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Pensions, Health Care and Long-term Care

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1 Executive Summary

Developments in the Estonian social policy in 2010-2011 were affected by several factors. First, the government aimed keeping the annual public deficit within the limit of 3% of GDP in 2009 in order to join the Euro area as of 2011. Second, there were general elections in March 2011 that limited the government's ability to raise taxes or lower social expenditure. Several political parties included social protection and tax policy as a part of their election campaign. Third, there were long-term concerns about the sustainability of the pension and health care expenditures.

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 indexation rule of pensions in 2009, which smoothed the value of nominal pensions; a temporary suspension of the transfers to the funded pension system in the second half of 2009 and in 2010 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 for plans to introduce a work accident and occupational disease insurance. The general election resulted in a pension supplement for parents, which increases pension expenditure, but it is targeted to those who potentially suffer most from the career breaks.

Concerning health care, topical anti-crisis measures have lead to an increased responsibility of individuals and health care providers in the funding of the system. Patients have to endure longer waiting times to receive care, and sickness benefits have become a lot less generous. Health care providers have also felt the effect of a tighter budget and have seen the compensation for services provided cut by 6% in 2010; a cut only partially undone in 2011.

Faced with the effects of population ageing, a new balance needs to be sought that ensures sustainability, quality and equity. It seems unlikely that personal responsibility can be further increased and still be seen as fair, and increased efficiency by itself will not allow providing the same level of services within the planned budget constraints. This paves the way for higher public spending in the system, an issue that is currently being discussed and examined.

In the provision of long-term care services, Estonia still seeks a balance between 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.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

The economic crisis hit public finances in Estonia hard. In 2009 real GDP fell by 13.9%. The employment rate dropped from its peak of 63% in 2008 to 55% in 2010 (in the age group 15-74) and the unemployment rate has reached 17% in 2010. Nominal wages declined about 5% in 2009. This all resulted in a drop of the nominal tax revenues of the central government by 9.4% in 2009, of which the revenues from social tax, which is earmarked for financing pension and health expenditure, fell by 11.3%. Although the economy started to recover in 2010 and real GDP already increased by 4.6%, the revenues from social tax declined further by 6%, being 15% lower compared to its peak in 2008.

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 government in general 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.

In 2009-2010, social expenditure increased, both nominally, as a share of GDP (19% in 2010 by preliminary estimates) and as a fraction of government expenditure (47% in 2009). Despite the reserves and low level of public debt, there were two important background factors that limited the flexibility of the government during this crisis regarding social expenditure. First, the government aimed keeping the annual public deficit within the limit of 3% of GDP in 2009 in order to join the Euro area in 2011. Second, there were general elections in March 2011 that limited the government's ability to raise taxes or lower social expenditure. In addition, several political parties included social protection and tax policy as a part of their election campaign.

Table 1: Government expenditure and revenue 2000, 2005-2009, % of GDP

	2000	2005	2006	2007	2008	2009	2010*	2011**
General government revenue	35.9	35.2	36.0	36.9	37.0	43.4	40.1	39.9
General government expenditure	36.1	33.6	33.6	34.4	39.9	45.2	40.0	40.3
Surplus / Deficit	-0.2	1.6	2.4	2.5	-2.9	-1.8	0.1	-0.4
Tax burden	31.0	30.4	30.4	31.6	31.9	35.7	33.4	32.9
Government consolidated gross debt	5.1	4.6	4.4	3.7	4.6	7.2	6.6	6.2
Government total expenditure on social protection and health	14.9	13.9	13.6	13.9	16.9	21.3	20.1	19.2
Social expenditure as a share in government expenditure	41.4	41.3	40.4	40.3	42.4	47.1	50.3	47.6
Social protection expenditure (ESSPROS methodology)	13.9	12.6	12.1	12.3	15.1	19.2*		

Source: Statistics Estonia, own calculations
* - preliminary estimates ** - Ministry of Finance forecast, Spring 2011

The current crisis has acted as a catalyst for several reforms and discussions. The crisis has shown that one possible weakness of the current social security system is a high dependence on labour taxes. The rapid decline in employment rates during this crisis has provided a window to the future, when demographic changes are predicted to result 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 2010 the Ministry of Finance initiated an independent study on alternatives for sustainable financing of the Estonian social insurance system (*Eesti sotsiaalkindlustussüsteemi jätkusuutliku rahastamise võimalused*). The study is expected to be ready in 2011 and to provide input into political debate on the future of the Estonian social insurance system.

In 2011, the government prepared four 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 Estonian National Reform Programme, named Competitiveness Strategy 'Estonia 2020' (*Konkurentsivõime kava 'Eesti 2020'*), and its accompanying action plan for the years 2011-2015, 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.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The Estonian pension system consists of three main schemes: state pension insurance (the first pillar); compulsory funded pension scheme (the second pillar); and voluntary funded pension schemes (the third pillar). The state pension insurance provides protection against the risks of old age, invalidity and survivorship and counts two separate tiers: flat-rate residence-based national pensions and employment-based old-age, work incapacity and survivors' pensions.

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.

Statutory pension age

In 2011 the statutory pension age was 63 for men and 61.5 for women. For women it was meant to increase to 63 by 2016. On 7 April 2010 the parliament approved an increase of the statutory pension age. The amendment of the law raises pension age further to 65 by 2026 for both sexes by 3-months-steps. For those younger than 50 in 2010, the retirement age will be 65; those who are between 50 and 56 the retirement age will depend on birth year and month; the retirement age will remain 63 for those currently older than 57.

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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 tegevusprogrammi 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.

Table 2: Changes in the pension age 2017-2026

Birth year	State pension age	Age in 2010
1953	63	57
1954	63 and 3 months	56
1955	63 and 6 months	55
1956	63 and 9 months	54
1957	64	53
1958	64 and 3 months	52
1959	64 and 6 months	51
1960	64 and 9 months	50
1961	65	49
1962	65	48

Source: Estonian National Social Insurance Board

Number of pensioners

As of 1 January 2011, the total number of pension recipients was 396,000 (29.5% of the population). Of those, 296,000 received old-age pension, 83,000 incapacity-to-work pensions (disability pensions), 11,000 were recipients of survivor's pensions and about 6,000 received national pensions.[4] Only working age persons (from 16 to pension age) are eligible for disability 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.[5] 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). Disability pensions depend also on the level of incapacity and survivor's pensions on the number of dependants.

[4] Source: Statistics Estonia, online database, table SW100: State Pension Insurance, retrieved on 6 May 2011 at http://pub.stat.ee/px-web.2001/dialog/varval.asp?ma=sw110&ti=state+pension+insurance%2c+1+january&path=../i_databas/social_life/15social_protection/06social_insurance/04pension_insurance/&lang=1.

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

Indexation and pension size of the state pensions

Pensions are indexed annually, on 1 April of each year. The index is a weighed average of past consumer price indices and past growth of social tax revenues to the pension insurance system (in a 20-80 proportion). During the crisis some ad hoc changes to the indexation were made (see Table 3). As Estonia had very high inflation and wage growth in 2008 the index should have been 1.138 (13.8%) for 2009. But due to the economic crisis already threatening, pensions were increased only by 5%. The difference of 8.8% has to be compensated during the next five years. For 2010 both components of the pension index were already lower than 1. The index of social tax revenues was 0.887 and annual consumer price index (CPI) was 0.999 in 2009, resulting in weighted average index 0.909 or 9.1% reduction in pensions. According to the legislation the pensions cannot be reduced and therefore they remained unchanged in 2010. This also meant that there was no compensation left from 2009. For 2011 the index of social tax growth was 0.939 and CPI 1.030, which resulted in the weighted average index of 0.957. Again the pensions were not reduced and the applied index was set equal to 1. The cumulative uncompensated part left to be compensated during next years is thus 4.6%.

