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Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

Estonia

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1 Executive Summary

Developments in the Estonian social policy in 2010-2012 have been affected by the temporary measures adopted during the recent economic downturn in 2008-2010 and their partial reversals, long-term concerns about the sustainability of the pension and health care financing, and the general elections in March 2011.

Regarding the pension system, the crisis has not led to any qualitative re-orientation, but it has accelerated some reforms. The main policy measures implemented during 2009-2011 were ad hoc changes in the pension indexation rule, which smoothed the value of nominal pensions; a temporary suspension of the transfers to the funded pension scheme in 2009-2011, and its compensation mechanism in 2014-2017; and an increase of the pension age for the period 2017-2026. In the compulsory funded pension scheme, the crisis has resulted in stricter control and clearer rules over the management of the private pension funds and more flexibility for employees and employers.

The crisis has strengthened the need for a reform in special pensions, and first steps have been made by the beginning of 2012. Increasing number of work incapacity pensioners has put pressure to finally introduce a work accident and occupational disease insurance, possible together with a major reform of temporary sickness benefits and work incapacity pensions. The general election resulted in a discussion over a pension supplement for parents, which increases pension expenditure in the future, but it is targeted to those who potentially suffer most from the career breaks.

In health care, crisis measures taken over the course of 2010 and 2011 have left the individual citizen more financially responsible than before. Patients face longer waiting times to receive care, social protection in case of short-term sickness has diminished, and dental care for adults is now left uncovered. As a result of this and other steps, the 2011 budget of the health care system has not derailed, and the 2012 budget shows improvement, with more funding flowing to health care providers and services.

The cuts that have occurred could have been avoided through use of the reserves held by the Health Insurance Fund. However, in a bid to improve overall state finances, these reserves are now being consolidated in the overall government account. This raises questions as to the independence of the health care sector and its ability to formulate policy based on own considerations rather than on budgetary circumstances. It also questions the involvement of the social partners in the administration of the scheme, and their weight around the table vis-a-vis government representatives.

At the same time, structural issues concerning the funding of the health care scheme have not been resolved. Faced with the effects of population ageing, a new balance needs to be sought that ensures sustainability, quality and equity. In this exercise, the options of increased government spending and of a different funding basis should not be rejected off-hand.

In the provision of long-term care services, Estonia moves towards a balance between the different competent levels of government and administration. The system of long-term care is fragmented in many aspects, which hampers a clear needs-driven approach. Studies made over the previous years have helped to crystallise the debate, and the new government plan for the years 2011 to 2015 contains elements that can allow central government to better play its role as a policy-setter and facilitator of service delivery by the main actors in the system, the local governments. Results are being reached, but tensions over funding and over the division of competences continue to make the implementation of a uniform and comprehensive policy difficult.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

Estonia was hit hard by the financial and economic crisis, but the recovery has also been quick. The cumulative loss of real GDP was 18% in 2008-2009, but it grow again in 2010 (3.1%) and 2011 (about 7%). The employment rate has also increased from its lowest level 55% in 2010 to 59% in 2011 (in the age group 15-74) and the unemployment rate has dropped to 12.5% in 2011 from its peak level of 16.9% in 2010. This all resulted in an increase of the nominal tax revenues of the central government by 7.3% in 2011, of which the revenues from social tax, which is earmarked for financing pension and health expenditure, increased 6.1%.

Before the crisis, over the years 2000 through 2007, Estonia was spending approximately 12 to 14% of GDP on social protection, being one of the least spending countries in the EU. In these better times, reserves were accumulated by the Estonian central government, the Estonian Health Insurance Fund and the Estonian Unemployment Insurance Fund. The overall level of public debt of the general government was very low, at only about 5% of GDP in 2008. Therefore, Estonia started from a low level of social expenditure and there was scope for an additional increase of social expenditure during the crisis.

Indeed, social expenditure increased in 2009-2010, both nominally and as a share of GDP (to 19% in 2009 according to ESSPROS definition) and as a fraction of government expenditure (to 49% in 2010). As expected with increasing GDP and falling unemployment, the proportion of resources going to social expenditure will decrease again.

Table 1: Government expenditure and revenue 2000, 2005-2011, % of GDP

	2000	2007	2008	2009	2010	2011*	2012*
General government revenue	35.9	36.9	37.0	43.2	40.3	38.8	38.0
General government expenditure	36.1	34.4	39.9	45.2	40.0	38.6	40.1
Surplus / Deficit	-0.2	2.5	-2.9	-1.8	0.1	0.2	-2.1
Tax burden	31.0	31.6	31.9	35.5	33.6	32.4	32.4
Government consolidated gross debt	5.1	3.7	4.6	7.2	6.6	5.8	5.8
Government total expenditure on social protection and health	14.9	13.9	16.9	21.3	19.7	17.8	18.3
Social expenditure as a share in government expenditure	41.4	40.3	42.4	47.1	49.0	46.3	45.7
Social protection expenditure (ESSPROS methodology)	13.9	12.3	15.1	19.2			

Source: Statistics Estonia, own calculations
** Ministry of Finance, State budget 2012, own additional calculations*

The crisis did not cause any drastic re-orientation of social protection policies compared to the pre-crisis situation in Estonia, but still several changes were implemented to achieve the balance of revenues and expenditure. Some of the measures were temporary and have been reversed already, such as temporary suspension of the transfers to the compulsory funded pension scheme or reduction of reimbursements to health care providers. Many policy changes, however, seem to be permanent, for example, the reduction of temporary incapacity benefits. The crisis also acted as a catalyst for several reforms, such as the decision to further increase pension age from 2016 onwards or start of the reform of special pensions.

The crisis has shown that one weakness of the current social security system is high dependence from labour taxes. About 80% of all social protection expenditure is financed from

labour taxes (social tax for pensions and health care, unemployment insurance contributions, income tax on labour). Rapid decline of employment rates during the last crisis gave a chance to look 15-20 years into the future when the demographic change would have resulted in a similar drop in employment figures. Therefore, the crisis has persuaded policy- makers to discuss what the adequate balance is between individual responsibility and coverage and depth of publicly provided and financed pensions, health care and long-term care.

In 2011, the government prepared several overarching documents that will shape economic, fiscal and social policy for next few years: the new coalition agreement[1] and accompanying government's action plan for 2011-2015[2], the state budget strategy 2012-2015 (*Riigi eelarve strateegia 2012-2015*)[3], the state budget for 2012 and the accompanying explanatory note[4], the Estonian National Reform Programme, named Competitiveness Strategy 'Estonia 2020' (*Konkurentsivõime kava 'Eesti 2020'*), and its accompanying action plan for the years 2011-2015, and Estonian Stability Programme 2011 (*Stabiilsusprogramm 2011*). The overarching common approach of these documents regarding social protection is that increased productivity, high employment rates, longer working life and a more efficient social protection system are key factors in contributing to the sustainability of the social expenditure in the situation of an ageing population. The government action plan for 2011-2015 provides detailed information on government initiatives in the sphere of social protection, ranging from very topical parametric reforms of the pension system to very general proposals of diversifying health care financing.

The government has also initiated a process of consolidation of the reserves of different social insurance funds with the central government's reserves at the end of 2011. While the reserves of the central government have diminished rapidly during the crisis, from 10.3% of GDP in 2009 to 2.6% in 2012 (forecast by the Ministry of Finance), the reserves of the Unemployment Insurance Fund (UIF) and Health Insurance Fund (HIF) have risen from 2.6% in 2009 to 3.7% in 2012. At the time of writing this report there were ongoing debates between social partners and the government whether it is prudent that the reserves of the UIF are used to cover the deficit of the central state budget. The social partners proposed to lower the unemployment insurance contribution rates in 2012 that were raised extraordinarily during the crisis, but the government refused, because of the high deficit of the central government, mostly due to the deficit of the state pension scheme. Only with the excessive reserves of the UIF the government can meet the -2.1% of the deficit target stipulated in the recommendations of the European Council. Overall, it has led to a strong disagreement between the government and social partners and has threatened tripartite governance of the UIF and HIF.

In 2010, the Ministry of Finance initiated an independent study on alternatives for sustainable financing of the Estonian social insurance system. The study was presented to stakeholders in November 2011 and several ideas from that report are being discussed further in various working groups or ministries. We will discuss some of the reform ideas in the following sections on pensions and health care in more detail.

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1 "Erakonna Isamaa ja Res Publica Liit ning Eesti Reformierakonna valitsusliidu programm" retrieved on 4 May 2011 at http://valitsus.ee/UserFiles/valitsus/et/uudised/taustamaterjalid/Valitsusliit%20I.pdf.

2 Vabariigi Valitsuse tegevusprogramm 2011–2015, April 2011, Tallinn, retrieved on 4 May 2011 at http://www.valitsus.ee/UserFiles/valitsus/et/valitsus/tegevusprogramm/valitsuse-tegevusprogramm/VV%20tegevusprogramm_28-04-2011_KINNITATUD.xls.

3 Riigi eelarvestrateegia 2012-2015, April 2011, Tallinn, retrieved on 4 May 2011at http://www.fin.ee/doc.php?107452.

4 Ministry of Finance (2012), "2012. aasta riigieelarve seaduse seletuskiri" (*Exlanatory note of the state 2012 budget*), pdf document, 2011, Tallinn, retrieved on 15 May 2012 at http://www.fin.ee/doc.php?108795.

2.2 Pensions[5]

2.2.1 The system's characteristics and reforms

The Estonian pension system consists of three main schemes: a state pension insurance (a pay-as-you-go system with defined benefit); a compulsory funded pension scheme (defined contribution scheme); and voluntary funded pension schemes (defined contribution scheme). The state pension insurance provides protection against the risks of old age, invalidity and survivorship and counts two separate tiers: employment-based old-age, work incapacity and survivors' pensions, and flat-rate residence-based national pensions. The purpose of the national pension is to guarantee a minimum income for those who are not entitled to the employment-based pension. National pensions are financed from the general state budget, whereas old-age, work incapacity and survivors' pensions are predominantly financed from an ear-marked social tax paid by employers and the self-employed at the rate of 16% or 20% of gross earnings depending on whether the insured person has joined the funded scheme or not. Additional transfers from the general state budget have been necessary in recent years.

In 2012, the statutory retirement age was 63 years for men and 61.5 years for women. It will be equalised at 63 by 2016, and as from 2017 it will gradually increase to 65 by 2026. The coverage of the state pension insurance system is practically universal. As of end of 2011, the total number of pension recipients was 406 thousand (about 30% of the population). Of those, 299 thousand received old-age pension (97.5% of the age group 60 and over), 90 thousand work incapacity pensions (i.e. disability pensions), about eight thousand families (with about 11 thousand persons) were recipients of survivor's pensions and about six thousand received national pensions.[6] Only working age persons (from 16 to pension age) are eligible for work incapacity pensions.

Old-age pensions are comprised of three components: the flat rate base amount, the pensionable length of service component (covering periods up to 1998) and the insurance component that is based on individual social tax payments (covering periods from 1999 onwards). The old-age pension is redistributive through the flat rate base amount, which on 1 January 2011 comprised about 38% of the average old-age pension.[7] Also the length of service component is strongly redistributive, but as this takes into account only employment periods up to 1998 its role is gradually diminishing for new pensioners. Redistribution is also achieved through crediting pension rights for some non-active periods (incl. child care and military service). Work incapacity pensions depend also on the level of incapacity and survivor's pensions on the number of dependants.

Indexation and pension size of the state pensions

Pensions are indexed annually, on 1 April of each year. The index is a weighted average of past consumer price indices and past growth of social tax revenues to the pension insurance system (in a 20-80 proportion). In 2009 ad hoc changes to the indexation rule of pensions were made. The changes allowed to smooth the value of nominal pensions during the crisis without having any long-term impact on the sustainability or adequacy of pensions. It resulted smaller increase

[5] This section draws heavily on and uses extracts of the following publications:
Estonian country profile published in European Commission (2010) "Joint Report on Pensions. Progress and key challenges in the delivery of adequate and sustainable pensions in Europe. Country profiles" http://ec.europa.eu/economy_finance/publications/occasional_paper/2010/pdf/ocp71_country_profiles_en.pdf
VÕRK, Andres, LEPPIK, Lauri, SEGAERT, Steven (2010) " Pensions, Health and Long-term Care". asisp Annual Report 2010.

[6] Source: Estonian National Social Insurance Board, online statistics, Table "Riiklik sotsiaalkindlustus 2011 IV kvartal", retrieved on 13 February 2012 at http://www.ensib.ee/public/statistika_ja_eelarve/RSK_2011IV.xls.

[7] Source: Estonian National Social Insurance Board, Statistics Estonia, own calculations.

of pensions than implied by the default index in 2009, no decline of pensions in 2010 and 2011, and predictably smaller increase again in 2012-2015.

