome measurement
Health and social care providers does not collaborate	Service providers in an wellbeing region will collaborate similar to accountable care organizations (TERVIK) in order to provide integrated care. Additional financing mechanism will encourage collaboration.
Missing service coordination between health and social care. No specialists who could access to the information system of both areas.	Trained care coordinators (ca 230 specialists) will work in each wellbeing region in each TERVIK.

Possible collaboration areas

- Prevention and health promotion incl health literacy
- Care coordination services for other target groups
- Primary care and social services preparedness (24/7)
- Collaboration of municipalities in providing social services
- Implementation of development and innovation projects
- Collaboration in emergency situations

Priority collaboration areas set by state

- Care coordination at primary care level for target group, who has multiple chronical diseases and social problems + need for social rehabilitation
- Care coordination in supporting discharge from the hospital
- Collaboration in strenghtening primary care

+Measured targets related to financing

Priority collaboration areas set by region

Examples:

- Health promotion in mental health
- Substance abuse
- Lonelyness

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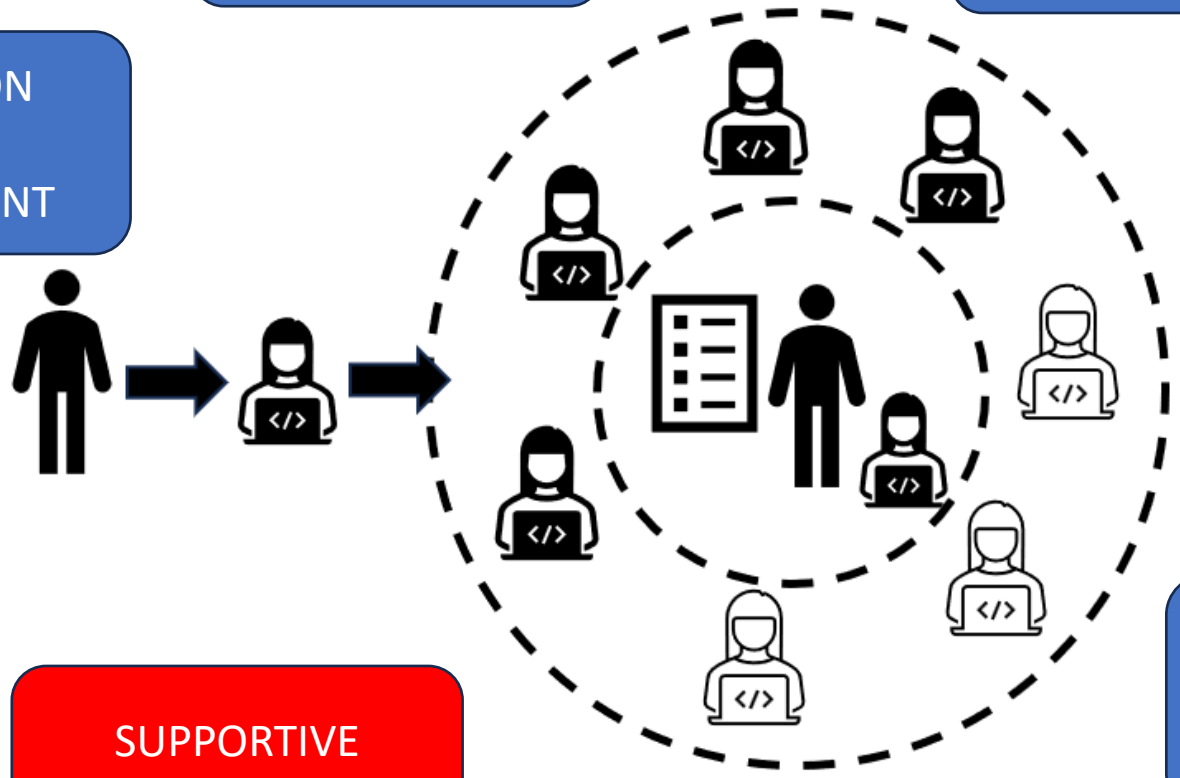

