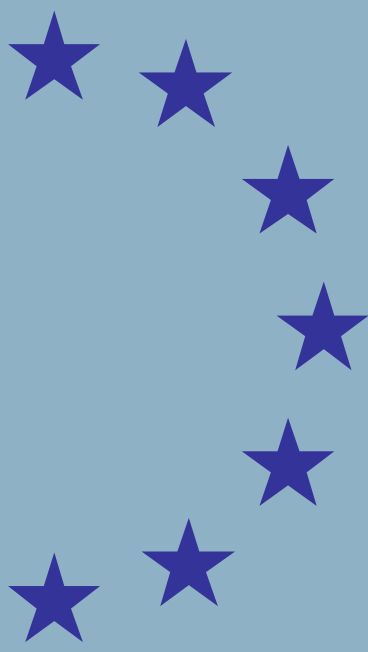




Estonia

Health Care & Long-Term Care Systems



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Estonia

Health care systems

1.8. ESTONIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

Estonia is the smallest of the Baltic States. GDP per capita (17.8 thousand PPS in 2013) is much below the EU average of 27.9 thousand PPS, although it has more than doubled since 1998 (7.2 thousand PPS).

Population was estimated at 1.3 million 2013. According to Eurostat 2013 projections, total population is projected to decrease from around 1.3 million in 2013 to 1 million in 2060.

Total and public expenditure on health as % of GDP

Total expenditure on health ⁽⁸⁷⁾ as a percentage of GDP (5.7% in 2013) is well below the EU average ⁽⁸⁸⁾(10.1%), having significantly increased since 2003 (4.9%) but decreased since 2009's peak of 6.9%. Public expenditure on health as a percentage of GDP (4.5%) is also much below the EU average (7.8% in 2013), but is still significantly higher than in 2003 (3.8%). The low and rather constant ratios may be partly explained by the 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 (1200 PPS in 2013) and public (934 PPS in 2013) per capita expenditure actually increased since 2008. However, they are still considerably lower than the EU average (2988 PPS and 2208 PPS respectively in 2013) and remains one of the lowest in the EU. Note though that the share of public expenditure in total expenditure on health is relatively high (77.9%, above the EU average of 77.4% in 2011).

Expenditure projections and fiscal sustainability

Public expenditure on health care is forecast to increase by 0.6 pps by 2060 according to the 2015

Ageing Report reference scenario. Under the risk scenario this could go up by 0.9 pps of GFP.

Overall, for Estonia no significant short-term risks of fiscal stress appear at the horizon, though some variables (namely, the change in the share of non-performing loans) point to possible short-term challenges.

No sustainability risks appear over the long run due to contained projected ageing costs and a close to neutral initial budgetary position.

Health status

Life expectancy (81.7 years for women and 72.8 years for men) and healthy life years (57.1 years for women and 53.9 years for men) are below the EU average and, particularly for men, amongst the lowest in the EU.⁽⁸⁹⁾ 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 30% and 26%, respectively, of deaths among men under-65 years, while accounting for only 22% and 14%, respectively, among women. 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. In contrast, infant mortality has fallen from 7 per 1000 live births in 2003 to 2.1 in 2013, falling below the EU average (3.9).

It should also be noted that Estonia has an amenable mortality rate per 100,000 inhabitants that is, at 132, only slightly above the EU average of 128.4 for 2012. Mortality rates associated with ischaemic heart disease and more generally, diseases of the circulatory systems are some of the EU highest, as are the death rates due to suicide, injuries and road traffic accidents. The incidence rate of tuberculosis is high as is the incidence rate of lung cancer for men. Estonia also registers a relatively high proportions of people that smoke regularly: 26% of adults in 2012 versus an EU average of 22%. Alcohol consumption, at 11.8 litres per capita is also one of the highest, compared with a EU average of 9.8. In 2010, 16.9% of the population was obese. These values

⁽⁸⁷⁾ Data on expenditure for Estonia is taken from WHO health for all database and Eurostat.

⁽⁸⁸⁾ 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.

⁽⁸⁹⁾ Data on life expectancy and healthy life years is from the Eurostat database.

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

Moreover, the 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 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 (22.13% in 2013) is slightly below the EU average (22.64%). Out-of-pocket expenditure constitutes about 18.9% of total health expenditure (13.2% in 1998, 25.1% in 2006) and stands above the EU average (14.1% in 2013). 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. 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 hospital (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.

