Estonia

Health Care & Long-Term Care Systems

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Health care systems

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2.8. ESTONIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

Estonia, the most northerly of the Baltic states, is a member of the European Union since 2004, has a GDP of around €24 bn., or 23.7 thousand PPS per capita, below the EU average of 30.0 thousand PPS per capita ([121]). Population was estimated in 2018 at almost 1.3 million inhabitants.

During the coming decennia the population will steadily decrease, from 1.3 million inhabitants in 2016 to 1.2 million inhabitants in 2070. Thus, Estonia is facing a considerable decrease of its population by 11%, while the EU average population is estimated to increase by 2%.

Total and public expenditure on health as % of GDP

Total expenditure([122]) on health as a percentage of GDP (7.1% in 2015) is well below the EU average ([123])(10.2%), having significantly increased since 2005 (5%). Public expenditure on health as a percentage of GDP (5.5%) is also below the EU average (8% in 2015), but is still significantly higher than in 2005 (4.1%). Looking at health care without long-term care([124]) reveals a different picture with public spending being closer to the EU average (5.2% vs 6.8% in 2015).The growing ratios may underestimate the actual growth in the health sector due to very high GDP growth: prior to the crisis Estonia registered one the highest GDP growth in the EU reaching a double-digit output growth. Indeed, total (1650 PPS in 2015) and public (1265 PPS in 2015) per capita expenditure have more than doubled since 2005. However, they are still considerably lower than the EU average (3305 PPS and 2609 PPS respectively in 2015). Note though that the share of public expenditure in total expenditure on health is relatively high (76.7%, slightly below the EU average of 78.4% in 2015).

Expenditure projections and fiscal sustainability

Public expenditure on health care is forecast to increase by 0.3 pps by 2070 according to the 2018 Ageing Report reference scenario ([125]). Under the risk scenario this could go up by 1.1 pps of GDP.

Overall, for Estonia significant no sustainability risks appear over the short-term and risks over the medium and long run are low ([126]).

Health status ([127])

Life expectancy in 2015 (82.2 years for women and 73.2 years for men) and healthy life years (56.2 years for women and 53.8 years for men) are below the EU average and, particularly for men, amongst the lowest in the EU ([128]). The large difference in male and female life expectancy in Estonia is also explained by differences in avoidable mortality. Specifically, cardiovascular diseases and external causes account for 29.6% and 21.1%, respectively, of deaths among men under-65 years, while accounting for only 22.4% and 12.2%, respectively, among women ([129]). It should be noted that Estonia has had the highest gains in health-adjusted life expectancy in the OECD between 2000 and 2015. Men's life expectancy shows a consistent increase from 1995 onwards but suffered a significant decline in the early 1990s, a period of substantial economic and political transition. Additionally, infant mortality has fallen from 5.4 per 1000 live births in 2005 to 2.5 in 2015, falling below the EU average (3.6).

It should also be noted that Estonia has an amenable mortality rate per 100,000 inhabitants

([121]) See page 84 http://www.oecd.org/health/preventing-ageing-unequally-9789264279087-en.htm.

([122]) Please note that these figures reflect current plus capital expenditure in contrast to OECD and EUROSTAT data series, which reflect only current expenditure.

([123]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units or units of staff where relevant. The EU average for each year is based on all the available information in each year.

([124]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

([125]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([126]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([127]) As well as the statistical annex, this section draws on the State of Health Country profile for Estonia https://ec.europa.eu/health/sites/health/files/state/docs/chp_et_english.pdf.

([128]) Data on life expectancy and healthy life years is from the Eurostat database.

([129]) Data referenced in this sentence comes from 2017.

that is, at 224, far above the EU average of 127 for 2015. Mortality rates associated with cardiovascular diseases nearly double the EU average. The incidence rate of tuberculosis is high as is the incidence rate of lung cancer. Estonia however registers a relatively moderate proportion of people that smoke regularly: 22.1% of adults in 2014, only slightly above the EU average. However, smoking rates are much are higher amongst men than women. Alcohol consumption, at 10.3 litres per capita is also close to the EU average of 10.2, although, again, binge drinking among men is high. In 2014, 19.7% of the population was obese, above the EU average of 15.5%. These values on the health status of the population deserve attention and action to protect population health outcomes and reduce the burden of disease.

System characteristics

Overall description of the system

The system is financed primarily through mandatory contributions (earmarked payroll tax on employees and self-employed) and through taxation revenues that pay for ambulance and emergency care and health promotion and disease prevention.