Table 2: Development of the pension index 2008-2011

Year	2008	2009	2010	2011
Growth of CPI	1.104	0.999	1.030	1.050
Growth of social tax revenues	1.147	0.887	0.939	1.068*
Index for next year	1.138	0.909	0.957	1.064*
Applied index on 1 April next year	1.050	1.000	1.000	1.044**
Difference	0.088	-0.091	-0.043	0.020
Cumulative difference to be compensated	0.088	-0.003	-0.046	-0.026

** Preliminary estimates*
***Prediction in 2012 state budget*
Source: Statistics Estonia, Estonian National Social Insurance Board, Ministry of Finance

In January 2011, the average gross old-age pension reached EUR 304, an increase by 1% compared to the average old-age pension at the beginning of 2010, which was EUR 301. The increase is due to changing structure of the pensioners and additional insurance components earned by working pensioners. Average work incapacity pension is about 60% of the average old-age pension. Average survivor's pension is about 40% of the average old-age pension. The flat rate national pension, which serves simultaneously as a minimum pension guarantee, amounted to EUR 128.45 in 2010 and did not change in 2011. Recipients of the national pension on grounds of age constitute less than 1% of all pensioners receiving a pension on the grounds of age.[8]

All pensions are taxed by income tax, but as there is an additional tax allowance for pensions, the effective tax rate on pensions is very low. The average gross old-age pension comprised about 37% of the average gross wage of a full-time worker in January 2011. The average net replacement rate is about 41-46%, depending whether a pensioner is working or not at the same time.[9]

Expenditures on state pensions amounted to EUR 1.3 billion or 8.4% of GDP in 2011. The total revenues from pension insurance component of social tax (20% of gross earnings) amounted to EUR 1.076 billion (6.9% of GDP). However, EUR 69 million of social tax revenues were redirected to individual accounts of participants of the funded scheme in 2011. As a result, of the total expenditures on state pensions 1.007 billion were financed from current social tax revenues, additional earmarked contributions from the state budget for special pensions were EUR 41 million and the remaining part (EUR 252 million or 1.6% of GDP) was additionally transferred from the general state budget.[10]

Mandatory funded defined-contribution scheme

The pay-as-you-go (PAYG) state pension insurance scheme is supplemented by a compulsory funded defined-contribution (DC) scheme that was introduced in 2002 by diverting a portion of contributions from the statutory PAYG scheme into private funds and introducing additional contributions by employees. The contribution rate is 6% of gross wages – the employee pays 2% from the gross wage and the employer another 4% (as part of the 20% pension insurance

[8] Source: see previous footnote.
[9] Source: Statistics Estonia, own calculations.
[10] Source: Estonian National Social Insurance Board (2012) 2011 cash flow report of the state pension insurance system, retrieved on 13 February 2012 at http://www.ensib.ee/public/statistika_ja_eelarve/kassakulu2011.pdf.

contribution). The amount of pension benefits depends on total contributions over the working career and yields of pension funds. The scheme covers the risk of old age, but not invalidity.

Participation in the scheme is mandatory for cohorts born in 1983 or later, whereas cohorts born in 1942-1982 had the option to join the scheme voluntarily. In 2010, last cohorts, born in 1980-1982, had to make a choice whether to participate in the pension scheme. As of 1 January 2012 622,723 people had joined the scheme, which is 14,113 people more than at the beginning of the 2011.[11] By the end of 2011, the scheme covers about 73% of the population aged 18 to 63. At the end of 2011 61% of the participants contributed.[12]

The funded scheme is run by private fund managers. By the end of 2011 the total value of assets in the compulsory funded scheme amounted to EUR 1.1 billion (about 7.3% of GDP). This was EUR 68 million (about 6.4%) more than a year earlier.

The EPI index (*Eesti Pensioniindeks*), which reflects the weighted average of the net rate of return of all mandatory pension funds, dropped 4.54% in 2011. Index for conservative funds (no stocks) increased by 1.25% and for the most aggressive funds (investing 75% to stocks) dropped by 9.64% in 2011.[13]

Since 1 January 2009, persons who joined the funded scheme in 2002 and meanwhile had reached pension age were entitled to withdraw benefits. In most cases, the accumulated assets are rather small. By the end of 2011 EUR 13.9 million were withdrawn from mandatory pension funds. At the end of 2011, about 15 thousand people had the right to collect benefits from the funded pension scheme. About one third had postponed withdrawal of their pensions. By the end of 2011 52.4% of withdrawals had periodic payments from the pension fund without entering into an insurance contract (relevant if accumulated funds are between 10 to 50 times national pension rate, i.e. EUR 1,284.5-6,422.5). Average monthly payment was EUR 34 in the last quarter of 2011. 40.4% of people had withdrawn their pensions in lump sum (relevant if accumulated funds are less than 10 times national pension rate, EUR 1,284.5). Average lump-sum amount was EUR 842 in the last quarter of 2011. Finally, 7.2% had insurance contracts, meaning that they had collected at least 50 times the national pension rate (at least EUR 6,422.5). Average insurance contract was about EUR 8,300. In 2011 there were three insurance companies that sold annuities. [14]

The main short-term policy reaction to the deficit in the state pension scheme in 2009 was the suspension of the contributions to the funded pension scheme. This was discussed in detail in 2011 asisp annual report. Transfers from social tax revenues to the mandatory funded scheme were temporarily suspended from 1 June 2009 until 31 December 2010 and partly suspended also in 2011 to reduce the deficit of the state PAYG pension system. In 2014-2017 there is a compensation mechanism that will transfer additional social tax revenues to the funded scheme.

In the mandatory funded pension scheme, the crisis has resulted in stricter control and clearer rules over the management of the private pension funds and more flexibility for employees and employers. On 26 January 2011, as a reaction to mismanagement and large losses that

[11] Source: Pensionikeskus, on-line statistics, Table "Kogumispensioniga liitujate arv", retrieved on 13 February 2012 at http://www.pensionikeskus.ee/?id=694&chartSelector=count.

[12] Source: Ministry of Finance (2012) "Kohustusliku kogumispensioni statistika. Jaanuar 2012", retrieved on 13 February 2012 at http://files.ee.omxgroup.com/pensionikeskus/dokumendid/kogumispensioni_statistika_012012.pdf.

[13] Source: Pensionikeskus, on-line statistics, table "Kogumispensioni indeksid", retrieved on 13 February 2012 at http://www.pensionikeskus.ee/?id=694&chartSelector=epi; own calculations.

[14] Source: Ministry of Finance (2012) "Kohustusliku kogumispensioni statistika. Jaanuar 2012", retrieved on 13 February 2012 at http://files.ee.omxgroup.com/pensionikeskus/dokumendid/kogumispensioni_statistika_012012.pdf.

investment funds had during the last real estate boom and the following financial crisis, the parliament adopted an amendment to the Funded Pensions Act and several other related acts to clarify management rules of the pension funds and how to report their activities.[15] The law took effect on 1 August 2011 with parts affecting income tax on 1 January 2012. The amendment makes the investment rules of conservative investment funds stricter and clearer regarding investment instruments and their ratings. It also made changing of pension funds more flexible for investors. As of 1 August 2011 it is possible to change pension fund shares up to three times a year (it was once a year). Since 1 January 2011, there is no minimum number of units to be transferred from one pension fund to another (it was 500 units). As a result about 115 thousand people (which is about every sixth people who have joined the scheme) switched pension funds in 2011, which is about three times more than in 2010.

Since 2011 new contributions can be directed to a new pension fund at any time (it was once a year). Again, the number of people who redirected their contributions grow significantly more than in 2010.

Pension funds have to publish their investment reports monthly (it was quarterly). Conservative funds, which invest only into fixed income assets, may now invest only into bonds that have investment rating at least Baa3 (Moody's) or its equivalent. Additional restrictions were set on investments and fees when investing into other funds belonging to the same fund manager.

Voluntary funded pension system

Voluntary funded pension system (the third pillar) plays a minor role in Estonia so far. It had about 50 thousand participants (6% of people aged 18-62) with assets about EUR 85 million (about 0.5% of GDP) on 3 January 2012. There were additionally about 70 thousand contracts in the form of life insurance at the end of the 2nd quarter of 2011.[16] Participation in the voluntary scheme has slightly dropped compared to previous year (5%).

Contributions to voluntary pension system can be deducted from the taxable income up to 15% of the employee's taxable income. The income tax rate on pension payments is also lower, 10% compared to the usual 21%, if conditions regarding investment duration and investor's age at the time of withdrawal are fulfilled.

The amendment of the Funded Pension Act in January 2011 also influenced the voluntary funded pension scheme. First, the exchange of fund shares was made easier and more flexible by abolishing the right of pension funds to set a minimum number of shares to be exchanged (it was up to 1000 shares) and time limit between consecutive exchanges (it was once in two years). Also, movement between different pension insurance or pension fund products is not taxed with income tax anymore, and regulations regarding exchange of different products were unified. Furthermore, a penalty was dropped when withdrawing pension savings before age 55 (it was 2%). Investment funds are also required to evaluate the suitability of voluntary pension shares to an investor.

Several changes were simultaneously made to the Income Tax Act. First, as of 1 January 2012 an additional upper limit, EUR 6,000 per annum, is set to tax-free contributions to the voluntary pension scheme. This makes investment to pension funds more expensive for high income earners. On the other hand, employers can now contribute to the voluntary pension fund of an employee up to the amount of 15% of an employee's annual salary or EUR 6,000 without

[15] Vabariigi Valitsus (2010), "Seletuskiri kogumispensionide seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde", (*The explanatory memorandum accompanying changes in the Funded Pension Act and other related acts*), retrieved on 6 May 2011 at http://www.riigikogu.ee/?page=eelnou&op=ems&emshelp=true&eid=1241326&u=20110513153951.

[16] Source: Pensionikeskus, statistical data, retrieved on 4 January 2012 at http://www.pensionikeskus.ee/?id=600.

paying the fringe benefits tax (equal to the sum of income tax and social tax), but only social tax. Effectively, employers' additional contributions to voluntary pension funds are now treated similar to labour income and not as fringe benefits, and they are treated similar to private contributions regarding taxation. The limits of EUR 6,000 and 15% per year are valid to employer and employee payments together.

All these changes are expected to encourage both individuals and employers to invest more to the voluntary pension scheme.

International aspects

There was neither explicit EU financial support nor direct pressure aimed to tackle the financial and economic crisis in Estonia. Still, the government wisely exploited the EU structural funds during the crisis by shifting the use of the funds of 2007-2013 programming period to earlier years. As a result, the share of foreign support in the central government's budget increased from about 9% in 2008 to 20% in 2010, and is foreseen to decline again in 2012-2013. Therefore, the front-loading of structural funds helped to smooth large swings in tax revenues during the crisis.

In September 2011, Estonia ratified a pension agreement with Russia that gives right to the citizens of both countries to apply for pensions from both countries in accordance with their employment history. By 16 January 2012 about four thousand people had submitted an application to the Estonian National Social Insurance Board.[17]

2.2.2 Debates and political discourse

In 2010-2012, debates on the pension system were influenced by three context factors. First, the economic crisis has caused the state PAYG pension scheme to run large deficit since 2009 (1.5% of GDP), and forecasts show that it may take a decades to close the gap. Meanwhile this deficit had to be covered from other sources, including short-run modifications in the indexation and temporary suspension of transfers to the funded pension scheme. Second, in March 2011, there were general elections and political parties included pension policy as an important component of their election campaigns. As a result, some of the election promises were included into the new coalition agreement and the government's action plan for 2011-2015. Third, events in Europe, where several countries struggle with their large public deficits and debt burden, partly caused by expensive social policy programmes, have served as a justification of prudent fiscal policy in Estonia, including curtailing of social expenditure, both in short and long run.

In 2011 and 2012, debates on the pension policy have concentrated on the following issues: additional pension supplements to parents who have raised children, the reform of the special pensions, reform of the work incapacity pension scheme, and long-term sustainability of the old-age pension scheme.

The new coalition agreement concluded in April 2011 foresees additional pension supplements for parents who have raised children. This was one of the main election promises by one of the coalition partners. The details were discussed in the previous asisp annual report. Although the reform increases pension expenditures, it is targeted to those who potentially suffer most from career breaks due to child rearing. The coalition agreed on the details of the mechanism on 11 October 2011 and the Ministry of Social Affairs sent the draft legislation for interministerial consultation on 8 November 2011, where it was at the time of writing this report.

[17] Source: Estonian National Social Insurance Board (2012) "Eesti-Vene uue pensionilepingu alusel on kolme kuuga esitatud 4006 taotlust", press release18 January 2012, retrieved on 15 February 2012 at http://www.ensib.ee/eesti-vene-uue-pensionilepingu-alusel-on-kolme-kuuga-esitatud-4006-taotlust/.

Another topic that is currently discussed and that is included in the new coalition agreement, is a gradual abolishing or amending the rules for special pensions and pensions under favourable conditions (e.g. pensions for the police, military, judges, etc.), which allow early retirement, reduce flexibility in the labour market, and hide some long-term fiscal obligations. At the time of writing this report a draft law to abolish the special pensions of the Auditor General and the Chancellor of Justice since 1 January 2013 has passed the first reading in the parliament. Parallel to the process of abolishing special pensions, a representatives of few occupations are claiming additional benefits. In October 2011, the Social Democratic Party, an opposition party, initiated a change in the Rescue Service Act that would allow rescuers working in difficult conditions to leave active duties ten years before the normal retirement age (currently 3 years). The proposal was rejected by the coalition in January 2012 with a justification that all special pensions are discussed jointly at the second half of 2012.

Regarding the long-term sustainability of the Estonian social insurance system a research report by Praxis Center for Policy Studies, commissioned by the Ministry of Finance, was published and presented for stakeholders, politicians and media in November 2011.[18] During the preparation of the report about 10 seminars and workshops with all major stakeholders and policy experts were held. Effectively, the topics discussed covered almost everything in the Estonian health care system, pension policy and unemployment protection scheme. The report ended up presenting 55 different policy options, from minor parametric changes, such as a small change in the social tax rate, to structural reforms, such as introducing a flexible retirement age or private health insurance. The main conclusions regarding the pension insurance scheme are summarised in Section 2.2.4.

Another topic that is being discussed, already since 1998, is the introduction of work accident and occupational disease insurance, now possibly together with a major reform of temporary sickness benefits and work incapacity pensions. At the time of writing this report, the Ministry of Social Affairs is preparing a working document describing policy options. Rising number of work incapacity pensions, especially during recent years, has put additional pressure to reform the system.

Regarding taxation, the new coalition agreement includes a plan to reduce labour taxes. First, the marginal income tax rate will be decreased by one percentage point from 21% to 20% in 2015. This would reduce the tax burden on both labour and capital. Second, from 2014, the government plans to set a ceiling, EUR 4,000 per month, on the pension insurance part of the social tax base. This reduces the tax burden of high labour income tax earners, reduces also state pension insurance revenues, and influences future obligations through the impact on the calculation of annual pension coefficients. Reductions in labour taxes and resulting short-run drop in revenues are planned to compensate by setting lower ceiling on various deductibles from income tax and increase of alcohol excise taxes in 2012 and 2013, and taxes on motor fuel in 2012.

In order to reduce tax burden on labour, also a possible reform of health care financing is being discussed, expanding the tax base of health insurance, optionally including both state and funded pensions in the future. But this is in an early stage yet, and it will be decided in the first half of this year, whether this option will be investigated any further.