Table 3: Development of the pension index 2008-2010

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

Source: Statistics Estonia, Estonian National Social Insurance Board

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 disability 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.[6]

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.[7]

[6] Source: see footnote 4.
[7] Source: Statistics Estonia, own calculations.

Expenditures on state pensions amounted to EUR 1.284 billion or 9% of GDP in 2010. That is the highest in the last ten years, as GDP dropped and pension expenditures increased. The total revenues from pension insurance component of social tax (20% of gross earnings) amounted to EUR 1.0 billion in 2010. In 2010 there were no transfers of the social tax revenues to the funded scheme. As a result, of the total expenditures on state pensions EUR 1.0 billion were financed from current social tax revenues, additional earmarked contribution from the state budget for special pensions were EUR 40 million and the remaining part, EUR 244 million, was additionally transferred from the general state budget.[8]

Mandatory funded defined-contribution scheme

The pay-as-you-go (PAYG) state pension insurance scheme is supplemented by a mandatory funded defined-contribution scheme, which was introduced in 2002. Participation in the scheme is mandatory for cohorts born in 1983 or later, whereas cohorts born between 1942-1982 had the option to join the scheme voluntarily. The funded scheme is run by private fund managers. The total contribution to the funded scheme consists of an individual contribution of 2% of the gross wage of an employee, supplemented by 4% of the gross wage redirected from the pension insurance part of social tax paid by the employer. The latter element entails transition costs of the pension reform, as the curve-out component of the funded scheme implies reduced revenues for state pensions. Although joining the second pillar was voluntary for cohorts born between 1942-1982, which means almost for all employees in the labour market at the time of introducing the new pillar in 2002, actual coverage rates are rather high. By the end of 2010, the scheme covers about 71% of the population aged 18 to 63, although only 59% of them made contributions in May 2009 (the latest time when contributions were compulsory, before temporary suspension).

By the end of 2010 the total value of assets in the compulsory funded scheme amounted to EUR 1.067 billion (about 7.4% of GDP). This was EUR 121 million more than a year earlier, while the total contributions made to the funded scheme in 2010 amounted to ca EUR 40 million (only individual contributions as contributions redirected from social tax were suspended in 2010).

The EPI index (*Eesti Pensioniindeks*), which reflects the weighted average of the net rate of return of all mandatory pension funds, increased by 10% in 2010 (it dropped by 24% in 2008 and increased by 13% in 2009). Index for conservative funds increased by 4.08% and for the most aggressive funds (investing 75% to stocks) by 16.2% in 2010.

From 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. At the beginning of 2011, there were about 16,450 people who had the right to collect benefits from the funded pension scheme. About half (8,050) postponed withdrawal of their pensions, 5070 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), 3029 had withdrawn their pensions in lump sum (relevant if accumulated funds are less than 10 times national pension rate, EUR 1,284.5), and 341 had insurance contracts, meaning that they had collected at least 50 times the national pension rate (at least EUR 6,422.5). At the beginning of 2011 there were only three insurance companies

[8] Source: Estonian National Social Insurance Board (2011) 2010 cash flow report of the state pension insurance system, retrieved on 6 May 2011 at http://www.ensib.ee/public/statistika_ja_eelarve/kassakulu2010.pdf.

that sold annuities.[9] By the end of 2010 EUR 6.5 million were withdrawn from mandatory pension funds.[10]

The main short-term policy reaction to the deficit in the state pension scheme in 2009-2010 was the **suspension of the contributions** to the funded pension scheme. Both the individual contribution of 2% and the 4% share transferred from social tax were temporarily suspended from 1 June 2009 until 31 December 2010 by default. In essence, this policy decision acknowledged the inability to finance pension reform transition costs in a situation of economic and financial crisis.

Persons with ten years from retirement (born 1954 or earlier) could, upon submitting a relevant application, resume individual contributions (2%) from 1 January 2010, in which case also state contributions on account of social tax (4%) were transferred. Other age groups could also continue to pay individual contributions (2%) from 1 January 2010, but no contributions from social tax were transferred (i.e. the scheme applied was 2+0%). For any other participant of the funded scheme (i.e. persons not opting for voluntary continuation of individual contributions), contributions to the funded scheme gradually resumed from 2011, when a 1+2% scheme is applied, and from 2012 in full amount of 2+4%.

Table 4: Contributions to the mandatory funded pension scheme in 2009-2017

<table>
<tr><td></td><td colspan="2">Born 1942-1954</td><td colspan="2">Born 1955 - ...</td></tr>
<tr><td>Person’s decision on individual contributions
Year</td><td>Continues</td><td>Suspends</td><td>Continues</td><td>Suspends</td></tr>
<tr><td>2009 I half</td><td colspan="4">2+4</td></tr>
<tr><td>2009 II half</td><td colspan="4">0+0</td></tr>
<tr><td>2010</td><td>2+4</td><td>0+0</td><td>2+0</td><td>0+0</td></tr>
<tr><td>2011</td><td>2+4</td><td>1+2</td><td>2+2</td><td>1+2</td></tr>
<tr><td>2012-2013</td><td colspan="4">2+4</td></tr>
<tr><td>2014-2017</td><td>2+4</td><td>2+4</td><td>2+6</td><td>2+4</td></tr>
<tr><td>2014-2017* (optional)</td><td>-</td><td colspan="3">3+6</td></tr>
</table>

Source: Ministry of Finance
Note: The first number refers to individual contributions and the second number refers state transfers from social tax. In 2014-2017 people may opt for 3+6 contribution scheme. The option will be available if the nominal GDP growth rate is at least 5%.

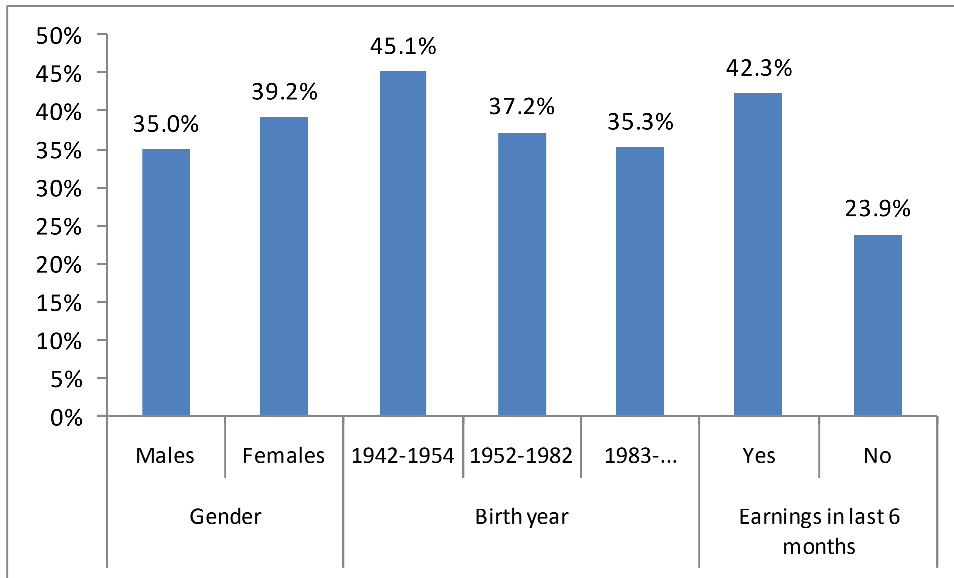
By 31 November 2009 people had to make the decision whether or not they continued their individual contributions in 2010. The default option was suspension of the contributions. About 220,000 persons decided to continue their contributions; it is 37.2% of all people who have joined the second pillar. Females, elder cohorts and people with positive earnings had higher share of continuing participation (see Figure below). People with riskier funds

[9] Statistics from Raivo Sormunen (2011), Teine sammas võib jätta nälga, 25 April 2011, Äripäev, referring to the Estonian Central Register of Securities, retrieved on 6 May 2011 at http://www.aripaev.ee/5027/rt_komm_502701.html.