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 (328 in 2013), slightly under the EU average (344). Data on the physician skill/mix indicates that the number of general practitioners (GPs) per 100 000 inhabitants (79 in 2013) has increased steadily since 2003 (66) is above 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 (617 in 2013) per 100 000 inhabitants is significantly below the EU average (837). 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 2013 – 77.2% 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 further wage increases since 2011, leading to significant wage increases for doctors (60%) and nurses (57%) between 2006 and 2012. 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 put 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 only slightly above the EU average (337 vs. 356 in 2013). Bed occupancy rates have stayed relatively constant and, at 69.4%, are slightly below the EU average at 70.2% in 2013.

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 (5.5 days in 2013) is under the EU average (6.3 days), having significantly decreased from 7.3 in 2001. The proportion of hospital surgery done as day cases was 29% in 2011, a significant increase from 4.3% in 2001, close to the EU average of 30.4%. Hospitals remuneration is a mixed 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 (1.1%) and public (0.6%) expenditure on pharmaceuticals ⁽⁹⁰⁾ as a percentage of GDP are below the EU average (1.44% and 0.96% respectively in 2013) and have been basically constant since 2003 (even since 1999, earliest available data). Public expenditure on pharmaceuticals is close to the EU average (13.1% compared to 12.5% in 2013). 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 treatment guidelines to harmonise and rationalise medical practices.

Data management and eHealth (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.

⁽⁹⁰⁾ 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.

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 (0.17% and 0.16% in 2013) are below the EU average (respectively 0.32% and 0.19%). However, public (2.2%) 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 2013, denoting the authorities' emphasis to improve life-styles and disease prevention.

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 and informal payment practices.

Recently legislated and/or planned policy reforms

In order to improve the access to health care, the Estonian authorities have adopted the following measures: for 2016, Estonia has increased the Health Insurance Fund budget by 6.4 % compared to 2015, and the budget for nursing services by 12 %. These changes cover wage increases and an increase in the number of health professionals trained. Estonia plans to invest 207,6 million euros into primary care and into developing regional hospital network competency centres in 2014-2020 to extend and increase the share of primary healthcare services and deliver specialised medical

care in a more efficient way and tackle alcohol abuse and addiction.

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 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 1.8.1: Statistical Annex – Estonia