WELLBEING REGIONS and formal networks

SUPPORTIVE LEGISLATION

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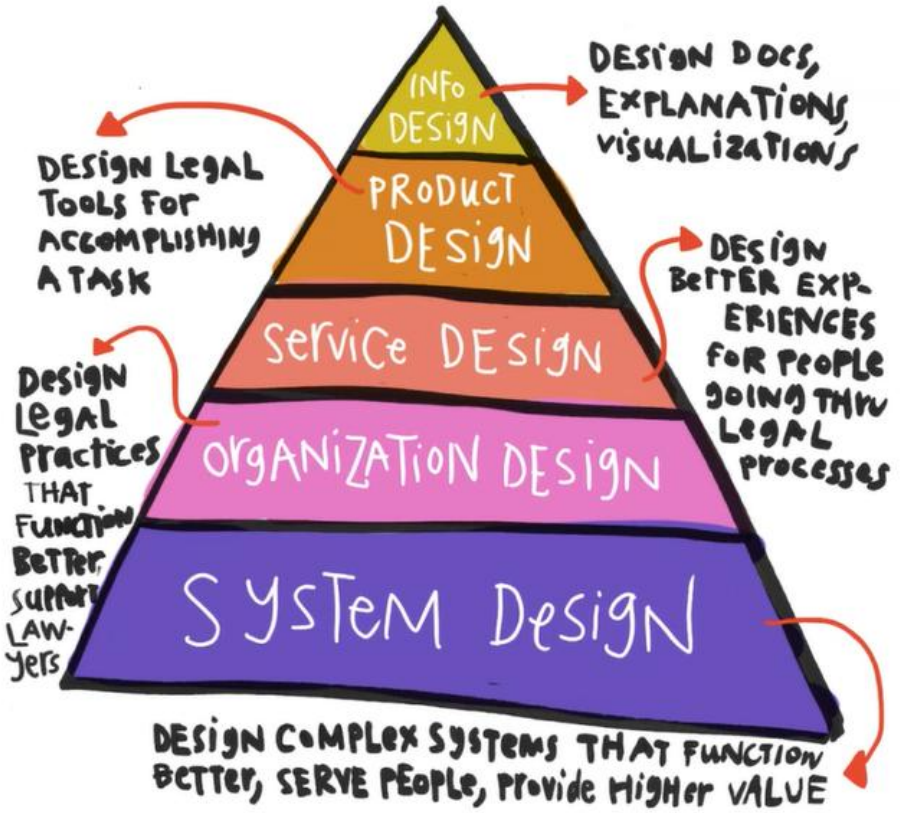
Planned changes in legislation

- Establishing wellbeing regions (15) and formation of integrated care organizations (TERVIK) within well-being regions (01.11.2027)
- Compulsory strategic management obligation for state representatives and municipal representatives in all well-being regions (01.05.2028)
- Legislation of coordination service, role of care coordinator (01.05.2028)
- Legal basis for a welfare plan and for data exchange, enabling involved specialists to share digitally necessary information and jointly plan support and services (01.05.2028)
- Population health management and widespread implementation of outcome-based financing (01.05.2028)