Finally, the current legislation stipulates that the government is obliged every five years, and it means that also in 2012, to investigate whether the formula of the indexation of pensions guarantees a fiscally and socially sustainable pension system. In addition, the legislation

[18] Aaviksoo, A., Kruus, P., Leppik, L., Sikkut, R., Veldre, V., Võrk, A. (2011), "Eesti sotsiaalkindlustuse jätkusuutlikku rahastamise võimalused" (*Opportunities for sustainable financing of social security system in Estonia*), Tallinn: Praxis Center for Policy Studies.

stipulates that the government has to make the decision whether to relate retirement age formally to life expectancy by 2019, and discussion about the most appropriate way have also slowly started.

2.2.3 Impact of EU social policies on the national level

EU policies influence Estonian social and fiscal policy through various channels. First, Estonian politicians, public finance and social policy experts, and a wider public are closely monitoring the experience of other European countries that are struggling to finance their high social expenditures, and the impact of the current crisis and population ageing on their fiscal sustainability. Estonia is very often compared with other EU countries in terms of pension age, replacement rates, tax burden, fiscal deficit, debt burden and long-term sustainability. Prevailing understanding by both the politicians and experts seems to be that current social expenditure should not be financed with long-term loans. Therefore, there is clear understanding that either taxes, insurance contributions or people's own financial responsibility need to be raised. Other countries' negative experience and comparison with the Estonian situation makes it easier for policymakers to carry out necessary reforms.

The Estonian pension policy is also influenced by the process of open method of co-ordination, primarily through EU common aims of pension policy, which are often used as a basis to evaluate the Estonian pension system, and through common indicators of social policy. The experience of other countries in reforming their pension systems, especially the countries that have introduced automatic stabilizers into their pension system, e.g., Sweden Finland, Germany, are explicitly used in debates about the Estonian pension system.

At the same time, Estonian short run policy documents and action plans closely follow recommendations of the Pact for the Euro and the Annual Growth Survey. According to those documents, Member States should make their pension systems more sustainable by increasing the retirement age and linking it with life expectancy, reducing early retirement schemes and using targeted incentives to employ older workers and promoting lifelong learning, and supporting the development of complementary private savings to enhance retirement incomes. The Estonian National Reform Programme (NRP), named Competitiveness Strategy 'Estonia 2020', its accompanying action plan for the years 2011-2015, the new coalition agreement, the state budget strategy 2012-2015, and the government's action plan for 2011-2015 all reflect the same messages and several steps, such as reforming special pensions have been started.

The recommendations of the European Commission[19], published in summer 2011, do not include any specific guidelines on the Estonian pension policy. Pensions are explicitly mentioned only in the context of the government's promise to tackle special pensions. The recommendation to "achieve structural surplus by 2013 at the latest, while limiting deficit in 2012 to at most 2.1 % of GDP, and keeping tight control over expenditure and enhancing the efficiency of public spending" indirectly influences also the pension system. However, at least in short-term the government has decided to balance the deficit of the pension system with surplus of the unemployment insurance scheme (see Section 2.1). The European Commission's White Paper on pensions[20] does not have any Estonia-specific recommendations either.

[19] Council Recommendation of 12 July 2011 on the National Reform Programme 2011 of Estonia and delivering a Council opinion on the Stability Programme of Estonia, 2011-2015.

[20] European Commission "White Paper. An Agenda for Adequate, Safe and Sustainable Pensions". Brussels, 16.2.2012.

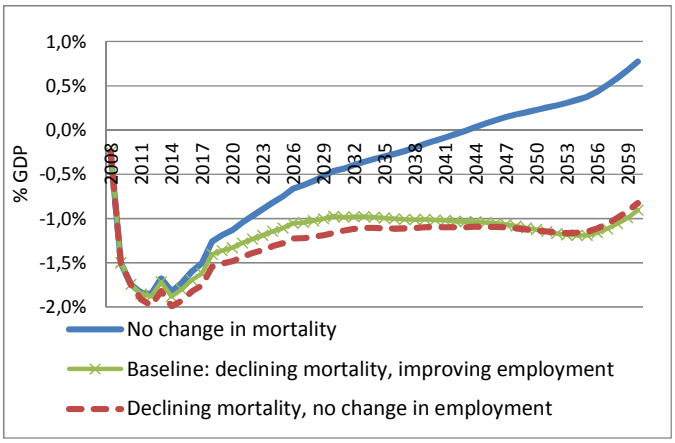
2.2.4 Impact assessment

Several publications and research reports were published in 2011 that analysed the Estonian pension system and the labour market situation of elderly.

Financial sustainability

The research report by Praxis[21], mentioned earlier, included a thorough analysis of the financial sustainability of the pension system, forecasts on average replacement rates and ex ante evaluations of several policy options. Regarding the pension system, it predicts that given the current pension rules and the Eurostat (Europop 2010) forecasts about the life expectancy, then social tax revenues may not cover the expenditure on state pensions for next decades. Additional transfers required from other tax revenues are about 1% of GDP in long run, and around 2% of GDP in next few years due to additional transfers to the funded pension scheme.

Figure 1: Difference of the revenues and expenditure of the state pension scheme (I pillar), according to main demographic and labour market assumptions



Source: The model of the social budget by Praxis, own calculations; see the report mentioned in the text for details.

The study claims that the Estonian financial sustainability of the pension system is most sensitive to life expectancy and therefore it suggests that some kind of automatic stabilisers should be incorporated into the design of the pension system. The study includes several stylized calculations where changes in pension age and/or pension size depend on changes in life expectancy.

Employment and poverty of elderly

The employment rate of elderly (aged 55-64 and 65-69) declined during this crisis about 7-8 percentage points (in 2010) compared to the peak values in 2007-2008, but this drop is similar to the employment rate change of prime-age workers. The employment rates have started to increase again in 2011.

Simultaneously, inflow into the pension system increased substantially in 2009 and 2010, especially via work incapacity pensions and early retirement. In 2010, the inflow into the work incapacity pension scheme was 50% higher than in 2007, and via early retirement scheme 60%

[21] AAVIKSOO, A., KRUUS, P., LEPPIK, L., SIKKUT, R., VELDRE, V., VÕRK, A. (2011), "Eesti sotsiaalkindlustuse jätkusuutlikku rahastamise võimalused" (*Opportunities for sustainable financing of social security system in Estonia*), Praxis Center for Policy Studies, Tallinn, retrieved on 15 February 2011 at http://www.praxis.ee/index.php?id=27&tx_ttnews%5Btt_news%5D=1124&cHash=0fced655f3.

higher. Preliminary data suggest that high inflow into the work incapacity scheme continued also in 2011.

At the beginning of the crisis in 2009, old-age pensions, work incapacity pensions and survivor's pensions increased, both in nominal and real terms. In 2010 and 2011, pensions did not decline in nominal terms. As a result, the at-risk-of-poverty rate of elderly declined from 33.9% in 2008 to 13.1% in 2010. The severe material deprivation rate for elderly has also declined steadily from 7.9% to 5.6% in the period 2007 to 2009, but with a small increase in 2010 to 6.6%. The absolute poverty rate of elderly was considerably lower than the population average and decreased in 2010 compared to 2007. These numbers suggest that, on average, old-age pensioners suffered less during the last crisis than the other demographic groups.

Table 3: Selection of indicators of poverty and employment of elderly, 2007-2011

Year	2007	2008	2009	2010	2011
Employment rate, %					
Age group: 25-54	84.6	83.7	76.2	74.6	78.0
Age group: 55-64	59.5	62.2	60.4	53.8	57.1
Age group: 65-69	25.9	24.2	19.6	18.2	19.5
Inflow into the pension system					
Old-age pensions (*vanaduspension*)	9,425	7,583	9,312	10,934	8,300**
Early retirement (*ennetähtaegne vanaduspension*)	1,618	1,372	2,327	2,590	1,200**
Work incapacity pensions (*töövõimetuspension*)	7,124	6,726	8,650	10,280	10,700**
At-risk-of-poverty rate (60% of median equivalent income), total*	19.5	19.7	15.8	17.5	
Age group: 65+	39.0	33.9	15.1	13.1	
Relative median at-risk-of-poverty gap, %, total*	20.3	17.0	23.2	26.0	
Age group: 65+	14.8	11.4	9.0	8.7	
Severe material deprivation (%), total	5.6	4.9	6.2	9.5	
Age group: 65+	7.9	5.8	5.6	6.6	
Relative median income of elderly (65+ versus other age groups)*	0.62	0.66	0.73		
Aggregate replacement ratio (income of pensions of 65-74 to income from work of 50-59)*	0.45	0.52	0.55		
Absolute poverty rate	6.5	na	na	11.7	
Age group: 65+	2.9	na	na	2.3	

Sources: Statistics Estonia, on-line database; Eurostat; Estonian National Insurance Board, annual statistical reports
**Note: Statistics Estonia defines year as income year in EU-SILC data. In Eurostat tables these figures refer to the values of next year*
*** - own forecasts based on preliminary data*

The Estonian pensioners' situation relative to the working age population before retirement is comparable to other EU countries. The current adequacy indicators are at the same level that the EU-27 average values (all numbers are from 2009 income year). For example, the aggregate replacement ratio is 55% (EU-27 average is 53%). The at-risk-of-poverty rate of those older than 65 is 15.1% (EU-27 average is 15.9). The severe material deprivation rate of those older than 65 is 6.6% (EU-27 average is 6.4%). The joint EU2020 indicator (either at risk of poverty or social exclusion) is 19.0% (EU-27 average is 19.8%). The median relative income of people 65+ as a ratio of income of people 0-64 is 73% (EU-27 average is 88%).

There is a considerable difference in the risk-of-poverty rate between elderly men and women (8.0% and 18.6% respectively). The main reason is simply that men statistically enjoy a shorter life-expectancy (14 years for men and 18 years for women at the age of 65) and therefore tend to live in couple households, where the risk-of-poverty is lower by definition (through equivalence scales). Worth noting is also that those men and women who are poor are equally poor: the relative median poverty gap of both men and women over the age of 65+ was 9% in 2009.

The current income distribution of Estonian elderly is considerably narrower (S80/S20 ratio is 2.9) than among younger population (5.4) or elderly in EU-27 (4.0). This is because of the redistributive flat rate base amount, which is about 38% of the average old-age pension. Also the length of service component is strongly redistributive, but as this takes into account only employment periods up to 1998 its role is gradually diminishing for new pensioners. In the future, when contributions matter more both in the state pension scheme and in the funded pension schemes, the distribution of pensions will be considerably wider. Therefore, the future adequacy of minimum pensions is an important problem. Currently the national pension serves as a minimum guarantee for pensioners, but its level has been about 20-27% of the medium income in 2004-2009 - below international standards and also below the national level of subsistence minimum (*elatusmiinimum*).

Majority of old-age pensioners are located near the relative poverty line of the income distribution. Small changes either in the distribution of the labour income or in old-age pensions may change the poverty line and shift a large proportion of old-age people either above or below the poverty line, with no significant change in their actual living conditions. For example, at-risk-of-poverty rate of those older than 65 was 39% in 2008 but only 13.1% in 2011.[22] Therefore it is crucial that other indicators, such as material deprivation rate or absolute poverty rate is used to evaluate the current situation of the Estonian elderly either over time or relative to other socioeconomic groups.

Those receiving national pension may have higher risk of poverty, but because there are not many of them (about 1.6% of all pensioners), there are no official poverty measures for them.

Another large group of pensioners that faces high risk of poverty, and which is not well represented in regular indicators, are those receiving work incapacity pensions. There are about 90 thousand people receiving work incapacity pension (about 22% of all people receiving any state pension). The average work incapacity pension was about 60% of average old-age pension in 2011. About half of work incapacity pensioners do any work, but even then their average annual earnings are less than half of the average wage.[23]

Statistics on applications for subsistence benefits[24] confirm that work incapacity pensioners are more likely to be in households that are eligible for subsistence benefits. There were 13,643 pensioners in approved applications during the first nine months of 2011. Of those 79% were work incapacity pensioners and only 11% were old-age pensioners (remaining 10% must be other categories). It shows that work incapacity pensioners face considerably higher risk of being in the households with very low income.

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22 Statistics Estonia. On-line database. Note that these years refer to EU-SILC survey years and correspond to the income year one year earlier.

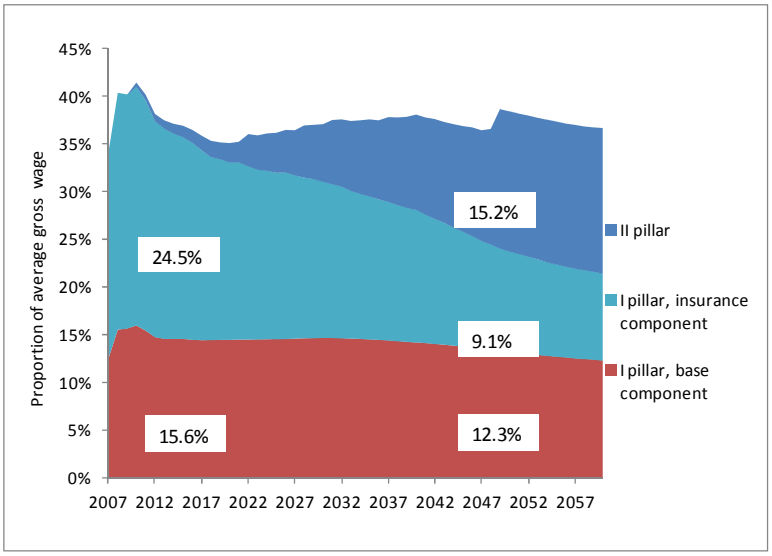
23 Estonian National Social Insurance Board "Riiklik pensionikindlustus 2011", retrieved on 6 February 2012 at http://www.ensib.ee/public/statistika_ja_eelarve/riiklikpension2011.ppt.