Health expenditure funding comes from social insurance contributions (earmarked payroll tax) plus government taxation, out-of-pocket contributions, private insurance and financial contributions from the rest of the world. An issue of concern is that funding is strongly based on employment-related contributions but the share of non- contributing individuals such as children and pensioners is almost half of the insured. The authorities recognise the narrow revenue base, strongly based on wages (notably in the context of ageing) and there is the intention to enlarge the revenue base for the sector to ensure the long-term sustainability of the sector financing.

Coverage

The Estonia Health Insurance Fund (EHIF) purchases and reimburses care for about 93.6% of the population based on residence and group membership (e.g. unemployed, children, pensioners, full time carers). 6% of the population are still uninsured and have access to emergency care only.

Administrative organisation and revenue collection mechanism

The EHIF establishes contracts with care providers, including General Practitioners (GPs). However, access to primary care is considered to be very good. Cost-sharing also appears to encourage greater use of primary care services vis-à-vis specialist and inpatient care, which can be cost-effective.

Nevertheless, different measures of the reform of the sickness insurance regime may have important, if not reverse effects in the future. For instance, EHIF compensations are only paid now from the 9th sickness day. Before that, the employer has to cover the costs. First three sickness days are compensated voluntarily by the employer. While some informal payments exist in the health sector, they do not appear to be widespread or significant in magnitude.

The EHIF (which has four regional branches but acts as one purchaser of care) uses its budget to establish contractual arrangements with providers, remunerate doctors, and reimburse medicines.

There is an overall budget constraint defined annually for public spending on health which is quite detailed and transparent. Expenditure cannot exceed revenue. However, revenue and expenditure do not necessarily have to match in each financial year, as the EHIF has some accumulated reserves (around 1% of GDP) and could in principle use those to finance expenditure. In practice though, expenditure has indeed followed the same pattern as revenue. Therefore, when for example the budget has run out, hospitals may in theory postpone surgical interventions for the following year or else the patient has to pay for the full cost. However, in practice such cases are extremely rare.

Role of private insurance and out of pocket co-payments

Cost-sharing applies to home and outpatient visits, hospital stays and medicines, though pensioners and children below 16 have lower out-of-pocket payment. Adult dental care and plastic surgery are

not covered by the EHIF. The share of private expenditure on health in total health expenditure (23.3% in 2015) is slightly above the EU average (21.6%). Out-of-pocket expenditure constitutes about 22.8% of total health expenditure and stands above the EU average (15.9% in 2015). Despite having one of the highest levels of self-reported unmet need for care in the EU ([130]), from the point of view of access, a smaller share of private expenditure than that of its Baltic neighbours and the way cost-sharing is applied across services may ensure better access to basic health care services in Estonia than in Latvia and Lithuania. This hypothesis is supported by higher life expectancy and lower amenable mortality than in those countries. Out-of-pocket expenditure may still pose barriers to access to low income groups and uninsured (authorities do acknowledge that socioeconomic differences have an impact in the use of health services).

While some informal payments exist in the health sector, they do not appear to be widespread or significant in magnitude.

Types of providers, referral systems and patient choice

Primary care is provided by self-employed family practitioners (FPs, equivalent to GPs) and nurses or by family practitioner group practices (owned by family practitioners). Ambulatory specialist care is provided in health care centres, hospital outpatient departments and specialists' own practices. Inpatient hospital care is provided in regional, central, general or local hospitals (state or municipally owned). Outpatient and inpatient providers establish contracts with the EHIF.

Access to primary care is considered to be very good due to the high numbers of general practitioners (GPs), the ability to see the GP within 3 days, and a 24-hour free primary care counselling phone line. Cost-sharing also appears to encourage greater use of primary care services vis-à-vis specialist and inpatient care, which can be cost-effective.

([130]) State of Health Country Profile (2017): Estonia https://ec.europa.eu/health/sites/health/files/state/docs/chp_et_english.pdf.

Authorities acknowledge long delays for specialist consultations and inpatient care. They have therefore established centrally managed waiting lists and additional resources to services with the longest lists.

The total number of practising physicians per 100, 000 inhabitants has been fairly stable during the last decade (342 in 2015), slightly under the EU average (344). Data on the physician skill/mix indicates that the number of general practitioners (GPs) per 100 000 inhabitants (71 in 2015) has also remained relatively flat since 2005 and is slightly below the EU average (78.3) as part of the authorities' long term effort to improve primary care provision. This has resulted in a relatively good access to primary care to the insured population. The number of nurses (601 in 2015) per 100 000 inhabitants is significantly below the EU average (833). Estonia may have suffered from staff migration to other EU countries where qualified health staff was needed and wage levels were higher. There is also a problem of ageing of the workforce, in 2017 – 73.1% of all physicians had more than 40 years of age (including age groups: 40-49; 50-59; 60+) To retain staff the authorities had increased wages in the sector prior to the crisis but this trend was reversed with the economic crisis to improve fiscal balances. However, there have been constant wage increases since 2011 for doctors (44%) and nurses (42%) between 2011 and 2017, similar to that of the overall wage increase in the country (46%). However, if there is no political will to increase total public spending on health care, salary increases will need to be covered by efficiency gains of hospitals and other health care organisations, as well as a limited increase in OOP payments.