[10] Source: Ministry of Finance (2011), Kohustusliku kogumispensioni statistika, Jaanuar 2011, retrieved on 6 May 2011 at http://www.fin.ee/doc.php?105135.

(aggressive and progressive strategy) and people in smaller pension funds had also higher propensity to continue their contributions.

Figure 1: Proportion of the people continuing contributions in 2010



Source: Estonian Central Register of Securities, press release, retrieved on 6 May 2011 at http://www.nasdaqomxbaltic.com/files/tallinn/bors/press/pension/pension_2009_jatkajad.pdf, own calculations

In 2009, many more people than in earlier years (60,770 people) changed their funds for 2010, either by changing all pension fund units or only redirecting new contributions to a new fund.[11] Mostly large funds, which were influenced by various affairs, lost investors and new small funds gained. Overall aggressive funds lost more clients than conservative funds, but this was mainly due to clients who left the two largest aggressive funds, which had taken too high risks in the local market. Several small aggressive funds, which had performed better during the crisis, gained clients, and so did almost all conservative funds. Since 2011 people can change funds more easily and more often and we expect more mobility between the pension funds.

On 26 January 2011, as a reaction to mismanagement and large losses that investment funds had during the last real estate boom and the following 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.[12] The law takes 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). Additional contributions can be directed to a new pension fund at any time (it was once a year). Pension funds have to publish their investment reports monthly (it was quarterly). Conservative funds, which invest only into

[11] Source: “60 770 inimest otsustas vahetada pensionifondi”, Press release by the Pensionikeskus, 03.11.2009 retrieved on 6 May 2011 at http://www.pensionikeskus.ee/?id=3188&year=2009.

[12] Kogumispensionide seadus ja sellega seonduvate seaduste muutmise seadus (870 SE), and accompanying explanatory notes and impact assessments, retrieved on 6 May 2011 at http://www.riigikogu.ee/?page=eelnou&op=ems&emshelp=true&eid=1241326&u=20110513153951.

fixed income assets, may now invest only into bonds that have investment rating at least Baa3 (Moody's) or its equivalent. During the boom years, several conservative funds had invested into bonds of local real estate developers and lost their investments during the crisis. 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 53,000 participants with assets about EUR 90 million (about 0.6% of GDP) on 9 May 2011. There were additionally about 71,000 contracts in the form of life insurance at the end of the 1st quarter of 2011.[13] 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 paying the fringe benefits tax (equal to the sum of income tax and social tax), but only income tax and unemployment insurance contributions. 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.

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

There was no explicit EU financial support 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.

2.2.2 Debates and political discourse

In 2010 and 2011 debates on pension system were influenced by three context factors. First, the economic crisis has caused the state PAYG pension scheme to run large deficit in 2009 and 2010, and forecasts show that it may take a decade or even more to close the gap.

[13] Source: Pensionikeskus, statistical data, retrieved on 11 May 2011 at http://www.pensionikeskus.ee/?id=695.

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.

Debates in pension policy have concentrated on the following issues: pension age increase, the suspension of contributions to the second pillar, additional pension supplements to parents who have raised children, indexation of pensions and calculation of annual coefficients in the state old age pension, and the reform of the special pensions.

In spring 2010, the parliament approved after emotional debates, extending to overnight sessions, an **increase of the statutory pension age**. The discussion about pension age started already in 2008 and it was covered in the previous Annual Reports. The eventual implementation of the pension age increase was rapid. The inter-ministerial working group presented the concrete proposal and its impact assessment to stakeholders (trade unions, employer associations, pensioner associations) on 9 December 2009. The government approved the proposal on 17 December 2009 and sent it to the Parliament. Despite heavy critics by the opposition parties and trade unions it was approved on 7 April 2010. The critique of the pension increase stemmed from two aspects. First, opposition parties, trade unions and a few social policy experts have proposed that there were much more important issues in the Estonian pension policy that needed to be tackled before the increase of pension age; for example, the implementation of insurance against accidents at work and occupational diseases, or the reform of special pensions rights, both of which had been in the government agenda already for several years. Trade unions emphasised that the increase in pension age also required comprehensive policy how to improve and maintain the productivity of elderly. It was also argued by the opposition parties that the government should focus its effort on reducing unemployment and increasing low life expectancy. Second, both political parties and academic people were discussing whether the pension age should be increased in an ad hoc manner, as it was eventually done in 2010, or should it be formally related to increased longevity and whether more flexibility should be introduced into the pension age, like in the Swedish system. The compromise reached was that the current legislation now stipulates that the government has to make the decision whether to relate retirement age formally to life expectancy by 2019.

Another topic that is currently discussed and that is included in the new coalition agreement concluded in March 2011, is **a gradual abolishment or amendment of 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. Already in November 2009, the government announced that they will reform special pensions so that eventually only the special pension for presidents remains. By spring 2010 several proposals had been discussed by the government and some of them had also been made public, but no concrete agreement was reached due to political pressure from some of the groups affected. The intention to reform these pensions is included again in the new coalition agreement and in the action plan of the Estonian NRP 2011.

The new coalition agreement also foresees **additional pension supplements for parents** who have raised children. This was one of the main election promises by one of the coalition partners, Union of Pro Patria and Res Publica (*Isamaa ja Res Publica Liit*). Although it increases pension expenditures, it is targeted to those who potentially suffer most from the career breaks.

Currently one of the parents who have raised children 8 years before 31 December 1998, i.e. children must have been born before 1 January 1991, receives a pension supplement equal to the value of two years of pensionable length of service. In addition, the actual time of child care leave (up to a child's age of three) was included in the pensionable length of the service component. The value of one year is 4.343 EUR per month. Since 1 January 1999 the system changed and one of the parents received annual pension insurance coefficients that depended on the minimum social tax base on which the state paid social tax. This amount used to be considerable lower than the average taxable earnings, varying from 10% of the average earnings in 2005 to 39% in 2010. Furthermore, for the parent who receives parental benefits, 1% of the parental benefit is additionally transferred to the funded pension scheme since 2004.

The government's action plan for 2011-2015 now includes the following plan for pension increments. For one parent of children who will be born after 1 January 2013 the state transfers 4% of the average taxable income to the funded pension scheme until the child reaches 3 years and if the parent does not work at the same time. One of the parents of children who were born between 1 January 1991 and 31 December 2012 receive a pension supplement equal to the value of two years of pensionable length of service when retired. As of 1 January 2015 one of the parents of all children who were born before 1 January 2013 receive additional pension supplement at the value of one annual coefficient. It is foreseen that all pension supplements are transferred from the general state budget and not from earmarked social tax revenues. Adding all these pension supplements would yield about 4.3% higher old-age pension for one of parents whose child was born between 1 January 1999 and 1 January 2013. For parents whose children will be born after 1 January 2013, the value of these new pension supplements depends on the performance of pension funds.