24 Ministry of Social Affairs (2011), "Toimetulekutoetus kohalike omavalitsusüksuste lõikes. 2011. aasta 9 kuu lõikes", Table Tabel 3. Leibkonnaliikmete arv rahuldatud taotluste järgi, 2011. aasta 9 kuud retrieved on 6 February 2012 at http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalsektori_statistika/Toimetulekutoetuse_maksmine_2011._aasta_9_kuu_jooksul.xls.

Pension adequacy in the future

Regarding the future adequacy of pensions, simulations of gross replacement rates either using numerical calculations of typical workers or cohort-based models by Ministry of Finance or by Aaviksoo et al. (2011) indicate that the average gross replacement rate from the statutory pension scheme does not change much, staying around 35-40%. Pension benefits from statutory funded scheme are projected to offset the fall in the replacement ratio in the public scheme to a certain extent.

Figure 2: The average gross replacement rate of pensions for the new old-age pensioners at the time of retiring in the retirement age



Source: The model of the social budget by Praxis, own calculations

Both future replacement rates and total revenues and expenditures of the pension system depend much on the developments in mortality, labour market and the rate of return of pension funds. Simulations by Aaviksoo et al. (2011) suggest that average gender-specific gross old-age pensions relative to economy-wide average gross wage at the time of retirement may vary between 35-50% for men and 28-36% for women in 2060 depending on the assumptions. Also, as pensions will depend more on life-time earnings both in the state pension scheme and in the funded pension schemes, the distribution of pensions is expected to be much wider than today.

Unfortunately, there are any simulation studies available predicting the distribution of future pension benefits and the possible poverty rate of pensioners.

The Ministry of Social Affairs has published preliminary ex ante evaluation of the planned **pension supplements for parents** who have raised children.[25] It shows that the additional expenditures are initially low, because only few parents whose children were born after 1991 have reached the pension age. In 2013 the additional expenditure will be EUR 2.8 million, but by 2017 it will increase to EUR 44 million. In long-run, the additional cost will reach 0.2-0.25% of GDP. For parents whose children have already been born the pension supplement will depend on the indexation of state pensions, but future parents will depend on the rate of return of the funded pension scheme. It is estimates that on average a parent with two children may

[25] Ministry of Social Affairs (2011), "Seletuskiri riikliku pensionikindlustuse seaduse, okupatsioonirežiimide poolt represseeritud isiku seaduse, soodustingimustel vanaduspensionide seaduse ja kogumispensionide seaduse muutmise seaduse eelnõu juurde" (*Exlanatory note for pension supplements for parents*), pdf document "Pensionilisa ja II sammas_SK_10.01.2012.rtf", retrieved on 15 February 2012 at http://eelnoud.valitsus.ee/main#iGiM0OyO.

receive around 4-10% increase of their pensions. Accordingly, it will decrease the gender pension difference, because in most cases it is a mother who is eligible to the pension supplement.

2.2.5 Critical assessment of reforms, discussions and research carried out

The reforms implemented in 2009-2012 have simultaneously aimed the short-term balance of the public finances and long-term financial sustainability of the Estonian social security system. Temporary suspension of transfers to the compulsory pension scheme and ad hoc changes to the indexation of pensions can be considered as an adequate reaction to the declining tax revenues during the crisis. Further increase of pension age to 65, gradual abolishing of special pensions, and improved transparency and flexibility of the funded pension schemes contribute to longer term financial sustainability and adequacy of pensions.

Government's plans to possibly link the statutory pension age with life expectancy in the future and introduction of a work accident and occupational disease insurance, together with a major reform of work incapacity pensions may contribute either to the reduction of pension expenditure or provide more adequate coverage of social risks, depending on the exact implementation of these reforms. However, intentions to introduce a work accident and occupational disease insurance or reform special pensions have been around already for many years by successive governments, but with no success. Therefore, one should not be too optimistic about the ability of the government to implement these reforms.

The current problem of the Estonian pension system is not high pensions, but large number of pensioners relative to employed people. The Estonian pension system includes strong incentives to work longer already today, as individual pension depends to a large extent on life-time individual social contributions. Also the possibility to receive simultaneously pensions and labour earnings after the normal retirement age has contributed to the high employment rate of elderly. However, the reduction of pensions when retiring before normal pension age is not actuarially neutral and may encourage early retirement of those who are long-term unemployed. This is strengthened by relatively short unemployment insurance benefits (180-360 day, depending on the length of a contribution period). Indeed, during the last economic crisis, early retirement both via old-age pension scheme and work incapacity pension scheme increased substantially. Therefore the economic crisis may have led to permanent reduction of labour force, because outflow from the early retirement and work incapacity pension scheme is negligible. Furthermore, those receiving early retirement pension before formal retirement age may not work at all, thus creating a potential inactivity trap up to three years and discouraging people to return to the labour market even after labour demand has restored. Therefore, making early retirement pensions more actuarial but simultaneously allowing part-time working may be worth considering.

In the compulsory and voluntary funded second-pillar pension scheme, the crisis has resulted in stricter control and clearer rules on the management of the private pension funds. Moreover, as people are now more easily allowed to change funds, an increased competition between the funds is expected. Indeed, in 2011, we already witnessed that many more people have changed their pension funds. To further encourage private savings employers are exempted from the fringe benefit tax on their contributions to employees' voluntary pension fund up to a certain amount. Next years will show how popular this will be among employers.

Given the low projected replacement rate, ensuring adequate pensions in the future will be a major challenge, in particular for people with short professional careers or with low earnings, and for disabled people or those receiving only residence-based national pensions.

Although Estonia does not have a large public debt and also the share of pension expenditure in GDP is not very high (9.1% in Estonia vs 13.1% in EU-27 in 2009), it is not very likely that additional funds are transferred to the PAYG system to increase current pension levels relative to labour earnings. Therefore higher replacement rates and/or lower poverty among pensioners could be achieved through a combination of different approaches: increasing effective retirement age, increasing voluntary savings, or using current expenditures more efficiently in targeting poverty.

More attention should be paid to the current situation of work incapacity pensioners whose pensions are considerably lower than that of old-age pensioners, but expenditures on medicines are higher. Regular indicators of deprivation and at-risk-of-poverty measures about these pensioners could be the first step. In addition, regarding the future adequacy of old-age pensions and poverty of pensioners more quantitative research is clearly needed in Estonia, possibly with the use of modern dynamic microsimulation models.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Health care in Estonia is provided through contracted private entities and financed by contributions and (marginally) through the general budget, which funds topical programmes and pays for emergency services.

The health care system is governed by several institutions. The Ministry of Social Affairs (*Sotsiaalministeerium*) sets out the policy, while the Health Care Board assures the quality of the services provided by keeping the register of health care professionals, by issuing licenses and by following up on patients' complaints. The Estonian Health Insurance Fund (*Haigekassa*), an independent government agency acting as the overall implementing institution, collects and distributes funding, contracts health care providers, checks the quality of the services provided and pays out benefits for temporary incapacity to work.

Health care coverage is provided to all residents who pay contributions by themselves (self-employed persons) or whose contributions are paid by their employer (as part of the "social tax"[26]) or by the State (parents on parental leave, persons taking care of disabled persons, non-active parents raising three or more children under 19 years of age with one child aged under eight years, conscripts, and registered job seekers, whether they receive unemployment benefit or not[27]).

A further group, which amounts to 48% of all insured persons, consists of persons who are entitled to insurance without any contributions being paid. These are children under 19 years of

[26] Social taxes are set at 33%. 13% is earmarked for health insurance, while 20% goes to the national pension insurance. Separate contributions are set for the unemployment insurance and the second pillar pension scheme; these, however, are not part of the social tax concept.

[27] Health insurance contributions for persons receiving an unemployment benefit are paid by the Unemployment Insurance Fund (Töötukassa), while contributions for persons who are not or no longer entitled to the benefit are paid by the state from the general budget.
The inclusion of job seekers was an important step in the increase of the coverage rate. Introduced in 2007, the measure was inspired by the observation that the majority of unemployed at that time had no entitlement to benefits, which meant that they also had no health care insurance. At the end of September 2011, 3.7% of the total of insured persons was insured through registration as unemployed (compared to 5.2% at the end of 2010). Of this group, some 64% does not receive an unemployment benefit and thus is covered via this measure.

age, students aged under 24, pregnant women[28], recipients of an Estonian state pension, and spouses who are dependent on an insured person and who are within five years of the retirement age.

Lastly, the health insurance system covers those who are insured on the basis of international agreements or EU regulations; 1% of all persons insured.

Coverage is high but not complete, with around 95.5% of the population included[29]. The remainder is comprised of unemployed persons not registered as job-seekers, persons insured abroad, persons avoiding taxes, and persons living on sources of income that are not subject to taxation (such as dividends). Uninsured persons are entitled to emergency services in case of need.

The system provides for benefits in kind through a system of family physicians, specialised care and emergency care. Health care services in kind are provided to the citizens irrespective of the amount of contributions paid, and are provided free of charge. Co-payments are required only for some services[30], for home calls made by family doctors and for outpatient specialised care. The fees are however limited[31] and constitute no real impediment. A few private hospitals (which do not have a contract with the Health Insurance Fund) require a higher contribution from the patient.

The health care system also provides for pharmaceuticals and for some cash benefits[32]. In these areas, the level of out-of-pocket payments is important.

Modern reform[33] of the health care system in Estonia started with the restitution of independence in 1991. The system, then based on the Soviet Semashko model, underwent a complete change in terms of financing, organisation and policy.

The Soviet Semashko model was characterised by a large network of secondary care providers and a fragmented primary health care level, organised through polyclinics and specialised dispensaries. Financing of health services was provided entirely through the state budget, with publicly owned health care facilities, staffed by public employees. Different levels of state administration – central, regional, and local – were responsible for planning, allocation of resources, and managing capital expenditures.

Against this background, the main focal points of the reforms that took place since the 1990s were to establish financing through social health insurance and to encourage decentralisation – partly in response to the changing needs of the Estonian population and partly to meet concerns

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[28] As from 1 July 2009, the Health Insurance Act stipulates that pregnant women are considered to be equal to insured persons from the moment of medical confirmation of pregnancy (instead of from the 12th week of pregnancy).

[29] This figure is derived from a comparison between the population register and the health insurance register, and should be approached with caution as the population register does not take into account several forms of migration.

[30] Insured patients share part of the cost of hospitalisation (through payment for "bed-days"), in-vitro fertilisation, termination of pregnancy for other than medical reasons, and medical rehabilitation in case of certain (mostly chronic) conditions.

[31] Fees for doctors and specialist are capped at EUR 3.20; co-payment for hospital stay is capped at EUR 1.60 for the first 10 days.

[32] The cash benefits provided for are benefits for temporary incapacity to work and supplementary compensations for pharmaceuticals. Prior to the crisis, dental care for adults was partially covered.

[33] For an encompassing overview of health care reform in Estonia, see KOPPEL, Agris, KAHUR, Kristiina, HABICHT, Triin, SAAR, Pille, HABICHT, Jarno and VAN GINNEKEN, Ewout, Estonia: Health system review, Health Systems in Transition, 2008, 10 (1), retrieved on 15 February 2012 at http://www.euro.who.int/en/who-we-are/partners/observatory/publications/health-system-reviews-hits/full-list-of-hits/estonia-hit-2008.

about financial sustainability of the system. The core ideas of this reform, found in the Health Insurance Act of 1991 and the Health Services Organisation Act of 1994 have not changed[34]. Also amongst these core ideas was the development of a primary health care that would act as a gatekeeper, as opposed to the role of a simple referral point to specialised care as under the Soviet system.

More recent evolutions build on the experiences of the initial reforms, and are meant to optimise the system. Amongst these more recent initiatives are a re-thinking of the initially planned decentralisation (and a subsequent re-centralisation of some tasks), the transformation of the Estonian Health Insurance Fund into an independent public body in 2000, and the mandating of all health providers to operate under private law[35].

Also to be mentioned is the 2002 Law of Obligations Act, which had as a result that the relationship between patients and providers is now defined as a binding agreement, with responsibilities on both sides.

At the end of 2007, a legislative framework for a Health Information System was established by way of amendments to the 1994 Health Services Organisation Act. The aim of the new digital database is to improve the quality of health services through efficient information sharing, while at the same time protecting patients' rights. Digital information further allows doctors to consult with specialists, without the need for the patient to make extra visits or undergo additional testing. Under the new act, health care service providers are obligated to enter medical data into the system, including what health services were provided to patients, information on their health status, digital recordings and information concerning waiting lists. This obligation was implemented starting from September 2008. Today, patients and doctors alike can see the results of tests online, via a secured access.

In addition, a system of digital prescriptions of pharmaceuticals was introduced in 2010, doing away with the need of prescription slips and the paper administration that accompanies them[36]. Doctors can now prescribe pharmaceuticals through their own information system and forward it to a national database, to which chemists can gain access using the electronic identity card of the patient. After some initial technical difficulties, today, nearly all pharmacies have joined the system and the majority of prescriptions are filled digitally. Apart from clear efficiency gains, the system also allows doctors to prescribe better by being able to take into account medication prescribed by other health professionals for the same person. In the longer run, the Estonian Health Insurance Fund expects to be able to research patterns of consumption and to add automatic processing that allows to improve treatment quality and to make better and more informed forecasts.

As a result, the Estonian Health Care System today is a modern operation, based on a client-service relationship between patients and doctors, and with an emphasis on the role of primary care.

2.3.2 Debates and political discourse

The focus of debate concerning health care in Estonia remains firmly on the issue of financial sustainability. Other topics of discussion such as the availability of services and service

[34] The Public Health Act of 1995 dates from the same period, and aimed to reform the Soviet Sanitary-Epidemiological service network (SANIPED) into a more modern system of public health services.

[35] The latter is enacted through the 2001 Health Services Organisation Act and the 2002 Health Insurance Act.

[36] For an overview of these projects, see http://eng.e-tervis.ee/. Note that Estonian citizens of all ages and classes routinely communicate with their government through electronic means. The choice for electronic service delivery channels raises much less concern as to accessibility or usability than it would in other countries.

providers, personal responsibility of the citizen, the role of the Health Insurance Fund in relation to other social security institutions are invariably linked to this issue.