Note that the authorities have made strong efforts to concentrate medical training, emphasise primary care training of doctors and nurses and bring training in line with EU law, and to start developing human resources planning in the sector.

Since the early 1990s, national authorities have made a significant and successful effort to enhance primary care provision and to strengthen the referral system from primary care to specialist doctors and the gatekeeping role of FPs (to reduce the unnecessary use of specialist and hospital

care). All inhabitants have to register with a FP, who acts as family doctor and as a gatekeeper referring patients to other specialists and hospital care. Patients can choose their FP and choose the specialist after referral.

Estonia has seen a large reduction in the number of acute care beds per 100 000 inhabitants in the last decades, and its number is now below the EU average (368 vs. 402 in 2015). Bed occupancy rates have stayed relatively constant and, at 67%, are slightly below the EU average at 78.3% in 2015.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Payments systems have evolved much over the years and consist of a mix of remuneration types. GPs receive a mix of capitation, base fee, distance fee for remote practices, fees for defined services and bonus payments for health promotion, disease prevention and disease management activities. This mixed system intends to render primary care more attractive and to provide incentives for primary care provision including some health promotion, disease prevention activities and disease management. All other staff is remunerated on a salary basis.

Hospital average length of stay (7.6 days in 2015) is at the EU average (7.6 days), having remained relatively flat from 2010. The proportion of hospital surgery performed as day cases was 31.7% in 2011, a significant increase from 4.3% in 2001, close to the EU average of 32.3%. Hospitals remuneration is a mix of activity-based payment using DRGs (diagnosis related groups), fee-for-services and bed-days. Further reliance on prospective payment on the basis of DRGs was planned. Although significantly improved and based on complex criteria, the basis for establishing contracts between the EHIF and the various providers could perhaps be further improved in the long run to favour cost-effective interventions when health technology assessment is applied more regularly.

The market for pharmaceutical products

Total (1.2%) and public (0.6%) expenditure on pharmaceuticals([131]) as a percentage of GDP are below the EU average (1.4% and 1% respectively in 2015) and have been relatively constant since 2003 (even since 1999, earliest available data). Public expenditure on pharmaceuticals as a share of public current health expenditure is close to the EU average (12.4% compared to 12.7% in 2015).This suggests that policies regarding pharmaceuticals have been fairly successful at controlling pharmaceutical expenditure.

Imported medicines now come from Western Europe rather than the former Soviet Union, which resulted in a large increase in prices. In order to control overall expenditure the authorities have implemented a large number of policies. The initial price decision is based on a) international prices, as well as b) economic evaluation and c) the cost of existing treatments. In addition, authorities implement 1) price-volume agreements, together with 2) reference pricing, whereby the maximum reimbursement level of a prescribed drug is based on the second lowest price of existing drugs that have the same active ingredient and form, and 3) the definition of positive lists (as much as possible based on economic evaluation). The authorities also implement prescriptions guidelines and monitor prescription patterns of physicians who get feedback once a year. These policies have been very useful in controlling pharmaceutical expenditure growth. Perhaps the authorities could explore if these policies, which currently apply only to reimbursable pharmaceuticals, could be extended to non-reimbursable medicines especially in the context of high out-of-pocket payments.

Use of Health Technology Assessments and cost-benefit analysis

Estonia has a Health Technology Assessment Centre that conducts health technology assessment. It was at first funded mainly from Structural Funds (01.02.2012-30.08.2015), and it will in the future be getting its budget from the state. The authorities and professional associations are developing

([131]) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 in the OECD System of Health Accounts. Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals.

treatment guidelines to harmonise and rationalise medical practices.

Data management and E-health (e-prescription, e-medical records)

Digital prescription was launched in 2010 and by 2012 most prescriptions were written electronically. Individuals can access their own medical data by using their electronic ID cards via the patient's portal.

Data has substantially improved in recent years. Information on activity and services is collected by the EHIF and the Ministry of Social Affairs on a routine yearly basis. Providers are obliged to provide annual data reports according to national standards. This information is used for contracting purposes and allocation of funds. The Hospital Network Development Plan is used to make projections of hospital activity and future hospital capacity needs and thus hospital licensing and hospital service regulation (and helped adjusting/reducing hospital capacity over the years). There are other plans for other services.