General context												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
GDP														
GDP, in billion Euro, current prices	9	10	11	14	16	17	14	15	17	18	19	9289	9800	9934
GDP per capita PPS (thousands)	16.5	17.4	18.4	19.1	19.4	17.9	15.4	16.1	17.1	18.1	17.8	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	8.2	6.6	9.2	10.4	7.5	-4.0	-14.0	3.3	8.7	4.5	2.2	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	10.9	11.4	6.7	10.4	10.5	12.7	-1.7	-5.8	0.3	5.6	-0.7	3.2	-0.2	-0.4
Expenditure on health*												2009	2011	2013
Total as % of GDP	4.9	5.1	5.0	5.0	5.2	6.1	6.9	6.3	5.8	5.9	5.7	10.4	10.1	10.1
Total current as % of GDP	4.9	5.1	5.0	5.0	5.1	5.8	6.7	6.3	5.8	5.7	5.9	9.8	9.6	9.7
Total capital investment as % of GDP	0.0	0.0	0.0	0.0	0.1	0.3	0.3	0.1	0.1	0.2	-0.2	0.6	0.5	0.5
Total per capita PPS	457	532	606	732	909	1089	1069	1016	1064	1166	1200	2828	2911	2995
Public as % of GDP	3.8	3.9	3.9	3.7	3.9	4.7	5.2	5.0	4.6	4.6	4.5	8.1	7.8	7.8
Public current as % of GDP	3.7	3.9	3.8	3.6	3.9	4.6	5.2	5.0	4.6	4.5	4.6	7.9	7.7	7.7
Public per capita PPS	347	397	458	525	674	804	792	781	844	918	934	2079	2218	2208
Public capital investment as % of GDP	0.0	0.0	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.1	-0.1	0.2	0.2	0.1
Public as % total expenditure on health	76.8	75.5	76.7	73.3	75.6	77.7	75.3	78.8	79.2	78.8	77.9	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	11.8	11.8	12.2	12.5	12.6	13.1	12.5	13.1	13.3	12.9	.	14.8	14.9	.
Proportion of the population covered by public or primary private health insurance	.	94.1	94.3	95.0	95.9	95.6	95.6	95.6	92.9	93.7	93.6	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	20.6	21.5	20.5	25.4	22.2	20.5	21.2	18.7	17.8	18.4	18.9	14.1	14.4	14.1
Note: *Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.														
Population and health status												2009	2011	2013
Population, current (millions)	1.4	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	502.1	504.5	506.6
Life expectancy at birth for females	77.2	78.0	78.2	78.6	78.9	79.5	80.3	80.8	81.3	81.5	81.7	82.6	83.1	83.3
Life expectancy at birth for males	66.4	66.7	67.6	67.6	67.5	68.9	70.0	70.9	71.4	71.4	72.8	76.6	77.3	77.8
Healthy life years at birth females	.	53.8	52.4	53.9	54.9	57.5	59.2	58.2	57.9	57.2	57.1	.	62.1	61.5
Healthy life years at birth males	.	50.0	48.3	49.6	49.8	53.1	55.0	54.2	54.3	53.1	53.9	.	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	161	143	136	128	105	90	79	74	152	132	.	64.4	128.4	.
Infant mortality rate per 1 000 life births	7.0	6.4	5.4	4.4	5.0	5.0	3.6	3.3	2.5	3.6	2.1	4.2	3.9	3.9
Notes: Amenable mortality rates break in series in 2011.														
System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP												2009	2011	2013
Inpatient curative and rehabilitative care	1.42	1.56	1.66	1.51	1.54	1.77	1.90	1.79	1.65	1.53	1.51	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.05	0.08	0.09	0.09	0.10	0.12	0.13	0.12	0.11	0.12	0.13	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.25	1.14	1.03	1.12	1.20	1.34	1.55	1.57	1.42	1.60	1.74	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.20	1.30	1.20	1.18	1.11	1.25	1.63	1.38	1.25	1.12	1.11	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.11	0.13	0.14	0.18	0.17	0.19	0.16	0.16	0.13	0.16	0.18	0.31	0.31	0.32
Prevention and public health services	0.10	0.11	0.12	0.13	0.14	0.16	0.16	0.17	0.16	0.19	0.17	0.25	0.25	0.24
Health administration and health insurance	0.21	0.18	0.15	0.14	0.13	0.13	0.14	0.13	0.13	0.11	0.13	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	1.36	1.45	1.51	1.40	1.40	1.66	1.81	1.72	1.57	1.50	1.49	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.05	0.08	0.09	0.09	0.10	0.12	0.13	0.12	0.11	0.11	0.12	0.16	0.16	0.18
Out-patient curative and rehabilitative care	0.93	0.85	0.83	0.82	0.95	1.12	1.33	1.24	1.16	1.16	1.18	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.54	0.60	0.53	0.48	0.47	0.54	0.67	0.67	0.61	0.60	0.60	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.04	0.05	0.06	0.06	0.06	0.08	0.08	0.09	0.08	0.08	0.10	0.13	0.12	0.13
Prevention and public health services	0.09	0.08	0.09	0.10	0.11	0.15	0.14	0.15	0.13	0.17	0.16	0.25	0.20	0.19
Health administration and health insurance	0.21	0.18	0.17	0.13	0.13	0.13	0.14	0.13	0.13	0.12	0.12	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.8.2: Statistical Annex - continued – Estonia