Health care was not on the list of hotly debated topics in the run-up to the parliamentary elections of March 2011. Where all parties noted challenges concerning the organisation of health infrastructure and making sure service provision is secured, solutions differ along with different views on society and the role of the state in society[37]. For the parties that make up the new coalition, government is to remain lean, prudent and efficient, and an increase in health care expenditure is something that needs to flow from economic growth. In essence, this means that evolutions in the health care system are expected to take place within the current budgetary framework.

At the same time, the current financing scheme is problematic. The Health Insurance System derives its funding primarily through targeted social tax payable on wages, which accounts for 98.8% of revenue of the Estonian Health Insurance Fund. This revenue covers health care expenditures and health care benefits and is complemented by funding from the state budget for topical programmes and for the provision of emergency care. Ambulance services, for example, are paid from the general budget, not from the health insurance part of social taxes.

However, contributions are paid for only 52% of all who are insured. Within the group for whom no contributions are collected we find those who receive a pension – arguably those in most need of health care. At the same time, out-of-pocket payments stand at a high level, especially when it comes to dental care and the purchase of medication[38]. In other words, personal responsibility is high and the involvement of government in terms of spending is low, leaving the system to be financed by a limited proportion of the population.

Extensive consultations with stakeholders and experts and partnership with the Regional Office of the World Health Organisation resulted in a report assessing the financial sustainability of health care, completed and published in the early spring of 2010[39]. In this report, projections on increasing costs are coupled with observations concerning the strengths and weaknesses of the current system. The recommendations in the report are formulated taking into account the goals and values of the health care system, support by the stakeholders in the system (who were consulted through seminars and interviews), and political feasibility of proposed changes (i.e. coherence with current policy).

The key message of this report is that the public revenue base of the system should be broadened through (amongst others) a stable and transparent revenue allocation from the

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[37] An analysis of the issues and positions as they are found in the different party manifestos is contained in AAVIKSOO, Ain, KRUUS, Priit, SALUSE, Janek, VELDRE, Vootele, LAARMANN, Heli and ERMEL, Reelika, Valimislubaduste analüüs: selged valikud tervishoiupoliitikas, PRAXIS Poliitikaanalüüs nr. 6/2011, 10, retrieved on 15 February 2012 at http://www.praxis.ee/fileadmin/tarmo/Projektid/Valitsemine_ja_kodanike%C3%BChiskond/OSI_valmisanalueuesid/Valimislubadusteanalyys_tervishoid.pdf (Analysis in election promises: clear options in health policy).

[38] For a detailed overview of the evolution in out-of-pocket payments over the years and its effects, see VÕRK, Andres, HABICHT, Jarno, XU, Ke and KUTZIN, Joseph, "Income-related inequality in health care financing and uitilisation in Estonia since 2000", WHO Health Financing Policy Paper 2010/3, 23p. retrieved on 15 February 2012 at http://rahvatervis.ut.ee/bitstream/1/2201/1/V%C3%B5rkjt2010.pdf.
The overall level of out-of-pocket payments stands at around 20%. Detailed figures in expenditure and the proportion of out-of-pocket payments for different categories of care provision can be retrieved from the Health Statistics and Health Research Database of the National Institute for Health Development (http://pxweb.tai.ee/esf/pxweb2008/Dialog/statfile1.asp).

[39] THOMSON, Sarah, VÕRK, Andres, HABICHT, Triin, ROOVÄLI, Liis, EVETOVITS, Tamás and HABICHT, Jarno, "Responding to the challenge of financial sustainability in Estonia's health system", 2010, Tallinn, World Health Organisation, retrieved on 15 February 2012 at http://www.euro.who.int/document/E93542.pdf.

central government budget to the Estonian Health Insurance Fund, for example by having the central government pay contributions on behalf of pensioners (who are now insured without contributions being paid). The report also points to the need to rationalise and simplify the rules governing out-of-pocket payments, to increase initiatives concerning generic pharmaceuticals, and to plan coverage of adult dental care. Other suggestions relate to a further improvement of investment and resource allocation processes (in line with the existing policy) and the maintenance of a strong governance of the health system.

In 2011, the World Health Organisation published an update of this report in which it criticises the fact that, where the professionals in the field have made important efforts to maintain reasonably good access to health care during a period of severe economic difficulty, this is not matched by political leadership. In particular, the report laments that the Health Insurance Fund was not allowed to use its reserve funds to the extent that would have avoided costs being shifted onto households, that nothing was done to broaden the public revenue base away from the narrow focus on payroll taxes, and that there is no decisiveness in implementing more stringent and strategic control over investment in the health sector[40].

Further shaping the debate is the 2011 OECD Economic Survey for Estonia[41] in which many of the same elements are mentioned. This report contains recommendations to further rationalise existing hospital networks, put more emphasis on primary care, and to pay more attention to the quality of care. The report also delves deeper into the issue of out-of-pocket payments and its consequences for access to health care, in particular for financially distressed households.

In Estonia, these reports are carefully considered and used as a basis for political discussion. The recommendations made in 2010 by the WHO were even repeated in the 2010 Year Report of the Estonian Health Insurance Fund[42], and were thus "internalised" as an outline of future action and concern. In parallel and partly as a result, the Ministry of Finance commissioned an independent study on alternatives for sustainable financing of the Estonian social insurance system as a whole. The results of this study were presented in November 2011[43] and must now lead to choices and decisions. Where the report has the merit of describing background and consequence of many different policy options ranging from the parametric to the fundamental, it is now up to the government to take position and to choose direction. As of yet, and apart from some ideas described in the press, this direction has not been made explicit.

Financials also lie at the basis of another debate, which has the potential to alter the financial basis and governance of the administration of the health care insurance and unemployment insurance. The health insurance system and the unemployment insurance system are conceived as fund-based operations, where surplus contributions are held in reserve to be used in times when contributions do not cover benefits. This set-up has proven useful during periods of

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40 THOMSON, Sarah, HABICHT, Triin, ROOVÄLI, Liis, EVETOVITS, Tamás and HABICHT, Jarno, "Responding to the challenge of financial sustainability in Estonia's health system: one year on", 2011, Tallinn, World Health Organisation, retrieved on 15 February 2012 at http://www.euro.who.int/__data/assets/pdf_file/0009/150102/E95604.pdf.

41 OECD, "OECD Economic Surveys: Estonia 2011", OECD Publishing, April 2011, 79-91 retrieved on 15 February 2012 at http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en.

42 Eesti Haigekassa, "Estonian Health Insurance Fund Annual Report 2010", 20-21, accessed on 15 February 2012 at http://www.haigekassa.ee/uploads/userfiles/Eesti_Haigekassa_majandusaasta_aruanne_2010_eng.pdf.

43 AAVIKSOO, A., KRUUS, P., LEPPIK, L., SIKKUT, R., VELDRE, V., VÕRK, A. (2011), "Eesti sotsiaalkindlustuse jätkusuutlikku rahastamise võimalused" (*Opportunities for sustainable financing of social security system in Estonia*), Praxis Center for Policy Studies, Tallinn. The full 337-page report can be obtained from the Praxis website: http://www.praxis.ee/index.php?id=27&tx_ttnews%5Btt_news%5D=1124&cHash=0fced655f3.

economic hardship, and has avoided the need for important cuts in service delivery or drastic increases in the contribution rate. However, not entirely.

In a move to improve overall state finances, the government has decided to consolidate the reserves of the health insurance and unemployment funds with the reserves held by the central government itself. In practice, this means that these funds are to a much lesser extent at the disposal of the respective systems. That this impacts policy is apparent in the fact that the Health Insurance Fund was not allowed to use reserve funds to the extend it wished to in 2011 (and therefore had to cut costs further, increasing the personal responsibility of the citizen), and – where it concerns the unemployment insurance – in the observation that a lowering of the contribution rate was denied by the government. The social partners, who play an important role in the governance of both health care and unemployment institutions and are represented in the respective supervisory boards subsequently walked out in protest.

This course of events is worrying in at least two ways. First, because it shows that the fund-based setup of the health insurance scheme is relative. In a way, the legitimacy of earmarked contributions is in question. While this does not need to threaten the functioning of the system, it does mean that the assumptions on which long-term policy can be based have changed. Second, because it demonstrates that, while professed otherwise, the social partners are not on an equal footing as the government in developing and implementing the social security system.

Still ongoing is the debate as to the setup and modalities of a separate work accident and occupational disease insurance. Ideas were discussed in the run-up to the elections, and its creation is included in the coalition agreement that shapes the policies of the newly formed government. Where agreement on what the system should look like, or a time-table, have as of yet not been reached, the discussion seems to go towards a major reform of temporary sickness benefits and work incapacity pensions[44].

Finally, the worry that skilled health care providers would rather go work abroad than stay in Estonia due to low pay and working conditions, and that there is thus a growing shortage of qualified nurses and physicians, remains. For physicians, the evidence seems anecdotal. When it comes to nurses however, Estonia falls short of what is regarded as an optimal level, with 6.4 nurses per 1000 inhabitants compared to the OECD average of 9 in 2008. While budget constraints are at play also in this regard, this issue receives proper attention, and the plan is to boost the number up to 8 by providing more state-financed study places in medical programmes at the University of Tartu, and by putting higher value on the job as nurse both in terms of remuneration and responsibilities[45].

2.3.3 Impact of EU social policies on the national level

The Estonian health care system underwent an important reform in the nineties and is widely recognised as a transparent and efficient system with low administrative cost, benefiting from

[44] A working document deriving from the Ministry of Social Affairs and describing different policy options was revealed in the press in the beginning of February 2012. See TANKLER, Lauri, "Riik otsib võimalusi töövõimetushüvitiste pealt kokku hoida" (*The State is looking for ways to save in disability benefits*), Eesti Päevaleht (newspaper), 1 February 2012, retrieved on 15 February 2012 at http://www.epl.ee/news/eesti/riik-otsib-voimalusi-toovoimetushuvitiste-pealt-kokku-hoida.d?id=63855782.
According to the article, the Ministry document suggests to entrust the administration of the system to the Estonian Unemployment Fund (with reference to providing active labour market services to the recipients of the benefit), while funding would only partially be transferred, leaving at least part of the system to be paid through contributions currently intended for the unemployment insurance scheme.

[45] OECD, "OECD Economic Surveys: Estonia 2011", OECD Publishing, April 2011, 89-90 retrieved on 15 February 2012 at http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en.

strong governance and a high involvement of all. The Estonian context however also includes a low level of financial participation by the government and a correspondingly high personal financial responsibility of patients. Mainly on these points, answers are sought that would lead to delivering the same with less money, while an increased government expenditure is considered but not seen as the preferred answer.

The influence of European policies and discussion is felt mostly on the issues on which communication is the strongest – fiscal and budgetary prudency and an emphasis on growth and employment. Comparison with other countries is often made, and lessons concerning what to do and what not to do are derived. The focus is however decidedly financial, and much less reference is made in public communication to common standards in terms of an overarching European social aspiration.

Efforts to improve the health care system build on much the same principles as those of the EU 2020 strategy, with attention to the financial sustainability and a move towards universal access to quality care. The desire for a rather lean government sector and an efficient use of existing resources (rather than a search for additional resources) shapes the nature of changes that are being considered. In line with this, the Estonian NRP focuses on fiscal prudency and on a higher participation in the labour market, seen as the best way to ensure a stable funding for the system. In this respect, the effects of an ageing population, while not as pronounced as in many other EU Member States[46], are of concern.

The Estonian National Health Plan 2009-2013 contains objectives that are derived from the European level, such as goals in terms of life expectancy and in terms of reducing health disparities amongst different population groups[47]. With a coverage rate of over 95%, universal coverage is perceived as less urgent. Plans to achieve near-complete coverage seem to have been reported to better economic and financial times.

Improving quality is a continuous concern, and is being approached within the limits of the existing budget through an optimal use of resources. The introduction of the digital prescription system is an important step in this respect, as is the further systematic development and updating of clinical practice guidelines to bring them in line with global best practices.

In all, apart from the austerity debate, reference to EU policies and to other EU Member States is most often made in terms of comparison. The main effect of the Open Method of Coordination at present seems to be the opportunities it brings for measuring and benchmarking reforms and adaptations.

2.3.4 Impact assessment

The financial crisis and the fiscal constraints imposed in order to meet the Euro zone requirements have lead to significant cost-saving measures in the health care sector. Amongst these measures are changes in the sickness cash benefit system, an increase in maximum waiting times in outpatient specialist care, the abolition of dental care benefits universal for all population groups, and a reduction in the compensations paid to health care professionals. The details of these measures can be found in previous asisp Annual Reports.

[46] In a worst-case scenario, the gap between health care revenue and expenditure is projected to be 1.4% of GDP in 2030.

[47] Sotsiaalministeerium, "Rahvastiku Tervise Arengukavaga 2009-2020". The National Health Plan is continuously reported upon. See http://www.sm.ee/tegevus/tervis/rahvastiku-tervise-arengukava-2009-2020.html.

The 2012 health care budget carries the promise of an improved financial situation. The coefficient that was imposed on the prices of health care services is removed[48] and a 10% yearly increase in nursing care expenses is planned until 2015. Overall, the budget of the Health Insurance Fund increased with 6.9% compared to 2011[49]. Moreover, new health services and devices are added to what is covered, improving for example the availability of treatment of diabetes and the quality of living of diabetics.

Following a performance evaluation of the family doctor system by the Estonian National Audit office of 8 April 2011[50], it was observed that the family doctor system is unable to perform all of its functions in the health system because family doctors do not always perform the agreed services and frequently refer patients to specialists without good reasons. Furthermore, the system is found to not guarantee accessibility of the family doctor service in all regions. The main reason behind the problems of the family doctor service, in addition to a limited awareness of patients, is the lack of family doctors in certain regions, their varying competence and the limited development opportunities of the system. To improve the way the system works, it is recommended that the state pays more attention to the specification of the functions of family doctors and the harmonisation of the qualifications of family doctors. Attention should further go to guaranteeing the quality of the work of family doctors, improving the accessibility of family doctor services and carrying out the other measures set out in the Primary Health Care Development Plan that was agreed upon in 2009.