Health promotion and disease prevention policies

The government has approved the Public Health Development Plan for 2009-2020 with the objective of continuously improving the health status of the population: increasing average life expectancy at birth, increasing healthy life years and reducing socio-economic inequalities in health. This plan denotes a recent much stronger concern with health promotion and disease prevention. Total and public expenditure on prevention and public health as a % of GDP (0.2% and 0.1% in 2015) are below the EU average (respectively 0.3% and 0.3%). The same is true for public expenditure on prevention as a proportion of public current health expenditure (2.4% vs a EU average of 3.2%) However, total (3.2%) expenditure on prevention and public health as a % of the total public expenditure on health is in fact slightly higher than the EU average in 2015.

Transparency and corruption

The Estonian health system is perceived to be transparent and featuring little corruption. The latest health sector corruption survey (University of Tartu, 2011) concluded that the role of informal payments is marginal; 2% of patients acknowledged having paid informally to obtain faster access to care and about 3% to have paid after getting the treatment. Overall, informal payments do not appear to be widespread or significant in magnitude. This may be because of the introduction of formal co-payments in 2002 or because of the generally low level of corruption ad informal payment practices.

Recently legislated and/or planned policy reforms

In order to improve access to health care, the Estonian government has legislated additional funds to the EHIF starting from 2018. Along with these funds, EHIF will take on some extra expenditures which were so far financed from the state budget (ambulance service, HIV/AIDS treatment, dental care and others). However, these costs amount to about half of these extra funds. The remaining funds are allocated to reduce unmet need – to reduce delays. These extra funds amount to 15% increase of the EHIF budget in 2022. The base for calculating the extra funds are the pensions for non-working pensioners. The rate is 13% ([132]), which is the same as the healthcare proportion of the social tax paid by the working population.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, many quite successfully (e.g. the development of a strong primary care system that patients can easily access and which can contribute to control cost and ensure the cost-effectiveness of the systems; the development of data collection and monitoring of inputs, processes, outputs and outcomes use for decision-making), and which Estonia should continue to pursue. The main challenges for the Estonian health care system are as follows:

- To improve, as acknowledged by the authorities, the basis for more sustainable and enhanced financing of health care in the future (e.g. considering additional sources of general budget funds), with a better balance between

([132]) There is a phasing-in period from 2018-2021 when the rate is lower.

resources and demand, between the number of contributors and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector it is important that they do not remain fragmented but are pooled together, maintaining the strong pooling mechanisms in place today.

- To define a comprehensive human resources strategy to ensure a balanced skill-mix, avoid staff shortages and motivate and retain staff within the sector in view of ageing and migration.

- Increasing insurance coverage to the uninsured population, while improving access, could also decrease the unnecessary use of emergency care services (currently the only services to which uninsured individuals have access).

- To continue the efforts to gather and make more use of cost-effectiveness information in determining the basket of goods and the extent of cost-sharing.

- To continue to work on public health priorities defined in the 2009-2020 Plan and continue to enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, lack of exercise, obesity).

Table 2.8.1: **Statistical Annex – Estonia**

GDP	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
GDP, in billion Euro, current prices	11	14	16	17	14	15	17	18	19	20	20	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	18.7	19.5	19.8	18.3	15.8	16.5	17.6	18.1	17.9	18.4	18.8	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	10.0	10.9	8.4	-5.1	-14.6	2.4	7.9	4.7	2.3	3.2	1.9	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	19.4	13.5	-5.0	6.8	-2.7	-0.6	7.7	4.7	6.0	9.2	3.7	0.2	0.2	4.1