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data		
												2009	2011	2013
Inpatient curative and rehabilitative care	29.1%	30.6%	33.3%	30.4%	30.3%	30.5%	28.6%	28.5%	28.7%	26.8%	25.7%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.0%	1.5%	1.8%	1.8%	2.0%	2.0%	1.8%	1.9%	2.1%	2.1%	2.1%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	25.6%	22.4%	20.6%	22.5%	23.6%	23.1%	23.3%	25.0%	24.7%	28.0%	29.6%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	24.6%	25.5%	24.0%	23.7%	21.9%	21.5%	24.5%	22.0%	21.7%	19.6%	18.9%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.2%	2.6%	2.8%	3.6%	3.4%	3.2%	2.4%	2.5%	2.3%	2.8%	3.1%	3.2%	3.3%	3.3%
Prevention and public health services	2.0%	2.2%	2.4%	2.6%	2.8%	2.8%	2.4%	2.7%	2.8%	3.3%	2.9%	2.6%	2.6%	2.5%
Health administration and health insurance	4.3%	3.5%	3.0%	2.8%	2.6%	2.2%	2.1%	2.1%	2.3%	1.9%	2.2%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	36.4%	37.7%	39.5%	38.6%	36.2%	36.5%	34.8%	34.6%	34.1%	33.3%	32.6%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	1.4%	2.0%	2.3%	2.4%	2.6%	2.6%	2.5%	2.3%	2.4%	2.5%	2.6%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	24.9%	22.1%	21.7%	22.6%	24.5%	24.6%	25.6%	24.9%	25.2%	25.8%	25.7%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	14.4%	15.6%	13.9%	13.2%	12.1%	11.9%	12.9%	13.5%	13.2%	13.3%	13.1%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	0.9%	1.4%	1.7%	1.7%	1.6%	1.7%	1.6%	1.9%	1.8%	1.8%	2.1%	1.6%	1.6%	1.6%
Prevention and public health services	2.4%	2.1%	2.4%	2.8%	2.8%	3.3%	2.7%	3.0%	2.8%	3.8%	3.5%	3.2%	2.7%	2.5%
Health administration and health insurance	5.6%	4.6%	4.3%	3.7%	3.4%	2.8%	2.7%	2.6%	2.7%	2.7%	2.7%	1.4%	3.5%	3.5%
Expenditure drivers (technology, life style)														
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data		
												2009	2011	2013
MRI units per 100 000 inhabitants	:	:	0.22	0.37	0.52	0.82	0.75	0.82	0.97	0.98	1.14	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	0.4	0.4	0.4	0.7	0.7	0.7	0.7	0.8	0.8	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	0.7	0.7	1.1	1.5	1.5	1.6	1.6	1.7	1.9	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	:	18.0	:	16.9	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	32.8	:	27.8	:	26.2	:	26.2	:	26.0	:	23.2	22.4	22.0
Alcohol consumption litres per capita	11.6	13.2	13.1	13.4	14.7	14.2	11.9	11.4	11.6	12.2	11.8	10.3	10.0	9.8
Providers														
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	316	321	317	319	326	333	327	322	326	328	328	329	335	344
Practising nurses per 100 000 inhabitants	621	631	633	632	640	640	613	608	618	617	617	840	812	837
General practitioners per 100 000 inhabitants	66	68	69	69	70	72	72	73	74	74	79	:	78	78.3
Acute hospital beds per 100 000 inhabitants	434	421	379	389	376	381	357	342	349	355	337	373	360	356
Outputs														
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	6.2	6.2	6.3	6.4	6.6	6.6	6.3	6.1	6.4	6.3	6.4	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	18.5	18.7	17.8	18.2	18.3	18.3	17.5	17.4	17.4	17.3	17.1	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	2,939	3,076	3,886	4,814	5,916	6,061	5,921	6,080	6,852	8,044	7,021	6368	6530	7031
Acute care bed occupancy rates	67.0	69.0	69.0	71.0	72.0	70.1	68.2	70.8	71.0	69.1	69.4	72.0	73.1	70.2
Hospital curative average length of stay	6.4	6.2	6.0	5.9	5.9	5.7	5.6	5.5	5.5	5.6	5.5	6.5	6.3	6.3
Day cases as % of all hospital discharges	6.8	8.1	12.2	14.2	16.2	16.8	25.3	25.8	28.2	31.8	29.0	27.8	28.7	30.4
Population and Expenditure projections														
Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060				EU Change 2013 - 2060			
AWG reference scenario	4.4	4.6	4.8	5.0	5.0	5.0	0.6				0.9			
AWG risk scenario	4.4	4.8	5.3	5.6	5.7	5.7	1.3				1.6			
Note: *Excluding expenditure on medical long-term care component.														
Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %				EU - Change 2013 - 2060, in %			
Population projections until 2060 (millions)	1.3	1.3	1.2	1.2	1.1	1.1	-17.2				3.1			

Source: EUROSTAT, OECD and WHO

Estonia

Long-term care systems

2.8. ESTONIA

General context: expenditure, fiscal sustainability and demographic trends

Estonia, the most northerly of the Baltic states, is a member of the European Union since 2004, has a GDP of around EUR19 bn., or 17.8 thousand PPS per capita, below the EU average of 27.9 thousand PPS per capita. Population was estimated in 2013 at almost 1.3 million inhabitants.

During the coming decennia the population will steadily decrease, from 1.3 million inhabitants in 2013 to 1.1 million inhabitants in 2060. Thus, Estonia is facing a considerable decrease of its population by 17%, while the EU average population is estimated to increase by 3%.