While this Primary Health Care Development Plan indeed still lacks some implementation, some changes in the organisation of primary care were made that partially answer the observations of the National Audit Office. In particular, the way family doctors are remunerated has been adapted to include more motivation for family doctors to work in remote or difficult areas.

For example, more money is allocated to new primary care practices opening in rural locations, and extra remuneration is provided for those practices which lie at a distance of more than 30 or 40 kilometers from a hospital. Not just taking into account distances, the per capita fee[51] is now diversified over five age categories instead of the previous three. As a result, operating a primary care practice in areas that are difficult to access or where the demographics are such that an average patient requires more care, is made more attractive.

An interesting pilot project aims to provide a state-organised replacement system for primary care physicians. Starting in March 2012, family doctors will be able to take a short leave of absence while being replaced by another doctor. The physicians who are available to offer the replacement service – mainly young residents, pensioners and doctors staying at home with children – receive a salary for the performed duties (paid for by the doctor who gets replaced) and a government-provided fee for being available.

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[48] In 2010, health care providers were allowed to charge only 94% of the set price of services. In 2011, this measure was partially reversed.

[49] In comparison with the 2011 budget, 5% more is set aside for health care professionals, and a 3% increase is calculated for services.

[50] National Audit Office of Estonia (Riigikontroll), "Perearstiabi korraldus", April 2011, Tallinn retrieved on 15 Fenruary 2012 at http://www.riigikontroll.ee/Riigikontrollipublikatsioonid/Auditiaruanded/tabid/206/Audit/2172/language/en-US/Default.aspx#resultshttp://www.riigikontroll.ee/Riigikontrollipublikatsioonid/Auditiaruanded/tabid/206/Audit/2172/language/en-US/Default.aspx#results.

[51] Family doctors are paid on the basis of the number of patients registered at their practice, and not on the basis of the amount of services provided. As young children or elderly persons on average require more care than healthy adults, without differentiating in the fees, doctors would be more attracted to those areas where the profile of the population is more likey to result in less work per patient.

2.3.5 Critical assessment of reforms, discussions and research carried out

The financial and economic crisis and the run-up to the accession to the Euro zone have necessitated important savings in the health care system. Where these savings were initially of an organisational nature, measures taken over the course of 2010 and 2011 have made a bigger difference resulting in a higher individual financial responsibility. The average adult citizen is now responsible for his or her own dental care[52], is not compensated for the first three days of sickness and at a lesser rate for the subsequent days, experiences longer waiting lists, and pays more for prescribed medication.

At the same time, no progress has been made in changing the overall financing base of the health care system. As a result, the system is still mainly financed by payroll taxes and upheld by contributions paid for only 52% of the insured. As the volume of wages on which contributions are levied diminished, the increase in out-of-pocket payments seems to be a logical result of having to do the same with less funding. However, much of this could have been avoided had the reserve funds been used to a larger extent.

As is described above, the desire to keep the reserve funds intact is inspired by the need to keep the overall government finances healthy. While this may be legitimate in a fiscal context, this course of action nevertheless means that funds are used for purposes other than what they have been collected for. This, in turn, changes the parameters within which important investment and coverage decisions can be made. Scrapping dental coverage for example could have been avoided had more reserves be used, and limiting the compensation for health care providers for longer than necessary might have unwanted effects on the supply of human resources in the long run.

Allowing fiscal and budgetary considerations to determine health care policy also risks ignoring the involvement of the different stakeholders in the system, as demonstrated by the walk-out of the social partners from the governing bodies of the system.

While the health care system in Estonia is of good quality and is well-administered, some fundamental and urgent choices need to be made. The most important choice pertains the structural financing of the system, but recent events also prompt fundamental reflection on the role of the different stakeholders and on the status of reserve funds as a tool for health care policy versus a tool for fiscal strategy. Such contemplation should take note of the considerations that have been at the basis of developing a fund-based system in the first place.

In the end, the available options to ensure future financial sustainability are finite. Either the range of care funded by the health insurance system is limited, leading to less quality, less width or depth of coverage or higher out-of-pocket payments; the efficiency of the system is increased even further; or more money is invested in the system. Most likely, a mix of measures along these three options is needed. Given that almost half of the population today enjoys the benefits of the system without contributing, which creates structural imbalances between revenues and expenditures, it seems inevitable that increased funding from the national budget will need to be added to the formula in order to reach sustainable solutions.

[52] Compensation remains in place for selected groups.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care in Estonia consists of a mix of health care services and welfare services[53]. The system today is fragmented, with different responsibilities concerning organisation, provision and financing of the different services available.

Local governments (municipalities) are the main providers and organisers of long-term care and cover the costs that are not borne by the Health Insurance Fund. They do so by either providing for the services themselves, or by administering the provision by third parties (which can also be other local governments, through cooperation).

Local governments provide this care in the framework of policy that is developed by the Ministry of Social Affairs. The Ministry further establishes the necessary legal framework to ensure availability and quality, collects and analyses data, and designs and implements welfare development programmes. The Ministry assists the 226 local governments via 15 counties, who can be seen as the "hand of the state" on the regional level. The counties are further also responsible for supervising the quality of care services, provided by the local governments.

While it is the health care system that provides for nursing care (both inpatient and outpatient), geriatric assessment services and home nursing care services; the welfare system provides for long-term institutionalised care, day centre services, home care, and housing services, amongst others. The organisation and financing of the health care system is a state affair, while welfare services became the financial and organisational responsibility of the municipalities in the 1990's.

Services can be classified as either community care services (where a person is supported in her/his own home), or institutional services (where care is given in a welfare institution).

Home care services are provided within the home, to help persons cope in familiar surroundings. The local governments determine the list of home services and the conditions and procedures through which they can be obtained.

Municipalities are required to provide adequate housing for persons and families who cannot afford it, and, where necessary, provide for social housing. Municipalities also assist persons who have difficulties with self-contained living, to adjust the dwelling to their needs or to find more suitable housing.

Another service is care in a suitable family that the person is not an original member of. This service is based on a written agreement between the municipality and the caregiver (host family), and is mainly provided for children.

Furthermore, care is provided in welfare institutions that operate during the day or round-the-clock and that provide the persons staying there with appropriate care according to their age and condition. Care homes, as not being part of the health care system, in principle do not offer medical care. Services are provided in the same way and on the same principles as would be provided to people living at home. Inhabitants are therefore visited by family doctors, and/or involve private nursing companies.

To support informal care, local governments also grant and pay a caregiver's allowance to caregivers or guardians of disabled persons aged 18 years or older. The aim of the allowance is minimal, and does not meet its goals to help to reimburse the costs related to the care and to

[53] The term "welfare services" points to services that are provided on the basis of a need, and are funded not by contributions but through the general budget of the state and of local governments.

alleviate the families' care burden to enable family members to be engaged in paid employment. Informal care plays an important role in Estonia; not only in practice but also from a legal perspective[54].

These services are financed through the budget of the municipalities, which in turn mainly consists of a percentage of income taxes forwarded to them by the state government. For community care services, co-payment by the individual or his or her family is rare. When it comes to round-the-clock care in care homes however, personal contributions can amount up to 65% of the cost (typically around EUR 400 to EUR 500), which translates to 85% of an average pension. However, when an individual or his family is unable to pay, the local government is obliged to cover the full cost as part of the provision of social assistance.

Medical services that are related to the services listed above are covered by the health care system and financed by an earmarked social tax levied on wages. This includes hospital care, access to physicians, and nursing care. With respect to the latter, a co-payment of 15% for inpatient long-term care (nursing care) was introduced from 1 January 2010 onwards[55], in part to avoid over-use of hospital resources by those not really in need of medical treatment.

2.4.2 Debates and political discourse

Many of the issues reported on in our previous annual report remain on the agenda in 2011. While advancements are made along the new governments' policy aspirations[56], problems connected to the fragmentation of the system continue to persist. These problems concern the financing of the long-term care system and the quality and accessibility of the services on offer.

The problematic nature of the current financing system is amply documented[57]. As long-term care is provided by local governments (municipalities), much depends on the capacity of these entities to offer services. The main source of income of any municipality is a share of the income tax, collected by the central government and forwarded to the municipality on the basis of the number of registered inhabitants. However, over two-thirds of the 226 municipalities have a population of less than 3,000. Small municipalities therefore receive less funding, yet have the same responsibilities to provide long-term care as larger ones.

With this in mind, it comes to little surprise that people in need of long-term care mainly have access to the services that are on offer by that particular local government (based on its financial and organisational possibilities), and not those services that are required on the basis of an assessment of what the person would really need. In this provider-driven context, basic services are available in every county but not in all municipalities, and many local governments do not provide all the services they are legally obliged to offer. This has consequences for the

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54 The role of the family in caring for dependent family members is not only factual, but finds a legal basis in the Constitution of the Republic of Estonia. Indeed, Article 27 of the Constitution stipulates that "the family has a duty to care for its needy members."

55 Regulation number 42 of the Estonian health insurance fund of 19 February 2009, Riigiteataja I 2009, 16, 99 retrieved on 15 February 2012 at https://www.riigiteataja.ee/ert/act.jsp?id=13231527.
In practice, this amounts up to EUR 6.13 per day or EUR 182 per month. Hospitals can ask for less, and many do as the compensation provided by the Health Insurance Fund for the price of a bed-day seems to be sufficient to cover more than 85% of the real cost.

56 The government programme (a result of the coalition agreement) was published on 6 May 2011 and can be consulted through http://www.valitsus.ee/et/valitsus/tegevusprogramm.

57 See the extensive review of the strengths and weaknesses of the financing of the current system in: PricewaterhouseCoopers, Hoolduskoormuse vähendamiseks jätkusuutlike eakate hooldussüsteemi finantseerimissüsteemi väljatöötamine, Etapp I (14 May), II (14 May), III (19 June), 2009. The study consists of three parts - one analysing the current situation and laying out the challenges, a second drawing parallels and comparisons with the systems in place in Finland and The Netherlands, and a third part outlining possible solutions.

quality and accessibility of services but also for the extent to which a private person is required to contribute, for example by being forced to procure services from the private market.

The overall solution lies in a better integration of the various services provided through the health care and welfare systems, in order to provide a comprehensive package in the best possible way. The aim is to achieve service delivery that is needs-based, rather than determined by the financial means of and options offered by the different providers.

The chosen overarching policy focus is to provide help to persons in their own homes for as long as possible, through services that are responsive to the individual's needs. In policy terms, emphasis is put on a thorough assessment of the need for care, and to provide a package of "personal assistance". This policy line is explicit, and the coalition agreement has given the Ministry of Social Affairs a mandate to develop more than "soft" guidelines.

However clear the aspirations for the long-term care system may be, achieving its implementation is not an easy affair. The current fragmentation in policy-making, service delivery and financing results in practical boundaries that can only be overcome by extensive cooperation between different organisers and financers. Local governments operate independently and are afforded considerable autonomy by the Estonian constitution. Therefore, implementing a "single government approach" is not a simple matter of the central government imposing standards on local governments but rather a delicate balance between competencies, financing mechanisms and different levels of professionalism.

An example of an issue where this becomes apparent is the delivery of medical services in welfare institutions. The health care system organises extensive nursing care through nursing care hospitals. Patients who however only require sporadic nursing care are expected to move to care home services or a home care arrangement, both under the welfare system, where medical help is provided for by family doctors. In reality however, many welfare institutions that provide round-the-clock care also organise nursing care nevertheless. Until recently, this happened outside of the health care system, which raised issues as to quality control and financing. In a bid to change this, the Health Services Organisation Act has been adapted so that welfare institutions now have the authority to organise different types of nursing services. The issue of financing is however not yet settled, as debate continues on who should be called to pay for these services.

A recent step towards increased transparency and improved and comprehensive service delivery is the elaboration of a set of quality standards which essentially describes what the different long-term care services should consist of. Finalised at the end of 2011[58], these quality standards can only be disseminated through awareness-raising activities and motivational mechanisms as it is argued that the state has no right to interfere because of the legal independence of the municipalities, and that establishing a regulatory framework with more responsibilities also needs to be accompanied by more resources.

Pertaining financing and viability of the system, the previously mentioned 2009 study essentially proposes to introduce an insurance scheme, with long-term care to be financed through personal contributions. This option has for the moment been rejected by the

[58] The government programme (see http://www.valitsus.ee/et/valitsus/tegevusprogramm) stipulates that, to "foster home care and telemedicine, and create additional opportunities for older, high-quality day care", the Minister of Social Affairs is empowered to "developing guidelines for social welfare services", with results expected by the end of 2011.
These guidelines are now published as a set of web-pages on the domain of the Ministry of Social Affairs – see http://www.sm.ee/tegevus/sotsiaalhoolekanne/kohalike-omavalitsuste-sotsiaalteenuste-soovituslikud-juhised.html.

government out of the desire to handle things without having to raise taxes[59]. Instead, the choice is made to develop a mechanism of partnership, where financing is provided by the individual, the local government and by (conditional on the adherence to certain standards) state funding. Again, no final decisions on the exact parameters of this arrangement are apparent.

2.4.3 Impact of EU social policies on the national level

Estonia's own 2020 strategy, outlining the direction for the coming years, follows much the same structure and content as the EU 2020 strategy and makes little direct reference to long-term care as such. Instead, the topic is implicitly discussed through issues such as poverty and pensions. The same holds true for the National Reform Programme, which, for lack of indicators, does not mention issues of access to or utilisation of long-term care services. Parallel to the 2012 "year of active ageing", Estonia plans to include long-term care topics in the strategy that will be set under this header.

In developing its policy and strategy, Estonia benefits to an important extent from concrete and direct confrontation with experiences gained in other countries. Moreover, the influence of the European Union is felt through the very important role of project-funding via the European Social Fund. ESF-funded initiatives not only increase the capacity for delivering long-term care through infrastructural projects[60], but also allow developing and piloting new services that would otherwise not have been achievable[61]. Success in these projects can deliver valuable learning experiences and might create incentives to turn them into structural solutions.