Expenditure on health*	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Total as % of GDP	5.0	5.4	5.6	5.6	7.0	6.7	6.2	6.3	6.5	6.7	7.1	10.2	10.1	10.1	10.2
Total current as % of GDP	4.7	4.9	5.1	5.0	6.5	6.3	5.8	5.8	6.0	6.2	6.5	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.3	0.5	0.5	0.7	0.5	0.4	0.3	0.5	0.5	0.5	0.6	0.9	0.6	0.2	0.3
Total per capita PPS	618	803	1,016	1,037	1,113	1,103	1,153	1,281	1,390	1,495	1,650	2,745	2,895	2,975	3,305
Public total as % of GDP	4.1	4.1	4.4	5.2	5.6	5.2	4.8	5.0	5.0	5.2	5.5	8.0	7.8	7.8	8.0
Public current as % of GDP	3.8	3.6	3.9	4.6	5.1	4.8	4.5	4.5	4.6	4.7	4.9	7.7	7.6	7.6	7.8
Public total per capita PPS	503	615	795	962	885	857	901	1,006	1,073	1,157	1,265	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.25	0.48	0.53	0.67	0.50	0.36	0.34	0.51	0.45	0.45	0.54	0.2	0.2	0.2	0.2
Public as % total expenditure on health	81.5	76.6	78.2	92.8	79.5	77.7	78.1	78.5	77.2	77.3	76.7	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	14.5	15.0	14.9	11.7	11.4	13.2	14.1	13.2	13.7	13.1	13.3	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	94.3	95.0	95.9	95.6	95.6	95.6	92.9	93.7	93.6	93.9	94.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	20.5	25.4	22.2	20.5	20.3	21.9	21.6	21.5	22.6	22.6	22.8	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Population, current (millions)	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	502.1	503.0	505.2	508.5
Life expectancy at birth for females	78.2	78.6	78.9	79.5	80.3	80.8	81.3	81.5	81.7	81.9	82.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	67.6	67.6	67.5	68.9	70.0	70.9	71.4	71.4	72.8	72.4	73.2	76.6	77.3	77.7	77.9
Healthy life years at birth females	52.4	53.9	54.9	57.5	59.2	58.2	57.9	57.2	57.1	57.1	56.2	62.0	62.1	61.5	63.3
Healthy life years at birth males	48.3	49.6	49.8	53.1	55.0	54.2	54.3	53.1	53.9	53.2	53.8	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	136	128	105	90	79	74	255	252	240	235	224	64	138	131	127
Infant mortality rate per 1 000 live births	5.4	4.4	5.0	5.0	3.6	3.3	2.5	3.6	2.1	2.7	2.5	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Inpatient curative and rehabilitative care	1.7	1.5	1.5	1.8	1.8	1.7	1.5	1.5	1.5	1.5	1.6	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.0	1.1	1.2	1.3	1.8	1.8	1.7	1.7	1.8	1.9	2.0	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.2	1.2	1.1	1.3	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.4
Prevention and public health services	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	1.5	1.4	1.4	1.7	1.8	1.7	1.5	1.5	1.5	1.5	1.6	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.8	0.8	1.0	1.1	1.4	1.2	1.2	1.2	1.2	1.3	1.3	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.5	0.5	0.5	0.5	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Prevention and public health services	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.8.2: **Statistical Annex - continued – Estonia**

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
Inpatient curative and rehabilitative care	35.1%	30.9%	30.2%	35.7%	27.2%	26.5%	26.1%	25.9%	24.9%	24.8%	24.1%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	1.9%	1.8%	2.0%	2.5%	2.0%	1.9%	1.9%	1.9%	2.0%	2.7%	2.9%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	21.8%	22.9%	23.6%	27.0%	28.1%	28.0%	28.4%	28.5%	30.2%	30.1%	30.4%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	25.4%	24.2%	21.8%	25.2%	20.0%	20.5%	19.9%	20.1%	19.3%	18.7%	18.3%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	3.0%	3.7%	3.3%	3.8%	2.8%	2.8%	3.1%	2.9%	3.3%	2.6%	2.6%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	2.5%	2.7%	2.7%	3.2%	3.2%	3.5%	3.3%	3.6%	3.0%	3.1%	3.2%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	3.2%	2.9%	2.6%	2.6%	2.1%	2.2%	2.4%	2.1%	2.0%	2.1%	1.8%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	39.5%	38.6%	36.2%	36.5%	34.5%	34.1%	33.6%	33.1%	32.2%	32.1%	31.4%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	2.4%	2.4%	2.6%	2.5%	2.5%	2.3%	2.5%	2.5%	2.6%	3.4%	3.7%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	21.5%	22.6%	24.5%	24.6%	26.5%	25.4%	25.7%	26.2%	27.0%	27.0%	27.2%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	13.9%	13.2%	12.1%	11.9%	13.1%	13.6%	13.2%	13.4%	13.2%	13.0%	12.4%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	1.8%	1.7%	1.6%	1.8%	1.6%	1.9%	1.8%	1.8%	2.2%	1.3%	1.2%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	2.4%	2.8%	2.8%	3.3%	2.2%	2.7%	2.5%	2.7%	2.0%	2.3%	2.4%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	4.5%	3.6%	3.4%	2.9%	2.7%	2.9%	3.1%	2.7%	2.4%	2.6%	2.4%	4.1%	4.0%	3.6%	3.4%

Expenditure drivers (technology, life style)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
MRI units per 100 000 inhabitants	0.22	0.37	0.52	0.82	0.75	0.82	0.97	0.98	1.14	1.14	1.22	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.4	0.4	0.4	0.6	0.6	0.6	0.6	0.7	0.7	0.5	0.5	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	0.7	0.7	1.1	1.5	1.5	1.6	1.6	1.7	1.9	2.0	1.7	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	15.9	:	18.0	:	16.9	..	19.0	:	19.7	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	27.8	:	26.2	:	26.2	:	26.0	:	22.1	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	13.1	13.4	14.7	14.2	11.9	11.4	11.6	12.1	11.9	11.1	10.3	10.4	10.3	10.1	10.2