All major political parties and social partner have also agreed that a **work accident and occupational disease insurance** needs to be introduced. The government expects that introduction of this insurance would improve working conditions, reduce work accidents and eventually lead to lower health care costs and reduction in the number of disability pensioners. The latter has increased since 2000, especially during this crisis. The government's action plan for 2011-2015 also states that the insurance scheme will be introduced, but does not offer details on the parameters or organisation of such schemes.

During the election campaign, opposition parties suggested that pensions must be increased in an ad hoc manner to compensate price increases in 2010 and 2011 and that the formula underlying the calculation of the pension points to be changed fairer, but these have not gained wider attention, simply because these are too expensive and would enlarge the deficit of the state pension system even further.

Other ideas that are being discussed in various expert working groups are related to how to reduce early retirement, whether to change actuarial adjustment of benefits in case of early retirement, whether and how to allow simultaneous working and receiving of old-age pensions, whether to increase qualification period, etc. All these ideas and propositions are aimed at reducing expenditure on pensions and motivate people to work longer, but no specific details have been proposed for public discussion.

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 both on 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.

There is also discussion related to a guaranteed minimum income in pension age, but this has remained at an inter-ministerial expert group level and has not gained wider public attention, because only about 1-2% of pensioners receive minimum pension. Currently a flat-rate national pension serves as a minimum guarantee for pensioners. Those who have not acquired the pension qualification period - at least 15 years of working with minimum wage or having equalised activity - are granted national pension provided they have resided in Estonia at least 5 years prior to claiming a pension and have reached statutory pension age. In addition, old-age pensions cannot also be smaller than the national pension. Because the level of national pension has been about 20-27% of the medium income in 2004-2009, below international standard of 40%, there is discussion whether the national pension should be raised, but then certainly together with the increased requirements to the duration of living in Estonia and also increased qualification period for old-age pension. No official documents or statements have been published regarding this issue yet.

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 both by 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 coordination, 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 reforms in Sweden and Finland, are explicitly used in debates about the Estonian pension system.

The Estonian government discussed the EU Green Paper on pensions at their cabinet meeting on 4 November 2010.[14] The meeting concluded that Estonia supported the range of the issues

[14] “Eesti seisukohad Euroopa Komisjoni rohelise raamatu "Piisav, jätkusuutlik ja kindel Euroopa pensionisüsteem" kohta” Valitsuse 04.11.2010 istungi kommenteeritud päevakord, retrieved on 6 May 2011 at http://www.valitsus.ee/et/uudised/istungid/istungite-paevakorrad/20372/valitsuse-04112010-istungi-kommenteeritud-paevakord

that the paper focused on, such as removing obstacles stemming from pension systems to people who work in different EU countries, encouraging the unification of regulations of funded pension schemes and the development of information systems of pension rights. Information on different pension schemes and pension investment products should also be modernised and available to help people to make informed saving decisions. At this meeting, the government also concluded that a minimum level of pensions can only be recommended, but not made compulsory, at the EU level. Any increase in the minimum level of pensions higher than currently set in the European Code of Social Security, may increase pension expenditures and threaten long-term fiscal sustainability.

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.

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. By September 2011 the ministry is supposed to have ready concrete list of activities. Already this year, the ministry will have a topical report about the elderly in the Estonian labour market (*Vanemaealised Eesti tööturul*) and by the end of 2012 the ministry has a responsibility to prepare a draft for the strategy about active ageing (*Eakate aktiivse vananemise strateegia eelnõu*).

2.2.4 Impact assessment

Both major changes - suspension of contributions to the funded pension scheme in 2009-2010 and old-age pension increase from 2016 - have been accompanied by published impact assessments by the Ministry of Finance.

The formal **impact assessment of the pension age increase** by the Ministry of Finance was already referred to in the 2010 annual report. [15] When fully implemented the increase of the pension age will influence about 30,000 persons annually (i.e. two cohorts) starting from 2027. In 2009 the Ministry of Finance predicted that annual deficit of the state pension scheme could reach about 2.5% of GDP by 2012 and it could remain until 2040 or even longer without the pension age increase. The increase of the retirement age would lower the annual deficit about 0.6% of GDP in 2026 (or about 5-10% of pension expenditure). The impact assessment also hoped for additional 15,000-20,000 employed people. In the long-run the pension age increase also raises the replacement rates of new pensioners as they work longer and have hence longer contribution periods both to the state pension scheme and the funded pension scheme. The impact assessment by the Ministry of Finance showed a general decline of the average net replacement rate in the long-run, from current 50% to about 35% by

[15] "Seletuskiri riikliku pensionikindlustuse seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde" retrieved on 6 May 2011 at http://www.riigikogu.ee/?page=pub_file&op=emsplain&content_type=application/rtf&file_id=888057&file_name=Riikliku%20pensionikindlustuse%20seletuskiri%20(655).rtf&file_size=999436&mnsensk=652+SE&fd=.

2050, despite the increasing share of funded pensions. The increase of the retirement age will increase the average replacement rate by 2-2.5 percentage points in long-run.

There are not many independent impact assessments available on the effects of the increase of the pension age. Võrk (2009a)[16] concluded, based on the experience of earlier pension age increases since 1995 (from 60 to 63 for men and from 55 to 60.5 for women), that there have been two main general effects: an increase of the average employment rate of elderly, and the use of alternative pathways to retire – especially early retirement pensions and incapacity to work pensions (i.e., disability pensions). The study concludes that the previous increase in retirement age has raised employment rates about 20 percentage points for men and about 25 percentage points for women in the affected age groups (age group 60-65 for men and 55-59 for women). Based on this earlier experience it has been suggested that this new pension age increase may raise employment of elderly by about 25,000 people, but also increase number of disability pensioners by 6000 and number of early retirement pensions by 2000.[17]

In 2011, the Ministry of Finance published new short-run estimates of the balance of the state pension insurance scheme in the State Budget Strategy 2012-2015 document. They estimate that the state pension insurance scheme will be in the deficit about 2.0% of GDP in 2012 and 2013, 2.4% in 2013 and 2.3% on 2014. The increase of the deficit is caused by compensation mechanism of the compulsory funded pension scheme which requires increased transfers of social tax revenues to the funded pension scheme (see section 2.2.1).

Pension expenditures are predicted to increase both due to regular indexation, for example, average old age pension is predicted to increase from EUR 304 in 2011 to EUR 357 in 2015, and increased special pensions. Ministry of Finance predicts that expenditures on special pensions to the police will increase by 50% during 2012 to 2015 and for judges they will double. Overall the pension expenditures increase by more than EUR 200 million (about 1% of GDP) by 2015 compared to 2011 (State Budget Strategy 2012-2015, page 41).

The **temporary suspension of the contributions to the funded pension scheme** in 2009 and 2010 substantially helped to improve the fiscal position of the central government during the crisis. The Ministry of Finance estimates that it saved EUR 156 million in 2010 and EUR 85 million in 2011 (about 1.1% and 0.6% of GDP, respectively). But the later compensation will increase costs by EUR 52 million in 2014 and EUR 57 million in 2015 (about 0.3% of GDP in both years).[18]

The Ministry of Finance has predicted that the suspension of contributions lowers the average replacement rate only marginally. First, the period of the suspension is short. Second, partly it is compensated by higher pensions from the state pension scheme. The Ministry of Finance predicted that the maximum impact on the individual net replacement rate would be 0.5% or, in other words, a drop in pensions about 1-1.5%. If an individual continues her or his part of the contributions and uses the compensation mechanism in 2014-2017, then there is practically no change in the replacement rate.[19]

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[16] Võrk, A. (2009) Labour supply incentives and income support systems in Estonia. IFAU Working paper Series, 2009:31, Uppsala.