2.4.4 Impact assessment

While the problem of population ageing and the corresponding increasing need for need-driven services is known, the Estonian system is still in the process of strategy-setting and codification. The direction seems to be to first develop home care services and assess their influence, to develop a cooperation with the health insurance system where nursing services are concerned, and to come to a partnership solution to solve the issues brought by a multi-dimensional fragmentation of the system, first focusing on home care services as the most economical and efficient solution. Bringing all this together should allow formulating an active ageing strategy, for which the ambition is to reach approval by the end of 2012.

Several published and internal studies are performed that are meant to support this policy-setting process and which retain their relevance today. Worth mentioning are the 2009 extensive review of the long-term care system[62] which remains the most encompassing look at the system to date; the fifth issue in the "Collection of Social Trends in Estonia" published by

[59] The rejection of this choice might not be final, as the Ministry of Finance currently researches different financing avenues for the social security system as a whole with additional (private) insurance not being excluded as an option. The activities of the Ministry of Finance were expected to be concluded by the end of 2011 (see point 2 (c) under the header "Taxation" of the Government Action Programme). Concerning long-term care, however, no definite proposals have been made.

[60] By 2013, 1,087 new places will be created in nursing homes and care homes, with an additional 730 existing places being reconstructed. From these 1,087, 878 places are in nursing care and 200 are in care homes, directly aiding local government in fulfilling their task.

[61] Under the call "Welfare measures supporting employment", projects were started to offer integrated guidance services to help persons with a care obligation to take part in employment (including services targeted to persons with an obligation to care for the elderly, disabled and disabled children).

[62] PricewaterhouseCoopers, Hoolduskoormuse vähendamiseks jätkusuutlike eakate hooldussüsteemi finantseerimissüsteemi väljatöötamine, Etapp I (14 May), II (14 May), III (19 June), 2009.

the government statistics agency[63], which offers a multi-facetted snapshot of the main clients of the system and shines a light on population ageing in its many aspects, covering topics such as demographic backgrounds, the participation of older people in the labour market, economic, material and social welfare, health and social cohesion; and two studies assessing the care burden of those providing informal care[64].

A recent OECD Public Governance Review[65] analyses the strengths and weaknesses of the Estonian public administration and makes concrete recommendations for improving the delivery of public services at all levels of government. The Review employs an analysis of social services for the elderly as a case study, and promotes a roadmap towards a "whole-of-government" approach. While it is doubtful that the detailed recommendations will know a swift implementation, the quality and depth of the Review surely offers elements that will influence – if not shape – the debate in years to come.

The 2011 OECD Economic Survey for Estonia[66] could be read in conjunction, where it briefly reflects on how local governments operate and are financed and how more efficiency could be obtained. The Survey concludes that local governments could be given more scope to obtain own revenues, but also to let financing depend in part on the adherence to quality standards.

2.4.5 Critical assessment of reforms, discussions and research carried out

Developing a comprehensive policy which leads to a mature and comprehensive set of long-term care services is problematic. The fragmentation of administrative competencies, service providers, organising capacity and financing possibilities implies that cooperation is required in every aspect, starting with a wider agreement on a unified policy. Actions taken by one stakeholder quickly have effects for others, and uncoordinated action by one can easily go against the aspirations of the other[67]. All in all, the difficulty seems not to be in a contradiction of ideas, but rather in competition for scarce resources and a correct division of responsibilities.

While significant progress has been made in recent years, moving forward requires a clear and comprehensive direction around which consensus and joint effort is possible. Central government is still in the process of building this consensus, but is legally and practically ill-equipped to push changes ahead. For the end-users of the system, this difference between stakeholder perspectives is somewhat beside the point. End-users desire care that is affordable, of sufficiently high and uniform quality, and based on their needs rather than on what a certain

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63 Statistics Estonia, "Sotsiaaltrendid - Social Trends", 5, Tallinn, 2010 retrieved on 15 February 2012 at http://www.stat.ee/publication-download-pdf?publication_id=21171.

64 SOO, K, LINNO, T, "Puuetega inimeste ja nende pereliikmete hoolduskoormuse uuring", Sotsiaalministeerium, Sotsiaalpoliitika info ja analüüsi osakond, 2009 retrieved on 15 February 2012 at http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/PIU2009_loppraport.pdf; LINNO, T, "Vanemaealiste ja eakate toimetuleku uuring 2009", Sotsiaalministeerium, Sotsiaalpoliitika info ja analüüsi osakond, 2010, retrieved on 15 February 2012 at http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/VEU2009_FINAL2.pdf.

65 OECD Public Governance Review "Estonia – towards a single government approach", OECD Publishing, August 2011, 418 (see http://www.oecd-ilibrary.org/governance/oecd-public-governance-reviews-estonia-2011_9789264104860-en).

66 OECD, "OECD Economic Surveys: Estonia 2011", OECD Publishing, April 2011, 91-99, retrieved on 15 February 2012 at http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en.

67 For example, the decision to introduce a 15% co-payment for nursing care offers an incentive for patients to not make undue use of hospitals and is beneficial to the health care system, but poses extra strain on the welfare system which has to absorb this move; the desire of local governments to compete by offering a wide range of services has an impact on the capacity to offer the best services; the need to come to unified quality and assessment standards benefits the end-user and makes comprehensive needs-based service delivery possible, but has an impact on the cost for municipalities; etcetera.

segment of government is willing or able to provide. What service they receive should not depend on whether they are taken care of by the health insurance system or the welfare system, whether they happen to live in a region where provider-determined access is high or low, or whether they are called patient or recipient of assistance.

In the coming years, a balance needs to be sought and found where a national long-term care policy can be implemented with respect for the position of all. Elements of this balance are a clear division of responsibilities between government levels and between the health care and social assistance systems, the assessment and definition of actual needs for long-term care, and sets of quality standards and service benchmarks on the basis of which monitoring can and should take place. This is not an easy task, and one that will take several years to complete. The issue touches more than social policy, necessitating the involvement of many stakeholders with many different motivations, different organisational and financial realities, and diverging interests. The amount of energy and reflection that is invested in the research and development of avenues of possible action and the focus on home care as the way forward are encouraging, but more decisive and centrally-steered action seems to be needed to reach conclusions and solutions.

Fitting the own societal context and the overall goal to provide better services utilising the same resources, Estonia puts much emphasis on home care and on helping people to live independently in their own homes for as long as possible. This is seen as the cheapest, most effective and most socially accepted option, and all action and ideas connected to long-term care represent this clear choice. However, this focus on home care risks diverting attention away from acute problems in the sector of intra-mural care, where the lack of enforceable quality standards and the high level of personal financial responsibility of patients cause problems.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

In general, Estonian social protection includes strong incentives to work longer. In addition to the compulsory and voluntary and funded pension scheme, where future pensions are linked directly to life-time contributions, also pensions from the state pension scheme depend on life-time social tax payments on labour earnings.

Retirement age and working are not mutually exclusive. Pensioners may continue working after normal retirement age without any decrease of pensions. Quite the opposite, individual pensions are recalculated every year if pensioners continue working and additional social tax payments are made.

Early withdrawal of pensions is discouraged and postponement of pension withdrawal is encouraged. For every month of early pension the pension entitlement is reduced by 0.4% (or 4.8% per annum). Although it is not actuarially neutral (actuarial reduction should be around 8%), it is further discouraged by not allowing to work at the same time until receiving formal retirement age. When the pension is deferred the entitlement is increased by 0.9% for every month (10.8% per annum) after the normal retirement age.

The increase of retirement age in 2016-2026 is gradual, reaching 65 by 3-month steps, allowing people change their labour market behaviour accordingly. The early retirement option will remain unchanged, allowing for some flexibility. As mentioned before, making early retirement pensions more actuarial but simultaneously allowing part-time working may be worth considering to encourage flexible transition from work to retirement.

Current legislation allows people working at hazardous occupations (e.g. workers in chemical, metal, glass, pulp industry, mining, etc.), civil servants (e.g. judges, military personnel, police officers, senior state auditors, prosecutors) and certain professional groups (e.g. pilots, mariners, miners, some groups of artists) whose professional abilities have declined before the normal retirement age, right to retire earlier. This leads to confusing and unequal pension system. As discussed in section 2.2 the government plans to reform the special pensions.

Collective agreements do not regulate retirement age in Estonia.

2.5.2 Participation in society

Volunteer work and unpaid work are not considered as contributory periods in the Estonian pension system. State pays social tax on behalf of some categories of non-active persons, such as periods of child care or care of disabled people, periods of military service.

The year 2012 as the European Year of Active Ageing and Intergenerational Solidarity is reflected in the action plan of the Ministry of Social Affairs. In 2012, the Ministry of Social Affairs has a responsibility to prepare a draft for the strategy about active ageing. The background working document indicates that the strategy will treat all different aspects of active ageing, including labour market participation, long-term care, and participation in society.

2.5.3 Healthy and autonomous living

While there is not yet a finalised active ageing strategy in Estonia, the social protection system clearly provides support that allows elderly people in need of care or assistance to be treated and helped at home for as long as is possible. In the Estonian context, a distinction needs to be made between services offered under the health care system, and welfare services.

The health care system offers nursing care to those in need of medical attention but for whom hospitalisation is not required. This nursing care is offered in intra-mural settings, but also as services at home. These services can be obtained on referral by a family doctor or specialist and are covered by the health insurance. Typical examples are wound care, supervision on taking medicines, or diagnostic services such as measuring temperature, blood pressure or blood sugar levels. When measured in terms of financing, the 2012 budget for ambulatory nursing care stands at about 28 million euro[68], while the budget for intra-mural nursing care is set at 15 million euro.

Concerning the welfare services that are part of the long-term care package, the focus of policy action is clearly on the provision of home care services as the most economical and efficient solution. As mentioned earlier in this report, the municipalities have a high level of autonomy when it comes to deciding to which services is adhered priority in terms of manpower and funding. As places in intra-mural care are scarce and expensive, different services such as grocery services or meals on wheels are routinely offered. Also popular are day care activity centres for elderly that support active community life through services such as hairdressers, washing places, etcetera.

While all these services play an important role in promoting autonomous living, services that help in cases where a person needs more intense personal care are less developed. This aspect of long-term care (for example, watching over a person with dementia) is mostly left to the family.

[68] Including home support treatment for cancer patients (4.3 million euro).

Different rehabilitation services and a specific health-care organised geriatric assessment service aim to prevent the need for more intense care and strive to correctly determine the moment where autonomous living becomes impossible.

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All hyperlinks valid at the time of finalising of this report (15 February 2012)

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

Overarching themes

[R1, R2, R3, R4, R5; H1, H3, H4, H5] AAVIKSOO, Ain, KRUUS, Priit, LEPPIK, Lauri, SIKKUT, Riina, VELDRE, Vootele, VÕRK, Andres. Eesti sotsiaalkindlustuse jätkusuutlikku rahastamise võimalused, Praxis Center for Policy Studies, Tallinn, retrieved from: http://www.praxis.ee/index.php?id=27&tx_ttnews%5Btt_news%5D=1124&cHash=0fced655f3
"Opportunities for sustainable financing of social security system in Estonia"

A major research report by Praxis Center for Policy Studies, commissioned by the Ministry of Finance, covered several aspects of the Estonian health care policy, pension policy and unemployment insurance. The report analyzes 55 different policy options stemming from minor parametric changes, such as a small change in the social tax rate or indexation formula, to structural reforms, such as introducing a flexible retirement age or private health insurance. It includes forecasts of the pension and health care revenues and expenditure and pension replacement rates until 2060.

[R2, H4, L] PRAXIS Center for Policy Studies "Eesti sotsiaalkaitse süsteemi korralduse efektiivsuse analüüs", research report, Tallinn, 2011, retrieved from:
http://www.praxis.ee/fileadmin/tarmo/Projektid/Tervishoid/Analyys_loppraport_v1_3_Praxis__01.pdf
"Analysis of the efficiency of the Estonian social protection system"

A research report by Praxis Center for Policy Studies, commissioned by the Ministry of Social Affairs and the Ministy of Justice, analyses the organisation and management of the Estonian social protection system. It includes a comprehensive analysis of legal acts, regulatory documents, inhouse procedures, information booklets of the Ministry of Social Affairs and managing authorities (including the Estonian Health Insurance Fund, the Unemployment Insurance Fund, the Estonian National Social Insurance Board), and interviews with representatives of these institutions and main stakeholders. The report shows that the government of Estonian social protection is fragmented and lacking central coordination, especially in the field of disability, rehabilitation, special care and long-term care. The report highlights that the current allocation of duties between the ministry and coordinating authorities may prohibit efficient use of resources. The report makes several recommendations to improve the management of the Estonian social protection system.

[R1, H1] Ministry of Finance, Stabiilsusprogramm 2011, April 2011, Tallinn/retrieved from: http://www.fin.ee/doc.php?107451
"Stability Programme 2011"

Estonian Stability Programme 2011 gives an overview of recent economic development and fiscal policy and detailed short-run forecasts for 2011-2015. It includes forecasts of the state pension insurance scheme and health insurance scheme up to 2050.

[R1, H1] Ministry of Finance, 2012. aasta riigieelarve seaduse seletuskiri, pdf document, 2011, Tallinn, retrieved on 15 May 2012 at http://www.fin.ee/doc.php?108795
"Exlanatory note of the state 2012 budget"

It includes forecasts of the public finances, including revenues and expenditure of the state pension insurance scheme and health insurance scheme.

[R1, H1] Ministry of Finance, 2011. aasta suvine majandusprognoos, September 2011, Tallinn/retrieved from:
http://www.fin.ee/doc.php?107942
"2011 Summer economic forecast"

This is a regular official economic forecast by the ministry of finance. It includes a recent overview of the economic development and fiscal situation of the public sector. It gives forecasts for tax and non-tax revenues, and balance of the state budget, social insurance funds and local governments.

[R1, H1] Ministry of Finance, Riigi eelarve strateegia 2012-2015, April 2011, Tallinn/retrieved from:
http://www.fin.ee/doc.php?107452
"State budget strategy 2012-2015"

State budget strategy 2012-2015 includes an overview of recent economic development, and detailed forecasts of revenues and expenditures for 2012-2015, including social insurance.