Health status

Life expectancy at birth for both men and women is respectively 72.8 years and 81.7 years and is below the EU average (77.8 and 83.3 years respectively). Similarly, the healthy life years at birth for both sexes are 57.1 years (women) and 53.9 years (men) and substantially lower than the EU-average (61.5 and 61.4 respectively). The percentage of the Estonian population having a long-standing illness or health problem is considerably higher than in the Union (44% in Estonia versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities has been decreasing from 2004 to 2010, but has increased since 2011 and is again above the EU-average (9.3% against 8.7% in 2013).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 0.11 million residents living with strong limitations due to health problems in 2013, an increase of 26% is envisaged until 2060 to 0.14 million. That is a less steep increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 8.6% to 13%, an increase of 52% (EU: 36%).

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 0.6 pps of GDP by 2060. ⁽³⁶⁵⁾ 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 3.1 pps of GDP by 2060. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run due to contained projected ageing costs and a close to neutral initial budgetary position. ⁽³⁶⁶⁾

System Characteristics ⁽³⁶⁷⁾

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

⁽³⁶⁵⁾ The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

⁽³⁶⁶⁾ Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

⁽³⁶⁷⁾ This section draws on OECD (2011b) and ASISP (2014).

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 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 reached 0.2% of GDP in 2012 in Estonia, below the average EU level of 1% of GDP. 42.9% of the benefits were in-kind, while 57.1% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is lower in Estonia with 44%. Overall, 5.8% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). 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 91% of public in-kind expenditure (EU: 61%), 9% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States Estonia might have some potential to focus more on home care, which may be cost-efficient. As institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

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 Organization 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 EUR 400 and EUR 500), which is equivalent to 85% of the average pension. The government is however obliged as part of social assistance to cover the full 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 EUR 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 2.8.1: Statistical Annex – Estonia

GENERAL CONTEXT																
GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	9	10	11	14	16	17	14	15	17	18	19	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	16.5	17.4	18.4	19.1	19.4	17.9	15.4	16.1	17.1	18.1	17.8	26.8	27.6	28.0	28.1	27.9
Population, in millions	1.4	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	:	1.0	1.0	1.0	1.0	:
Per capita PPS	7.1	13.6	18.3	22.9	29.8	33.7	34.6	34.2	34.8	37.0	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	77.2	78.0	78.2	78.6	78.9	79.5	80.3	80.8	81.3	81.5	81.7	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	66.4	66.7	67.6	67.6	67.5	68.9	70.0	70.9	71.4	71.4	72.8	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	53.8	52.4	53.9	54.9	57.5	59.2	58.2	57.9	57.2	57.1	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	50.0	48.3	49.6	49.8	53.1	55.0	54.2	54.3	53.1	53.9	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	41.3	38.5	38.6	40.2	38.1	40.1	42.6	44.7	43.7	44.4	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	13.1	13.0	9.5	9.3	9.9	7.7	7.9	8.6	9.8	9.3	:	8.1	8.3	8.6	8.7
SYSTEM CHARACTERISTICS																
Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	4	5	6	8	8	8	15	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	6	8	10	12	12	12	6	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.7	1.0	1.2	1.5	1.5	1.5	1.6	2.0	2.2	2.2	2.3	2.1
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	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.8.2: Statistical Annex - continued – Estonia

PROJECTIONS								
	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population								
Population projection in millions	1.3	1.3	1.2	1.2	1.1	1.1	-17%	3%
Dependency								
Number of dependents in millions	0.11	0.12	0.13	0.14	0.14	0.14	26%	40%
Share of dependents, in %	8.6	9.5	10.7	11.9	12.4	13.0	52%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.6	0.7	0.8	1.0	1.1	1.2	116%	40%
AWG risk scenario	0.6	0.8	1.1	1.7	2.5	3.7	559%	149%
Coverage								
Number of people receiving care in an institution	15,088	18,222	20,473	24,479	27,144	28,951	92%	79%
Number of people receiving care at home	6,272	7,493	8,555	9,599	10,767	11,169	78%	78%
Number of people receiving cash benefits	14,819	16,735	18,364	19,891	22,033	22,816	54%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	2.7	3.3	3.9	4.7	5.3	5.8	110%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	32.0	34.9	36.9	39.2	42.7	44.4	38%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	39.2	38.8	39.2	41.4	42.0	42.9	9%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	60.8	61.2	60.8	58.6	58.0	57.1	-6%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	90.1	90.4	90.3	90.8	90.7	91.0	1%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	9.9	9.6	9.7	9.2	9.3	9.0	-9%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	17.5	17.0	17.1	17.2	17.8	18.0	3%	-2%
Unit costs of home care per recipient, as % of GDP per capita	4.6	4.4	4.4	4.4	4.6	4.6	0%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	30.6	32.3	32.8	33.0	33.4	33.5	9%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)"