[17] Võrk, A. (2009) Kuhu sprindid, pensioniiga? (Where are you sprinting, pension age?) Eesti Päevaleht, 15.09.2009.

[18] Ministry of Finance (2011) Stabiilsusprogramm 2011. Tallinn, retrieved on 6 May 2011 at http://www.fin.ee/doc.php?107451.

[19] Ministry of Finance (2009) “II samba peatamise briifing.ppt”, retrieved on 6 May 2011 at http://www.fin.ee/doc.php?82123.

In 2010, the Ministry of Finance published a major study[20] on **the impact of the financial crisis on funded pension schemes**. The study analysed investment regulation, portfolio management, information dissemination, investors' behaviour, et cetera. The study formed a basis for the amendment of the Funded Pensions Act, which was discussed in section 2.2.1. The study concluded that because of the financial crisis, by September 2009, both the nominal and real return of the pension funds were negative (the total value of assets was smaller than contributions to the funds). Even conservative funds showed negative returns, which implied that investment regulation of these funds was not sufficient, and eventually this resulted in considerable stricter regulation in the new amended act. The study also found information dissemination of the pension funds was not adequate, timely and comparable, which hindered the comparison of the performance of pension funds by investors.

A full **impact of the economic crisis on pensioners** cannot be evaluated yet as 2010 income data is not yet available, but 2008 and 2009 data suggest that the economic crisis did not have any major impact on the poverty of pensioners, compared to other socio-economic groups. The employment rate of elderly (aged 55-64 and 65-69) declined during this crisis about 7-8 percentage points compared to the peak values in 2007-2008, but this drop is similar to the employment rate change of prime-age workers. Simultaneously, inflow into the pension system increased substantially in 2009 and 2010, especially via disability pensions and early retirement. In 2010, an inflow into the disability pension scheme was 50% higher than in 2007, and via early retirement scheme 60% higher.

At the beginning of the crisis in 2009, old-age pensions, disability pensions and survivor's pensions increased, both in nominal and real terms. As a result, the at-risk-of-poverty rate of elderly declined from 33.9% in 2008 to 15.1% in 2009. The severe material deprivation rate for elderly has also declined steadily from 7.9% to 5.6% in the period 2004 to 2009.

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.

[20] Ministry of Finance (2010) "Kohustusliku kogumispensioni kogemused finantskriisist", March 2010, Tallinn.

Table 5: Selection of indicators of poverty and employment of elderly, 2007-2010

Year	2007	2008	2009	2010
Employment rate, %				
Age group: 25-54	84.5	83.7	76.2	74.6
Age group: 55-64	59.5	62.2	60.4	53.8
Age group: 65-69	25.9	24.2	19.6	18.2
Inflow into the pension system				
Old-age pensions (*vanaduspension*)	9,425	7,583	9,312	10,934
Early retirement (*ennetähtaegne vanaduspension*)	1,618	1,372	2,327	2,590
Incapacity to work pensions (*töövõimetuspension*)	7,124	6,726	8,650	10,280
At-risk-of-poverty rate (60% of median equivalent income), total*	19.5	19.7	15.8	
Age group: 65+	39.0	33.9	15.1	
Relative median at-risk-of-poverty gap, %, total*	20.3	17.0	23.2	
Age group: 65+	14.8	11.4	9.0	
Severe material deprivation (%), total	5.6	4.9	6.2	
Age group: 65+	7.9	5.8	5.6	
Relative median income of elderly (65+ versus other age groups)*	0.62	0.66		
Aggregate replacement ratio (income of pensions of 65-74 to income from work of 50-59)*	0.45	0.52		

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.

The relative median income of elderly people compared to younger people (up to 64) is 66% in 2008, compared to the EU-27 average of 86%. However, the aggregate replacement ratio (ratio of income from pensions of persons aged between 65 and 74 years and income from work of persons aged between 50 and 59 years) is on par with the EU average (52% in Estonia and 51% in EU-27). Therefore the Estonian pensioners' situation relative to the working age population before retirement is comparable to the other EU countries. The relatively low aggregate replacement rate of the income of the current Estonian pensioners is caused by the high income of younger age groups (24-49).

The income inequality amongst the current pensioners is low in Estonia compared to the EU average, or compared to the inequality in labour income in Estonia. The income quintile share ratio of people older than 65 was 3.2 in Estonia, compared to the EU-27 average of 4.0. This is expected to change as future pensions are gradually more related to individual life-long contributions and inequality in labour earnings will therefore transfer to a large extent into an increased inequality in pensions. 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*).

The formal ex ante evaluation of **pension supplements for parents** who have raised children has not been published yet, although various estimates have been discussed in working groups

and in the media, both by the political party who raised the topic and independent researchers. The new supplements will reduce the inequality between the parents whose child was born at different points of time. The additional expenditures are initially low, because only few parents whose children were born after 1991 have reached the pension age. Over time the expenditures will grow. But because the absolute number of children does not grow in long run, but rather diminishes, the additional expenditures relative to GDP should not increase over time.

2.2.5 Critical assessment of reforms, discussions and research carried out

Changes in the Estonian pension system experienced in 2009-2011 were a combined result of the economic crisis, the Government's simultaneous aim of keeping the public deficit within the limit of 3% of GDP in order to join the Euro area since 2011, and long-term concerns about the sustainability of the pension expenditures.

As a decrease in pensions was not seen as an option in the context of the general elections forthcoming in March 2011, the suspension of the contributions to the mandatory funded pillar was the only realistic temporary choice. Without that step, even larger transfers from the general budget would have been necessary, but that would have been impossible without further tax increases or larger deficits. To avoid a decline in the value of mandatory funded pensions in long run, a compensation mechanism was proposed for years 2014-2017. It means that the protection of current pensioners during the crisis has been achieved by postponing the transition costs of the pension reform and the related tax burden to later years (2014-2017), when additional contributions to the funded system need to take place. In addition, because of the introduction of a compensation mechanism into the indexation scheme during the crisis, pensioners themselves cover some of the costs, as future pensions will increase at lower pace.

The pension increase in 2009 and a simultaneous drop in employment caused the annual deficit of the state pension scheme to reach around 2.0% of GDP by 2012 and 2.4% in 2014[21] and the Ministry of Finance has predicted that the annual deficit of the PAYG pension scheme could persist for 20 years.[22] Still, the long-term outlook of the sustainability of Estonian public finances is good in comparison with other member states. Estonia does not have a large public debt and the costs of pensions, although growing in the long run, increase from a much lower base level, and there is an agreement that the deficit will be covered from general tax revenues. Also, the government has an obligation to analyse the fiscal and social sustainability of the state pension system every five years and may modify the indexation formula if necessary. Hence, there is an ad hoc balancing mechanism introduced into the legislation.

Simultaneously, the increase of the statutory pension age, possibly linking it with life expectancy in the future, intended reforms of the special pensions, and plans to introduce a work accident and occupational disease insurance should contribute to the reduction of pension expenditure. In addition, preliminary data suggest that the economy is recovering quicker than expected in 2011, relieving the pressure on the state pension system.[23]

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[21] Ministry of Finance (2011), Riigi eelarvestrateegia 2012-2015, retrieved on 6 May 2011 at http://www.fin.ee/doc.php?107452.