Providers	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Practising physicians per 100 000 inhabitants	317	319	326	333	327	322	326	328	328	332	342	324	330	338	344
Practising nurses per 100 000 inhabitants	633	632	640	640	613	608	618	617	557	565	601	837	835	825	833
General practitioners per 100 000 inhabitants	69	69	70	72	71	73	74	74	70	72	71	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Doctors consultations per capita	6.3	6.4	6.6	6.6	6.3	6.1	6.4	6.3	6.4	6.3	6.4	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	18	18	18	18	17	17	17	17	17	17	:	17	16	16	16
Day cases discharges per 100 000 inhabitants	3,886	4,814	5,916	6,061	5,921	6,080	6,852	8,044	7,021	7,862	:	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	69.0	71.0	71.9	70.1	68.2	70.8	71.0	69.1	69.4	69.1	67.0	77.1	76.4	76.5	76.8
Hospital average length of stay	6.0	5.9	7.9	7.8	7.7	7.6	7.7	7.9	7.5	7.6	7.6	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	12.2	14.2	16.2	16.8	25.3	25.8	28.2	31.8	29.0	31.7	:	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps. Estonia	EU
AWG reference scenario	5.3	5.2	5.1	5.2	5.3	5.4	5.5	5.6	5.6	5.6	5.6	5.6	0.3	0.9
AWG risk scenario	5.3	5.3	5.4	5.6	5.8	6.0	6.2	6.3	6.4	6.4	6.5	6.4	1.1	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in % Estonia	EU
Population projections until 2070 (millions)	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.2	1.2	1.2	1.2	-10.3	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Estonia

Long-term care systems

3.8. ESTONIA

General context: expenditure, fiscal sustainability and demographic trends

Estonia, the most northerly of the Baltic states has a GDP of 23.7 thousand PPS per capita, below the EU average of 30.0 thousand PPS per capita ([466]).

During the coming decennia the population will steadily decrease, from 1.3 million inhabitants in 2016 to 1.2 million inhabitants in 2070. Thus, Estonia is facing a considerable decrease of its population by 11%, while the EU average population is estimated to increase by 2%.

Health status

Life expectancy at birth for both men and women was estimated at respectively 73.2 years and 82.2 years in 2015 and is below the EU average (77.9 and 83.3 years respectively). Similarly, the healthy life years at birth for both sexes are 56.2 years (women) and 53.8 years (men) and substantially lower than the EU-average (63.3 and 62.6 respectively in 2015). The percentage of the Estonian population having a long-standing illness or health problem is considerably higher than in the Union (46.2% in Estonia versus 34.2% in the EU in 2015). The percentage of the population indicating a self-perceived severe limitation in its daily activities decreased from 2006 to 2009, but has increased since 2010 and is again above the EU-average (10.4% against 8.1% in 2015).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.13 million residents living with strong limitations due to health problems in 2016, an increase of 17% is envisaged until 2070 to 0.14 million. That is a less steep increase than in the EU as a whole (25%). Also as a share of the population, the dependents are becoming a bigger group, from 9.6% to 12.6%, an increase of 31% (EU: 21%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.5 pps of GDP by 2070 ([467]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.8 pps of GDP by 2070. However, no sustainability risks appear over the short-term and risks over the medium and long run are low ([468]).

System Characteristics ([469])

The long-term care system in Estonia consists of nursing care and welfare.

LTC services can be split into community care services (where the recipient is supported while continuing to live in her/his own home) and institutional services (care is provided in a welfare institution). Local governments determine the basket of home services and the relevant conditions and procedures to obtain them. Municipalities also provide adequate housing for those who cannot afford it. Where necessary they also provide social housing or assist persons who need assistance with self-contained living, by adapting the dwelling or helping them find more suitable housing.

Fostering is also provided, care in a suitable family that the recipient is not a member of. This service is provided mainly for children and needs to be based on a written agreement between the caregiver (host family) and the local municipality.

Institutional care is provided in welfare institutions that provide the recipients who stay there with appropriate care according to their level of dependency and age. Services are provided according to principles and in the same manner as

([466]) Eurostat, 2017.

([467]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf .

([468]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([469]) This section draws on OECD (2011b) and ASISP (2014).

they would be provided to recipients living at home.

To support informal care, a carer's allowance is paid by local governments to guardians or caregivers of disabled persons aged 18 years or above.