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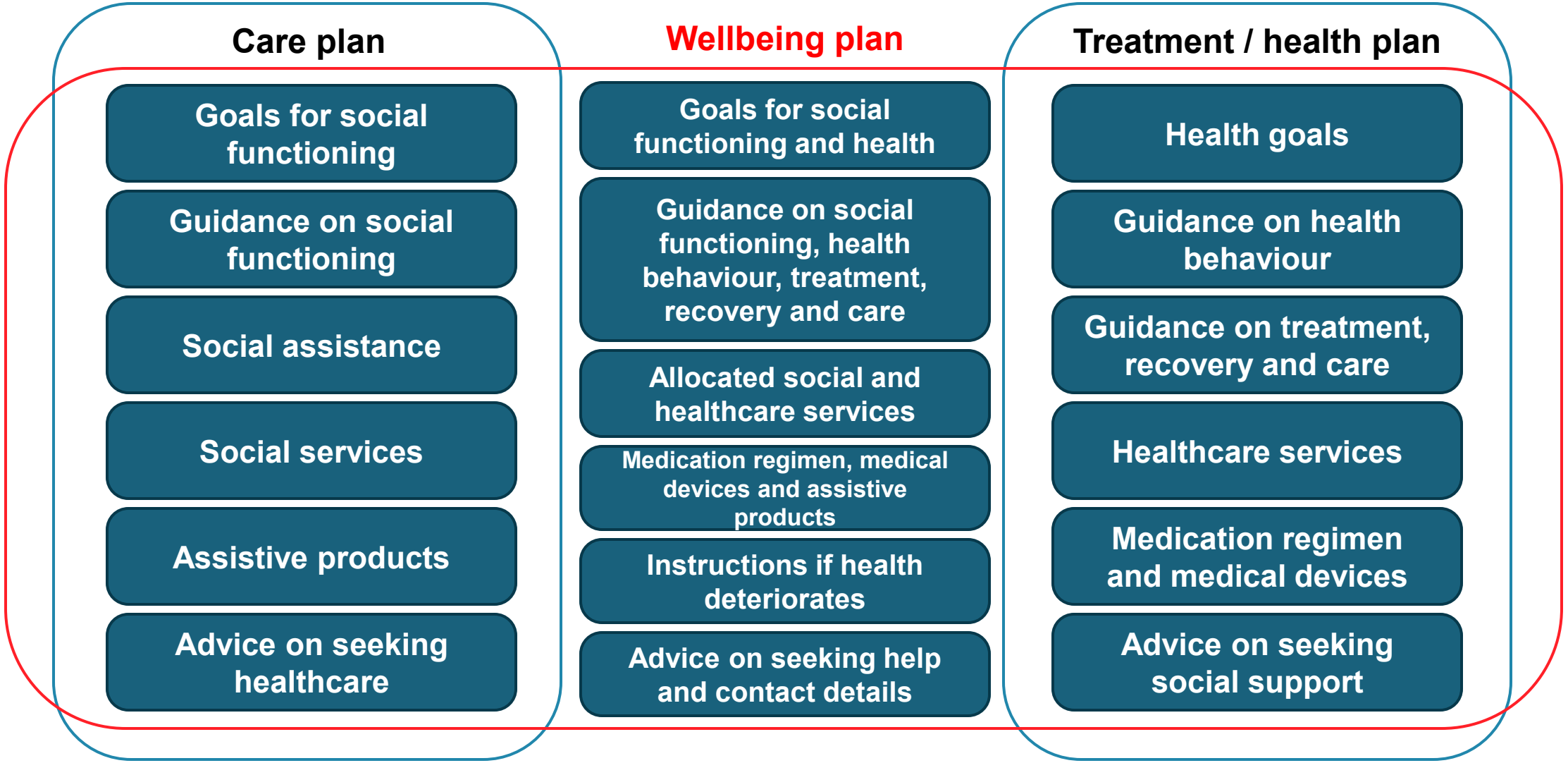


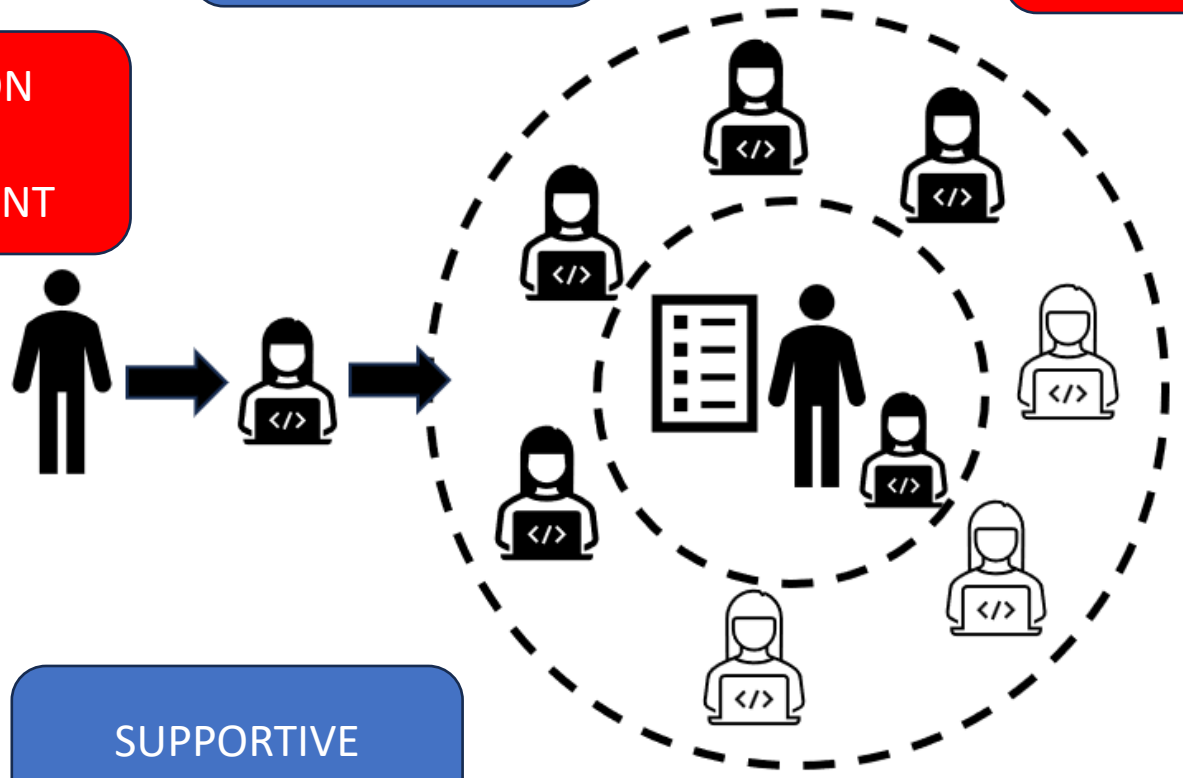
- Local authority social workers use a care plan in the **social information system**. The person itself cannot view this plan.
- Healthcare professionals use a treatment/health plan in the **health information system**. The person cannot view this plan.
- The wellbeing plan brings the information together for the multidistsiplinary team in **wellbeing information system** and person can see this in **the Health Portal.**