[22] "Seletuskiri riikliku pensionikindlustuse seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde" retrieved on 6 May 2011 at http://www.riigikogu.ee/?page=pub_file&op=emsplain&content_type=application/rtf&file_id=888057&file_name=Riikliku%20pensionikindlustuse%20seletuskiri%20(655).rtf&file_size=999436&mnsensk=652+SE&fd=.

[23] According to Statistics Estonia, GDP growth was estimated 8% in the first quarter of 2011 compared to the same period year ago. Source: "Majanduskasvu veab jätkuvalt töötleva tööstuse tugev eksport", press release by Statistics Estonia, 12 May 2011, retrieved on 13 May 2011 at http://www.stat.ee/49259

On the other hand, intentions to reform special pensions or introduce a work accident and occupational disease insurance 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.

In the compulsory funded second-pillar pension scheme, the crisis has resulted in stricter control and clearer rules on the management of the private pension funds. This should re-establish confidence towards investment funds and encourage private saving. Moreover, as people are now more easily allowed to change funds, an increased competition between the funds is expected. 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. Therefore, the steps taken after the economic crisis have improved economic and legal environment for private savings.

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. On the other hand, the reduction of pensions when retiring before normal pension age is not actuarially neutral and may encourage early retirement. This is strengthened by relatively short unemployment insurance benefits (180-360 day, depending on the length of a contribution period). Indeed, during the economic crisis, early retirement both via old-age pension scheme and disability pension scheme increased substantially. Therefore the economic crisis may have led to permanent reduction of labour force, because outflow from the early retirement and disability pension scheme is negligible. Hence, in addition to the current focus on increasing statutory pension age and reducing special pensions, the government should also focus on increasing effective retirement age, which requires combined efforts from pension policy and active labour market policy.

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"[24]) 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

[24] 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.

eight years, conscripts, and registered job seekers, whether they receive unemployment benefit or not[25]).
The inclusion of job seekers into the health insurance was an important step in the increase of the coverage rate. Introduced in 2007[26], at the end of December 2010, 5.2% of the total of insured persons was insured through registration as unemployed. Of this group, some 60% does not receive an unemployment benefit and thus is covered via this measure.
A further group, which amounts to 49% of all insured persons, consists of persons who are entitled to insurance without contributions being paid. These are children under 19 years of age, students aged under 24, pregnant women, 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. 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).
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 95.2% of the population included in 2010 (compared to 95.6% in 2009[27]). 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, for pharmaceuticals, and for cash benefits (benefits for temporary incapacity to work, partial and fragmented compensation for dental care, and supplementary compensations for pharmaceuticals). In these areas, the level of out-of-pocket payments is important.
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[28], for home calls made by family doctors and for outpatient specialised care. The fees are however limited[29] 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.

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[25] 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.

[26] A 2010 WHO report on the financial sustainability of Estonia’s health system places this decision in 2009. In reality, however, the measure dates from 2007 and was inspired by the observation that the majority of unemployed at that time had no entitlement to benefits – not by the financial and economic crisis as such.

[27] The 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.

[28] 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.

[29] 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. Out-of-pocket payments are mainly an issue where it concerns dental care (which is, for persons aged over 19, only symbolically covered by the health insurance system), and pharmaceuticals.

Modern reform[30] 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 answer concerns 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[31]. 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[32].
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[33].
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[34]. 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

[30] 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).
[31] 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.
[32] Family doctors are compensated on the basis of the number of patients they provide services to, and not on the amount of service actually provided. In principle, one family doctor has 1200 patients, and is assisted by at least one family nurse. In places where there are less patients (e.g. on small islands), the family doctor is nevertheless compensated as if there were the standard number.
[33] The latter is enacted through the 2001 Health Services Organisation Act, and the 2002 Health Insurance Act.
[34] For an overview of these projects, see http://eng.e-tervis.ee/.

identity card of the patient. After some initial technical difficulties, today, nearly all pharmacies have joined the system. Three out of four 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 main ongoing debate today concerns the financial sustainability of the health care system, more precisely how the setup is to be funded in the near and distant future and what the role of the different stakeholders should be. A closer look at the figures allows situating the issue.

The Health Insurance System derives its funding primarily through targeted social tax payable on wages, which accounted for 98.8% of revenue of the Estonian Health Insurance Fund in 2010. 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.

Of all the insured persons, only 51% pay contributions through employment or through other arrangements, for example because they receive unemployment benefits and are insured by the Estonian Unemployment Fund. For 49%, no contributions are paid. Within the latter group we find persons who receive a pension – arguably those in most need of health care.

The level of out-of-pocket payments is important, especially when it comes to dental care and the purchase of medication[35].

Recent efforts to decrease the cost of medicine by promoting the prescription of generic medication, by forcing pharmacies to offer the cheapest version, and by making more price arrangements for reimbursed, medication seem to have had a limited effect in the expenditure of the health insurance system.

The issue of too high out-of-pocket payments is connected to the overall question of how the system will be financed in the future. The main question is if the government should increase spending in the health care system, whether the depth of the coverage is to be changed, whether the contribution base should be increased, and whether personal responsibility can be further increased through various measures such as partial private insurance systems. Final decisions have not been made, even if the coalition agreement contains the plan to come to "more diverse financing", which would indicate that the government is not keen on increasing government spending by, for example, contributing for the large number of people who are insured without contribution payments.

[35] 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 6 May 2011 at http://rahvatervis.ut.ee/bitstream/1/2201/1/V%C3%B5rkjt2010.pdf
In 2009, the overall level of out-of-pocket payments was calculated to be 20.3% (http://www.tai.ee/?id=5619).

Some debate goes to the setup and modalities of a separate work accident occupational disease insurance, which all major political parties and the social partners have agreed to introduce. 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. Agreement on what the system should look like, or a time-table, have as of yet not been reached.

A recurring issue is 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. 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[36].

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 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.

In the field of health care, and apart from the financial debate, less reference is made to European practices. Nevertheless, efforts to improve the 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 that respect, the effects of an ageing population, while not as pronounced as in many other EU Member States[37], 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[38]. With a coverage rate of 95.2% in 2010, universal coverage is perceived as less urgent. Plans to achieve near-complete coverage seem to have been reported to better economic and financial times.

[36] OECD, "OECD Economic Surveys: Estonia 2011", OECD Publishing, April 2011, 89-90 retrieved on 6 May 2011 at (http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en).

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

[38] 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.

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.

2.3.4 Impact assessment

In the course of 2010, a measure already taken the year before revealed its full impact. In February 2009, by way of crisis intervention, the Parliament had amended the Health Insurance Act (implemented from 1 July 2009 onwards) regarding the payment of sickness cash benefits, transferring some responsibility for payment of sickness cash benefits to employers and increasing the number of unpaid sick days. Before, the sickness cash benefit scheme entailed a waiting period of only one day, and benefits at the rate of 80% of former wage were paid by the Health Insurance Fund from the day following that of issuing the sick list.

According to the new rules, the waiting period is extended to three days, hence no benefits are paid for the first three days of sickness. The employer is responsible to pay the benefit from the 4th to the 8th day of sickness, assuming a responsibility for a total of five days per sickness period, whereas the responsibility of the Health Insurance Fund commences from the 9th day of sickness. At the same time, the compensation rate was reduced to 70%39.

Where it was difficult to assess the impact of this measure for the second half of 200940, the figures for 2010 reveal a significant effect. The cost for sickness cash benefits decreased from EEK 1.192 billion in 2009 to EEK 0.519 billion in 2010, a savings of 56%. That this was unexpected is illustrated in the 2010 budget on which the Health Insurance Fund operated, and which took into account a cost of EEK 0.892 billion – meaning that only 58% of the budgeted amount was actually used. The full difference can of course not be accounted to this measure alone. Other factors such as a 7% decrease in the number of insured people in employment (to whom this measure applies) and a significant drop in gross salaries (on which contributions are paid and benefits are calculated) are also to be taken into account.