[R] Pensions

[R1] Government of the Estonian Republic**,** Vabariigi Valitsuse tegevusprogramm 2011–2015, April 2011, Tallinn/retrieved from:
http://www.valitsus.ee/UserFiles/valitsus/et/valitsus/tegevusprogramm/valitsuse-tegevusprogramm/VV%20tegevusprogramm_28-04-2011_KINNITATUD.xls
"Government action plan 2011-2015"

The government action plan describes at detailed level the government's activities during next governing period. It includes a list of planned reforms in social protection, including pensions and health care.

[R4] Ministry of Social Affairs, Töövaldkonna areng 2009-2010. Trendide kogumik. Sotsiaalministeeriumi toimetised nr 9/2010, 2010, Tallinn/retrieved from:
http://www.sm.ee/fileadmin/meedia/Dokumendid/V2ljaanded/Toimetised/2010/toimetised_20109.pdf
"Developments in labour market 2009-2010"

The publication gives an overview of labour market developments up to the second quarter of 2010 and it compares Estonia with other EU countries. The document includes analysis of employment, unemployment and inactivity of different socio-economic groups, including elderly; dynamics of wages and working time. It includes analysis of passive and active labour market measures during the economic crisis.

[R4] MARKSOO, Ülle, MALK, Liina, PÕLDIS, Eva. Vanemaealised Eesti tööturul. Sotsiaalministeerium, Sotsiaalministeeriumi toimetised nr 4/2011, Tallinn 2011, 18p/retrieved from: http://www.sm.ee/fileadmin/meedia/Dokumendid/V2ljaanded/Toimetised/2011/toimetised_20114.pdf
"Elderly in Estonian labour market"

This working paper by the Ministry of Social Affairs gives an overview of the elderly, aged 55-74, in the Estonian labour market in 2000-2010. The paper describes their employment and unemployment rate, causes of inactivity, occupational structure, education, participation in active labour market measures. Both regional and gender dimension is presented.

[R1, R2] RAHNEL, Pertti, ROOSA, Kaarel, RAHE, Katrin. Estonia's Multi-Pillar Pension System. Solid First Miles of the Marathon. Journal of Investment Consulting, Volume 12, Number 2, pp. 42-52, 2011/retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2004647

The article gives an overview of the Estonian pension system, focusing on the mandatoru and voluntary funded pension schemes. The article analyses whether pension reform so far has met initial goals of securing fiscal sustainability and guaranteeing adequate pensions. It provides an overview of Estonia's reform experience in terms of participation rates, competition among fund managers, client asset allocation, and pension fund performance. It also includes an overview of the legislative and regulatory response to the economic recession in Estonia.

[R1, R2, R3, R5] SOE, Ralf-Martin. The possibilities of implementing automatic balancing mechanisms in the Estonian pension system. MSc thesis, Maastricht University, Maastricht Graduate School of Governance, Maastricht 2011

The main research objective of this thesis is to analyse whether Estonia should consider implementing automatic balancing mechanism in the pension system. The thesis builds a simulation model with the purpose of modelling different approaches on how to create a sustainable pension system using ABMs. The following pension policy options are analysed in the thesis: 1) indexing pensions for life-expectancy, 2) linking the retirement age to life expectancy, 3) linking pension to the change in the number of pensioners, 4) linking the retirement age to the ratio of pension period over working period, 5) adjusting pensions to the difference in long-term pension system financial balance.

[R2, R3, R5] MEDIJAINEN, Mikk. Incentives to Retire Imposed by Old-Age Pension Policy in Estonia. In *Discussions on Estonian economic policy: Theory and practice of economic policy.* Vol 19, No 2 (2011)/ retrieved from http://ojs.utlib.ee/index.php/TPEP/article/download/419/412

The paper analyses the incentives that Estonian state pension scheme imposes on retirement. The specific focus is on actuarial neutrality and benefit equivalence of adjustments for early and late retirement.The paper claims that current benefit adjustments for early and deferred retirement are not actuarially neutral and do not assure benefit equivalence. The paper presents optimal adjustment rates.

[H] Health

[H1] Ministry of Finance, Stabiilsusprogramm 2011, April 2011, Tallinn/retrieved from: http://www.fin.ee/doc.php?107451
"Stability Programme 2011"
Estonian Stability Programme 2011 gives an overview of recent economic development and fiscal policy and detailed short-run forecasts for 2011-2015. It includes forecasts of the state pension insurance scheme and health insurance scheme up to 2050.

[H3] National Audit Office of Estonia (Riigikontroll), Perearstiabi korraldus, April 2011, Tallinn, 61p/retrieved from:
http://www.riigikontroll.ee/Riigikontrollipublikatsioonid/Auditiaruanded/tabid/206/Audit/2172/language/en-US/Default.aspx#results
"Organisation of the family doctor service"
The National Audit Office assessed in the course of its audit how the family doctor system performs its functions. In the opinion of the National Audit Office, the family doctor system is unable to perform all of its functions in the health system, because family doctors do not always perform the agreed services, frequently refer patients to specialists without good reasons, and the system does not guarantee accessibility of the family doctor service in all regions. The main reason behind the problems of the family doctor service in addition to the limited awareness of patients is the lack of family doctors in certain regions, their varying competence and the limited development opportunities of the system.

[H5] OECD, "OECD Economic Surveys: Estonia 2011", OECD Publishing, April 2011, 79-91/retrieved from: http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en
The 2011 Economic Survey of Estonia contains a chapter where public sector spending efficiency in the sectors of health care and in local government is examined.
Concerning health care, the Survey recommends accomplishing efficiency gains by further rationalising the hospital network to reflect changing health care consumption patterns, by developing a wider system of quality indicators and by boosting the role of primary care. It further discusses the possibility to introduce a means-tested cap on out-of-pocket payments. Finally, more attention should go to promoting generic and least expensive medicine and to reviewing existing remuneration in the health care sector in order to increase wages, in particular for nurses.

[H1, H3, H4, H5, H6] THOMSON, Sarah, HABICHT, Triin, ROOVÄLI, Liis, EVETOVITS, Tamás and HABICHT, Jarno "Responding to the challenge of financial sustainability in Estonia's health system: one year on", World Health Organisation, 2011, Tallinn, 27p/retreived from: http://www.euro.who.int/__data/assets/pdf_file/0009/150102/E95604.pdf
This follow-up report takes a brief look at major changes in health care financing from 2010, nearly one and a half years since the 2010 comprehensive review of the Estonian health care sector with the focus on the sustainability of health care financing. The report reviews developments in those four areas of recommendations where the original report found that these can significantly affect the financial sustainability of health care to facilitate further policy dialogue. It concludes that interventions in the system were necessary and well-advised, but laments the lack of political leadership in coming up with structural solutions.

[H1] LUTS, Harles. Meditsiini säästukontode rakendamise otstarbekus Eesti tervishoiu rahastamises, Master's thesis, University of Tartu, Faculty of Economics and Business Administration, Tartu 2011
"The expediency of employing medical savings accounts in Estonian health care financing"

This Master's thesis analyses the possible financial and redistribution effects of the introduction of medical savings accounts in Estonia. It gives an overview of the experience of other countries and discusses their suitability to the Estonian health care financing scheme. The thesis includes a small mathematical simulation model to illustrate the possible quantitative effects. The overall conclusion is that medical savings accounts are not suitable to Estonia.

[H3] Haigekassa, Sotsiaalministeerium, Saar Poll OÜ. Elanike hinnangud tervisele ja arstiabile 2011. Tallinn 2011, 141 p/retrieved from
http://rahvatervis.ut.ee/bitstream/1/4823/1/Sotsiaalministeerium2011.pdf
"Assessments of health and health care in 2011"

This is a regular annual population survey about the assessment of health and health care. The report presents the results of 2011 survey and compares them with 2005-2010 results.

[L] Long-term care

[L] OECD, OECD Economic Surveys: Estonia 2011, OECD Publishing, April 2011, 91-99/retrieved from: http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en
The 2011 Economic Survey of Estonia contains a chapter where public sector spending efficiency in the sectors of health care and in local government is examined. The observations and conclusions in the latter are relevant to the provision of welfare services, part of the long-term care system.
The main findings of the Survey in this respect are that the fragmentation of local governments is best resolved through either a reform whereby less local governments are left to exist, or whereby a greater degree of cooperation is achieved. Own revenue raising possibilities could be increased through land taxes. To tackle the problem of local governments underperforming in the provision of social services, indicators and quality standards of public service provision should be developed and monitored, and adherence to these standards should be reflected in the financial aids local government received from the central level.

[L] OECD, Estonia. Towards a single government approach, OECD Public Governance Reviews, OECD Publishing, August 2011, 418/retrieved from http://www.oecd-ilibrary.org/governance/oecd-public-governance-reviews-estonia-2011_9789264104860-en
This review investigates the strengths and weaknesses of the Estonian public administration. The provision of long-term care is taken into account as a case study. It concludes that Estonia needs a "whole of government" approach whereby the different levels of government in the fragmented system cooperate and act as one towards the citizen, and a common agenda towards which to progress. The capability of local governments to meet their obligations to deliver social services needs to be enhanced by practical assistance from the central level, and financing mechanisms can be adapted to reward better performers.

4 List of Important Institutions

Eesti Gerontoloogia ja Geriaatria Assotsiatsioon – Estonian Association of Gerontology and Geriatrics

Address: Lembitu 8, Tartu
Webpage: http://www.egga.ee/

An NGO of professionals (medical doctors, nurses, social workers, rehabilitation specialists, nurse helpers, care workers, managers of care institutions) working with elderly persons. The NGO has developed a concept paper on integrated long-term care in Estonia and issues occasional working papers and other publications on long-term care.

Eesti Haigekassa – The Estonian Health Insurance Fund

Address: Lembitu 10, 10114 Tallinn
Webpage: http://www.haigekassa.ee/

The Estonian Health Insurance Fund, an independent public body, created in 2001, organizes the compulsory health insurance.

Eesti Rakendusuuringute Keskus CENTAR – The Estonian Center for Applied Research (CentAR)

Address: Rotermanni 5/Roseni 10-60, 10111 Tallinn
Webpage: http://www.centar.ee

The Estonian Center for Applied Research (CentAR) is a private consultancy and research institute. Their main strands of research are labour market analysis and cost-benefit analysis of transport studies.

Eesti Töötukassa – The Estonian Unemployment Insurance Fund

Address: Lasnamäe 2; 11412 Tallinn
Webpage: http://www.tootukassa.ee

The objective of the Estonian Unemployment Insurance Fund, an independent public body, is the implementation of labour market policy in Estonia. The funds pays unemployment benefits and organizes active labour market policy measures.

Eesti Väärtpaberikeskus AS – Estonian Central Securities Depository Ltd

Address: Tartu road 2, Tallinn 10145
Webpage: http://www.e-register.ee/

Private company administering the central register of securities, including units of the mandatory pension funds. Provides regular information, news and statistics on funded pension and administers a web portal on the overall pension system www.pensionikeskus.ee.

Poliitikauuringute Keskus PRAXIS – PRAXIS Center for Policy Studies

Address: Tornimäe 5, Tallinn 10145
Webpage: http://www.praxis.ee/

The largest non-governmental independent think-tank conducting applied research and policy analysis and initiating public debates in the areas of labour market and social policy, health policy, innovation and economic policy, education policy, governance and civil society policy. PRAXIS issues regular Working Papers, Policy Analysis Series and Policy Briefs, and occasional monographs.

Sotsiaalkindlustusamet – Estonian National Social Insurance Board

Address: Lembitu 12, 15092 Tallinn

Webpage: http://www.ensib.ee/index_eng.html

The main task of the Social Insurance Board is the organisation and coordination of the granting and payment of the state pensions, benefits and compensations throughout its local offices. Its main objective is to ensure that pensions and benefits according to the national legislation and international agreements are paid to people in due time.

Sotsiaalministeerium – The Ministry of Social Affairs

Address: Gonsiori 29, 15027 Tallinn

Webpage: http://www.sm.ee

The Ministry of Social Affairs develops policy concerning all issues in the field of social affairs, labour and health. The Ministry commissions and publishes regular studies, and oversees the social security system.

Tallinna Ülikooli Sotsiaaltöö Instituut – Institute of Social Work, Tallinn University

Address: Narva road 25, 10120 Tallinn

Webpage: http://www.tlu.ee/?LangID=2&CatID=2835

Public institute of higher education and research, a structural unit of the Tallinn University. The institute provides graduate and post-graduate training (master and doctoral programmes) in social work. Its research and development projects include studies in the area of active ageing and long-term care.

Tartu Ülikooli Sotsiaalteaduslike rakendusuuringute keskus RAKE – The Centre for Applied Social Sciences (CASS) in the University of Tartu

Address: Lossi 36-124, 51003, Tartu

Webpage: http://www.ec.ut.ee/en/cass

The Centre for Applied Social Sciences (CASS) in the University of Tartu is an interdisciplinary research centre, established in 2007, that offers applied research and analyses in social sciences. CASS is the knowledge organisation of a network type and co-operation division in the University of Tartu. Their research includes a few studies on health care, such as analysis of the national R&D programme for health care, and corruption in health care system.

Tartu Ülikooli Tervishoiu Instituut – Department of Public Health, University of Tartu

Address: Ravila 19, Tartu 50411

Webpage: http://www.arth.ut.ee/

Public institute of research and higher education, a structural unit of the Faculty of Medicine at the University of Tartu. The institute provides graduate and post-graduate training (master and doctoral programmes) in public health and conducts research projects in the domain of public health.

Tervise Arengu Instituut – National Institute for Health Development

Address: Hiiu 42, Tallinn 11619

Webpage: http://www.tai.ee/

Public research and development institution under the Ministry of Social Affairs of Estonia. The main aims of the Institute are to support health promotion and improvement of the quality of life through applied research and development activities. The Institute collects data and conducts research in the broad area of health, including biomedicine, epidemiology, health

economics, occupational health, public health, health behaviour and health status of the population, environmental health hazards etc. The institute also coordinates and implements national health programmes under agreement with the Ministry of Social Affairs and participates in the development of health strategies and action plans.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en