Population health management and financing

SHARED VISION+ strategic management

GOAL ORIENTED FINANCING

POPULATION HEALTH MANAGEMENT



WELLBEING REGIONS and formal networks

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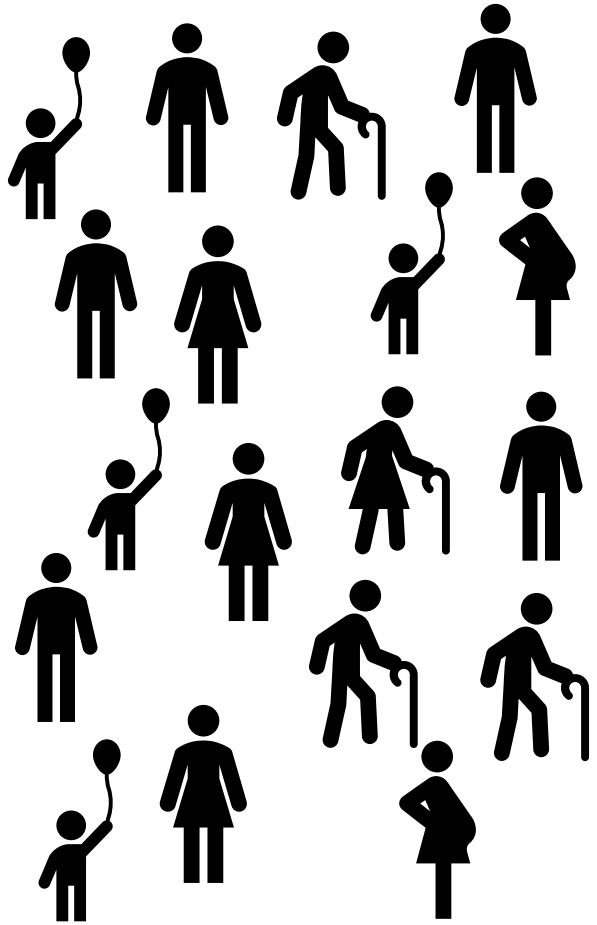
Population health management