Published impact assessments concerning the Estonian health care system focus mainly on efficiency gains and on its financial sustainability in the coming years. In essence, the major discussion is whether financing health care from social tax revenues only is a sound and future-proof strategy.

At the beginning of 2009, the Health Insurance Fund was assigned the task by the Minister of Social Affairs to take a close look at financial sustainability, and to offer solutions. Extensive consultations with stakeholders and experts and partnership with the Regional Office of the World Health Organisation resulted in a report, completed and published in the early spring of 2010[41]. In this report, projections on increasing costs are coupled with observations

39 At the same time, the benefit received in case of caring for a sick child at home has been lowered from 100% to 80% of wages. Health Insurance Act, par. 54.

40 The cost for sickness cash benefits *sensu strictu* (EEK 1.147 billion in 2008) decreased in 2009 (to EEK 1.192 billion), but this decrease was not overly significant when taking into account that the number of applications for medical leave in the first half of 2009 (before the measure took effect) already dropped by 17% compared to 2008.

41 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 6 May 2011 at (http://www.euro.who.int/document/E93542.pdf).

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).

A first recommendation is to broaden the public revenue base of the system through (amongst others) a stable and transparent revenue allocation from the 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). To improve financial protection offered by the system, the report further suggests rationalising and simplifying 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.

These recommendations are repeated in the 2010 Year Report of the Estonian Health Insurance Fund[42], and now form the basis of political discussion.

Further shaping the debate is the recently published OECD Economic Survey for Estonia[43]. 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.

Finally, a major research project is being finalised by an independent research group, looking into alternative options on how to guarantee the overall sustainability of the Estonian social insurance schemes (including health care). While the final report is expected only in the summer of 2011, it is already clear that the government expects meaningful and usable results, mentioning the study explicitly in the Government’s Action Plan 2011-2015[44].

Meanwhile, some important immediate measures have been taken in response to the economic and financial crisis. In the health care sector, these changes amount to an increase of individual financial responsibility and an increase of maximum waiting lists in outpatient specialist care and, on the supply side, a 6% reduction in the compensations paid to health care professionals[45]. Details of these measures and their impact can be found in the previously mentioned 2010 Year Report of the Estonian Health Insurance Fund.

Further worth mentioning is a performance audit by the Estonian National Audit office of 8 April 2011 on the family doctor system[46]. The National Audit Office concludes that the

[42] Eesti Haigekassa, “Eesti Haigekassa majandusaasta aruanne 2010”, 20-21. The report can be consulted via http://www.haigekassa.ee/uploads/userfiles/HK_majandusaasta_aruanne_2010(1).pdf. The English version was not yet available at the time of writing of our report.

[43] OECD, “OECD Economic Surveys: Estonia 2011”, OECD Publishing, April 2011, 79-91 retrieved on 6 May 2011 at (http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en).

[44] Vabariigi Valitsuse tegevusprogrammi 2011–2015, April 2011, Tallinn, retrieved on 6 May 2011 at http://www.valitsus.ee/UserFiles/valitsus/et/valitsus/tegevusprogramm/valitsuse-tegevusprogramm/VV%20tegevusprogramm_28-04-2011_KINNITATUD.xls.

[45] This reduction has been partially undone in 2011. Prices in specialist care were allowed to rise by 2%, and those in primary care by 4%. What health care providers are allowed to charge is neverthless still 4 and 2% less, respectively, than what was allowed before the financial and economic crisis hit.

[46] National Audit Office of Estonia (Riigikontroll), “Perearstiabi korraldus”, April 2011, Tallinn retrieved on 6 May 2011 at

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.

This plan, which is described in more detail in the previous Annual Report, still lacks some implementation.

Following this document, midwives are now allowed to work independently instead of only in conjunction with gynaecologists, including the prescription of some medication but excluding the competency to act alone during birth, with the aim of reducing the take-up of specialist care for routine check-ups and reducing waiting lists[47]. As a result, several family doctor centres now offer midwife consultations.

Further, since January 2010, the definition of "family nurse" has been added to the Health Services Organisation Act[48], resulting in the obligation for every family doctor to be assisted by at least one registered nurse who is allowed to consult and observe patients and acts as a gatekeeper for the family doctor. This measure is neutral with regards to the budget, as the per-capita compensation provided to family doctors by the Estonian Health Insurance Fund already takes into account the cost of employing a nurse. Registered nurses are required to offer 15 hours per week of independent consultancy time. However, despite discussions and plans to this effect, nurses connected to family doctors are at present still not allowed to prescribe medication. The issue here is that the basic nurse training (other than the training a midwife undergoes) does not include modules on pharmaceuticals. A change in the package of competencies therefore also requires changes in the training curriculum.

2.3.5 Critical assessment of reforms, discussions and research carried out

While the current focus on financial sustainability and efficiency can be applauded, the full picture behind the figures is less clear. Increased waiting lists have clearly lead to an increased share of emergency care in 2009 as medical conditions can worsen if a doctor or specialist is not consulted in time; an increase in personal financial responsibility could very well lead to higher inequality; and the options currently discussed to safeguard the sustainability of the system (such as the introduction of private insurance provisions) may very well bring adverse effects to the overall health of the population, and especially of more vulnerable groups within society.

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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

[47] The changes are incorporated in the 2001 Health Services Organisation Act (https://www.riigiteataja.ee/ert/act.jsp?id=13264247); see also Regulation nr. 22 of 19 March 2010 (https://www.riigiteataja.ee/ert/act.jsp?id=13289780). The change is in force as of April 2010.

[48] See also Regulation nr. 2 of 6 January 2010 (https://www.riigiteataja.ee/ert/act.jsp?id=13263878).

Assessing the impact of the changed rules concerning the sickness cash benefits, one must remark that it is as of yet unknown what the real-world effect of this change is. Next to a decrease in expenditures, the 2010 figures[49] also reveal a drop in the number of certificates issued by doctors from around 340,000 in 2009 to around 247,000 in 2010; a decrease by 27%. When we look at the number of certificates for temporary incapacity for more than eight days (i.e. those periods for which the health insurance system reimbursed), the difference is even greater – from around 305,000 in 2009 to around 169,000 in 2010, or a drop by 45%. While this can partially be explained by the fact that the health insurance fund now reimburses less quickly, at the same time the total number of sickness days (including those days paid for by the insured and by the employer) dropped by 26% and the average duration of leave paid for by the health insurance fund (i.e. the days beyond the eight day) increased from 15.4 in 2009 to 18.8 in 2010.

In other words, while the number of instances a worker stays home sick has decreased, the temporary incapacity for work periods, as an average of periods for which the health insurance fund eventually needs to step in, seem to last longer.

Moreover, comparing the number of sickness days for which the insurance system does not intervene with the number of corresponding certificates, the average duration of sickness leave computes at 5.4 days – which would indicate that workers are mostly sick at their own expense, or else are sick for much longer, on average.

These figures deserve further scrutiny and some deep-delving analysis. While it may well be that sickness leave is taken more seriously than it was before and that the data follows logically from the reform, they might also indicate that workers are prompted by the changes in the compensation structure to take less good care of themselves, allowing futile sickness to evolve into more serious conditions. At the same time, one could wonder what the real distribution of responsibility between workers and employers is, if undue pressure exists to continue working despite ill health, and if a mechanism of re-insurance for employers is needed to counteract possible ill effects of the measure.