Public spending on LTC ([470]) reached 0.5% of GDP in 2016 in Estonia, below the average EU level of 1.6% of GDP. 45.1% of the benefits were in-kind, while 54.9% were cash-benefits (EU: 80 vs 20%).

In the EU, 50% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is higher in Estonia with 100%. Overall, 13.1% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.6%). On the one hand, high coverage rates couple with low overall expenditure may imply a lack of focus in the provision of long-term care services, possibly calling for increased prioritisation. On the other hand low shares of coverage may indicate a situation of under-provision of LTC services.

The expenditure for institutional (in-kind) services makes up 59.2% of public in-kind expenditure (EU: 66.3%), 40.8% being spent for LTC services provided at home (EU: 33.7%).

Types of care

As explained in the previous section, long-term care is provided either at home or in institutional settings. The development of home nursing care (including home nurses and home nursing services) is still at an early stage and faces a large financing gap.

Care homes are not part of the health care system, and therefore do not in principle provide medical care to long-term care recipients. The latter therefore are visited by family doctors, and/or use private nursing companies.

In accordance with *Tervishoiuteenuste korraldamise seadus* (Act of Organisation of Health Services), nursing services include nursing healthcare services and are provided in home-based, day care and institutional settings. For more demanding cases of nursing care for the elderly, optional geriatric assessment has been available in Estonia since 2004.

The long-term care budget for the first half of 2013 was 23% higher year-on-year, a three times higher increase than for healthcare as a whole. The main drivers for this budget increase were increased investments into infrastructure supported by EU structural funds. Simultaneously, the number of long-term care cases financed by EHIF, has increased by 12% year-on-year. The availability of long-term care has significantly increased – the number of day care nursing home visits and the number of persons serviced increased by 8% and 11% respectively.

Eligibility criteria

Need for care is assessed by a local social worker, who will take into account the dependency needs and preferences of the potential recipient and their family. The need for nursing care is assessed by a doctor (whether a general practitioner or a medical specialist). The involvement of doctors is related only to the assessment of eligibility and not to the provision of long-term care itself.

An interdisciplinary assessment team performs the assessment of the recipient's level of dependency and, based on this, sets up a personalised nursing care plan. This team includes a physician specialised in geriatrics (geriatrician or an internist trained in geriatrics) as well as a nurse, a social worker and other relevant specialists.

Co-payments, out of the pocket expenses and private insurance

LTC services are financed by the municipalities, the budget of which mainly consists of a proportion of income taxes distributed to them by central government. Community care services do not usually require co-payment by the individual or his or her family. In institutional care homes, however, cost-sharing can amount up to 65% of the cost of provision (in general terms between €400 and €500), which is equivalent to 85% of the average pension. The government is however obliged as part of social assistance to cover the full

([470]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

cost for recipients and their families when they are unable to pay.

Geriatric assessment and nursing care are generally covered for by the Estonian Health Insurance Fund (EHIF), which suggests a diverse funding scheme that goes beyond what is strictly healthcare. Limited local government and EHIF budgets lead to significant financial constraints for the service. Similarly, many welfare institutions and LTC are faced with a shortage of bed capacity and staff.

Although formally part of the healthcare sector rather than the long-term care sector, for nursing care a co-payment of 15% (some €6 per day) for inpatient long-term care was introduced from 1 January 2010 onwards. The aim was, in part, to restrict the use of hospital resources to those in need of medical treatment. This rate is however a ceiling, and many hospitals ask for lower co-payments, as the bed-day reimbursement from EHIF appears to be sufficient to cover more than 85% of the cost of provision.

Formal/informal caregiving

Informal care plays an important role in Estonia and this is recognised in legal terms. As explained above, local governments also provide a carer's allowance. The impact of the allowance in helping to reimburse care and alleviating the care burden of family members and allowing them to maintain their attachment to the labour market.

eHealth

The combination of long-term care and ICT has not been a major priority. There have been some pilot projects in the field of homecare but these are still at an early stage. Pilot projects currently are mostly concerned with either social care (Virtu) or secondary/tertiary care (DREAMING and Eliko).

Prevention and rehabilitation policies/measures

Neither prevention nor rehabilitation measures are defined as (part of) LTC in Estonia; i.e. prevention and rehabilitation are part of health care.

Recently legislated and/or planned policy reforms

In the recent past, there have been no significant legislative reforms in the field of long-term care. However, there have been some policy changes in this area. For instance, a 15% co-insurance rate was introduced in 2010 for inpatient nursing care. The aim of the plan was to involve patients in the financing of the LTC system. However, the plan met with resistance and was not implemented until tough austerity measures were adopted as a response to the financial crisis. As a consequence, EHIF expenditure budgeted for inpatient nursing care in 2011 fell by 4% lower expenditure in the planned EHIF budget for inpatient nursing care in 2011. However, the number of patients was 1% greater than planned. Additionally, EU structural funds aiming to strengthen infrastructure have been granted to LTC hospitals.