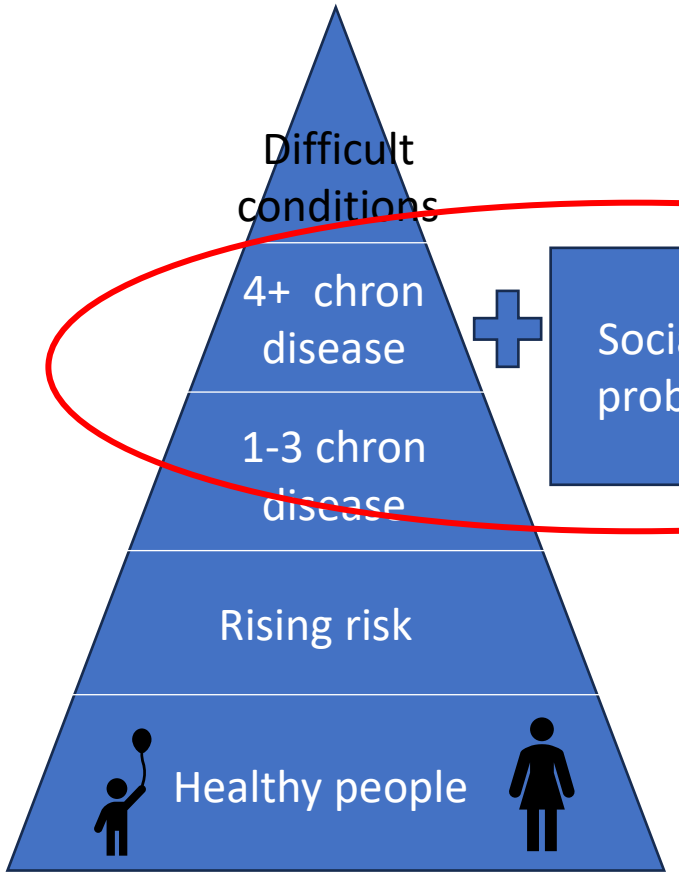
TODAY

County population (mostly reactive service provision)



PLANNED

County population (target groups) & targeted services (incl proactive)



Social probl.

HOSPITAL

RISK MANAGEMENT + COORDINATION

RISK MANAGEMENT

PRIMARY PREVENTION, PROMOTION

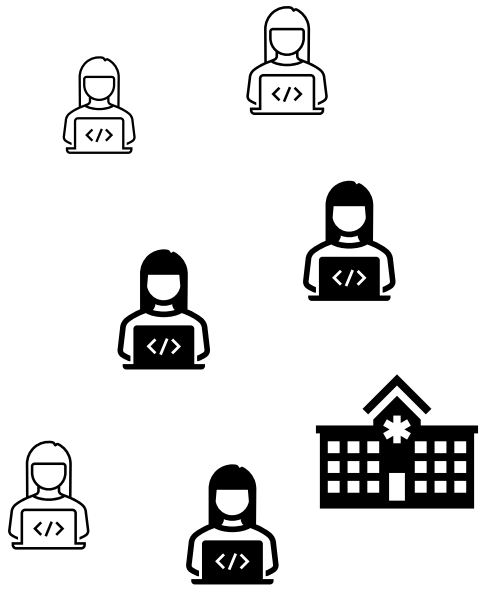
One person, one plan!

WELLBEING PLAN

Bonus financing – redistribution of the saved resoursses to the prevention

Financing of integrated care

TODAY



Social and health care providers in a county

PLAN

Financing of coordinated care

Health services financing

Financing of coordination services and collaboration

Social services financing

Separated

Separated

- Base cost for 15 TERVIK ca 1,5 mln eur annually
- Coordination service cost ca 8 mln eur annually
- TERVIK development support for 2029-2034 ca 16 mln
- Primary care strenghtening 2029-2034 ca 10 mln

ICIC27 Tallinn, Estonia – 10-12 May 2027

International Conference on Integrated Care

Web page: [ICIC27 Tallinn | International Conference on Integrated Care]

ICIC27 conference themes

From Integration to Impact: Delivering better outcomes through data, coordination and population health (200 sessions over 3 days with more than 400 presenters)

1. From Data Silos to Shared Intelligence: Technology as an Enabler of Integrated Care

This topic explores how digital infrastructure enables integrated care across organisational and sector boundaries. It includes the use of shared electronic health records, data interoperability, AI-enabled decision support, and digital tools that support care coordination and population health insights. Discussion could include governance, data sharing barriers, ethical use of AI, and how technology can strengthen person-centred and community-based models of care.

2. Measuring What Matters: Outcomes, Value and Population Health in Integrated Care Systems

Integrated care systems increasingly shift from measuring activity to measuring outcomes that matter for people and communities. This theme focuses on population health management approaches that combine data, risk stratification, prevention strategies and cross-sector collaboration to improve health outcomes. It may include examples of value-based care, integrated commissioning, and the use of outcomes frameworks to guide system improvement.

3. System Resilience Through Integration: Responding to Public Health Emergencies and Crises

Major crises such as pandemics, climate events, humanitarian emergencies and system shocks expose fragmentation in health and care systems. This theme explores how integrated care structures support resilience, coordination and rapid response. Topics may include cross-sector governance, community partnerships, public health integration, and lessons learned from COVID-19 and other emergencies.

4. Making the Case for Care Coordination: Demonstrating Value and System Efficiency in Integrated Care

Care coordination is a cornerstone of integrated care but is often viewed as an additional cost. This theme explores whether coordination functions such as case management, multidisciplinary teams, care navigators and community connectors improve system efficiency and outcomes. Evidence on cost-effectiveness, workforce roles and organisational models could be explored.

THANK
YOU!