Interdisciplinary working groups are developing strategies for better integration of health care and social care (including LTC). Successful implementation will require consensus between the HC and LTC systems, as well as a supportive legislative framework.

Challenges

Estonia has taken significant steps to ensure the fiscal sustainability of LTC expenditure and increasing its availability. The main challenges of the system appear to be:

- **Improving the governance framework**: to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to share data within government administrations to facilitate the management of potential interactions between

LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** to face the increased LTC costs in the future; to explore the potential of private LTC insurance as a supplementary financing tool; to determine the extent of user cost-sharing on LTC benefits.

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, by setting a need-level triggering entitlement to coverage; the breadth of coverage, that is, by setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, by setting the types of services included into the coverage; to provide targeted benefits to those with highest LTC needs; to reduce the risk of impoverishment of recipients and informal carers.

- **Encouraging home care:** to develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; monitoring and evaluating alternative services, including incentives for use of alternative settings.

- **Encouraging independent living:** to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care; to increase the retention of successfully recruited LTC workers, by improving the pay and working conditions of the LTC workforce, training opportunities, more responsibilities on-the-job, feedback support and supervision.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.8.1: **Statistical Annex – Estonia**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	11	14	16	17	14	15	17	18	19	20	20	12,451	13,213	13,559	14,447
GDP per capita, PPS	18.7	19.5	19.8	18.3	15.8	16.5	17.6	18.1	17.9	18.4	18.8	26.8	28.1	28.0	29.6
Population, in millions	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	34.4	35.7	35.2	35.7	38.4	43.0	47.4	54.5	264.1	283.2	352.1	373.6
As % of total government expenditure	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	78.2	78.6	78.9	79.5	80.3	80.8	81.3	81.5	81.7	81.9	82.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	67.6	67.6	67.5	68.9	70.0	70.9	71.4	71.4	72.8	72.4	73.2	76.6	77.3	77.7	77.9
Healthy life years at birth for females	52.4	53.9	54.9	57.5	59.2	58.2	57.9	57.2	57.1	57.1	56.2	62.0	62.1	61.5	63.3
Healthy life years at birth for males	48.3	49.6	49.8	53.1	55.0	54.2	54.3	53.1	53.9	53.2	53.8	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	38.6	40.2	38.1	40.1	42.6	44.7	43.7	44.4	45.9	46.2	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	9.5	9.3	9.9	7.7	7.9	8.6	9.8	9.3	9.8	10.4	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	4	5	6	8	8	8	15	16	16	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	6	8	10	12	12	12	6	6	7	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	0.7	1.0	1.2	1.5	1.5	1.5	1.6	1.7	1.7	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	21	18	16	15	14	14	13	13	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.8.2: **Statistical Annex - continued – Estonia**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	1.3	1.3	1.3	1.3	1.3	1.2	1.2	-11%	2%
Dependency									
Number of dependents in millions	0.13	0.13	0.14	0.14	0.15	0.15	0.15	17%	25%
Share of dependents, in %	9.6	9.8	10.5	11.2	11.7	12.1	12.6	31%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.9	0.9	1.0	1.1	1.2	1.3	1.4	52%	73%
AWG risk scenario	0.9	1.0	1.3	1.7	2.2	2.9	3.8	321%	170%
Coverage									
Number of people receiving care in an institution	13,235	14,188	15,308	17,217	18,038	18,965	20,386	54%	72%
Number of people receiving care at home	25,836	26,791	28,341	30,031	31,500	32,292	33,098	28%	86%
Number of people receiving cash benefits	132,722	136,115	141,791	147,976	149,477	148,575	148,390	12%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	13.1	13.4	14.2	15.2	15.9	16.4	17.2	31%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	:	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	45.1	45.4	47.5	50.1	52.8	55.3	57.0	26%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	54.9	54.6	52.5	49.9	47.2	44.7	43.0	-22%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	59.2	60.1	60.0	61.1	60.8	61.1	62.0	5%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	40.8	39.9	40.0	38.9	39.2	38.9	38.0	-7%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	23.9	23.5	24.8	25.7	27.2	28.2	27.9	17%	10%
Unit costs of home care per recipient, as % of GDP per capita	8.4	8.3	8.9	9.4	10.0	10.5	10.6	25%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	4.9	4.9	4.9	4.9	4.8	4.8	4.7	-4%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).