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 come to sustainable solutions.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care in Estonia is comprised of a mix of health care services and welfare services[50]. The system today is fragmented, with different responsibilities concerning organisation, provision and financing of the different services available.

[49] See the 2010 report of the Estonian Health Insurance Fund: Eesti Haigekassa, "Eesti Haigekassa majandusaasta aruanne 2010".

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

While the health care system 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 health care system is a state affair, while welfare services became the financial and organisational responsibility of the municipalities in the 1990's.

The Ministry of Social Affairs is responsible for developing social welfare policy in general (including long-term care), establishing the necessary legal framework to ensure availability and quality, collecting and analysing data, and designing and implementing 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.

Local governments (municipalities) are thus the main providers of long-term care services, 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).

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 alleviate the families' care burden to enable family members to be engaged in paid employment.

Long-term care 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).

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 400 to 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.

The health care system provides for related medical services and is 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[51], in part to avoid over-use of hospital resources by those not really in need of medical treatment.

Informal care plays an important role; not only factual but also from a legal perspective[52].

2.4.2 Debates and political discourse

Following an extensive review of the system by an independent consultancy in 2009, different options to solve the issues concerning the long-term care system have been discussed. The study aimed to assess the strengths and weaknesses of the financing of the current system and consists of three parts – one analysing the current situation and laying out the challenges, one drawing parallels and comparisons with the systems in place in Finland and The Netherlands, and a third part outlining possible solutions[53].

The overall solution, meant to tackle the fragmentation of the system, is to better integrate the various services provided through the health care and welfare systems. The aim is to achieve service delivery that is needs-based, rather than determined by the financial means of and services delivered 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. Emphasis is put on a thorough assessment of the need for care, and to provide a package of "personal assistance".

Achieving the cooperation this requires is not an easy affair. As long-term care is provided by local governments (municipalities), much depends on the capacity of these entities to offer services. However, over two-thirds of the 226 municipalities have a population of less than 3,000. 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. Small municipalities therefore receive less funding, yet have the same responsibilities as larger ones. Previous state-driven attempts to reduce the number of municipalities have failed, and cooperation between municipalities is limited[54]. 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.

Local governments operate independently and are afforded considerable autonomy by the Estonian constitution. Therefore, implementing a "single government approach" is not a

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[51] Regulation number 42 of the Estonian health insurance fund of 19 February 2009, Riigiteataja I 2009, 16, 99 retrieved on 6 May 2011 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.

[52] The role of the family in caring for dependent family members is not only factual, but finds also 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."

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

[54] SOOTLA, G, KALEV, L and KATTAI, K, "Perspectives of local government amalgamations in a transition society: the case of Estonia", Studies on transition States and societies, Vol. 1, Issue 1, Tallinn, 2009 retrieved on 6 May 2011 at http://htk.tlu.ee/stss/?page_id=179.

simple matter of the central government imposing standards on local governments. It is a delicate balance between competencies, financing mechanisms and different levels of professionalism.

For example, 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 by family doctors. In reality however, 71 out of 120 welfare institutions that provide round-the-clock care organise nursing care nevertheless, even though they are not legally allowed to do so and do not get compensated for that through the health care system. Moving between these systems, however, also means that the normal procedural and quality rules of the health care system do not apply there. Even if counties are empowered and expected to hold inspections, there are no quality standards for the care provided.

One solution to this problem would have been to legally allow care homes to provide nursing care, which would then be financed through the health care system, resulting in the application of the same rules concerning levels and quality of provision. An Act to this extent was prepared last year and is now in the official consultation process, but is opposed by most stakeholders, either because it means that more service providers would then compete for the same budgets, or because worries exist that the quality cannot be maintained.

Another solution would be to impose quality standards concerning the services provided under the welfare system, but this draft proposal is held back by the arguments 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. Nevertheless, the intention to do so is inscribed in the Government Action Programme for 2011 to 2015[55].

Also in the government's plans is the emphasis on home care instead of on the provision of services through care homes. For the first time, this policy line is stated clearly, and is coupled with concrete mandates to develop measures that are meant to support the assistance of people in their own homes. To this end, different initiatives are underway to develop assistance to people providing home care (for example through the elaboration of a handbook) and by developing quality standards in this respect, together with a co-financing system. As the Ministry of Social Affairs now has the mandate to develop more than "soft" guidelines, a concrete comprehensive package can be hoped to emerge.

Concerning financing and viability of the system, the 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 government out of the desire to handle things without having to raise taxes[56].

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

[55] The government programme (a result of the coalition agreement) was published on May 6th and can be consulted through http://www.valitsus.ee/et/valitsus/tegevusprogramm. Translated, 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.

[56] The rejection of this choice is however possibly not 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 are expected to be concluded by the end of 2011 (see point 2 (c) under the header "Taxation" of the Government Action Programme).

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

The Estonian 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 the pension debate. 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 terms of policy and strategy, Estonia benefits to an important extent of the assistance of the OECD, which is deeply involved in analysis of the overall state organisation and which, through attention to the working of local government in relation to the state government, also offers comments on the long-term care system[57].

Currently, the influence of the European Union is not so much felt through mutual learning and reporting exercises, but all the more through the very important role of project-funding via the European Social Fund. ESF-funded initiatives will not only increase the capacity for delivering long-term care through infrastructural projects[58], but also allows to develop and pilot new services that would otherwise not have been achievable[59]. Success in these projects can deliver valuable learning experiences and might create incentives to turn them into structural solutions.

2.4.4 Impact assessment

The topic of long-term care in all its aspects, and broader, of social welfare, receives much attention. 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.

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[57] An OECD Public Governance Review "Estonia – towards a single government approach" is expected to be published in June 2011. The advanced copy of the Review which we were able to consult for this report 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 contains an analysis of social services for the elderly, which is used as a case study.
See http://www.oecd.org/document/28/0,3746,en_2649_33735_45625948_1_1_1_1,00.html for more details and information on the final document.

[58] 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.

[59] 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).

Earlier, we made reference to the extensive review of the system of June 2009, ordered by the Ministry of Social Affairs and performed by an independent consultancy[60]. This study remains the most encompassing view at the system to date.

A multi-facetted snapshot of the main clients of the system is offered through the fifth issue in the Collection of Social Trends in Estonia, published by the government statistics agency[61]. This issue focuses on population ageing in its many aspects, and covers topics such as demographic backgrounds, the participation of older people in the labour market, economic, material and social welfare, health and social cohesion.

The care burden, i.e. the situation of those providing informal care to people in need of long-term care services, is researched through two studies commissioned by the Ministry of Social Affairs. They conclude that the care burden is high, and that home services often simply do not exist. The problem that people with care burden are not able to work because of a lack of time seems to be less important than previously thought. Instead, care-givers enjoy little or no free time, which puts stress on families[62].

With respect to the fragmented administrative organisation, there are two publications by the OECD – one already published and one in preparation – that deserve attention. The first is the recently published OECD Economic Survey for Estonia[63], which 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.

Another – upcoming – OECD report[64] takes a much closer look at the issue of fragmentation to which we have made reference when discussing what is problematic in the long-term care system, and is expected to make concrete recommendations for improving the delivery of public services at all levels of government, taking the organisation of long-term care as a case-study. The recommendations there, when finalised, will surely help shape further debate.

2.4.5 Critical assessment of reforms, discussions and research carried out

Estonia puts much emphasis on home care and on helping people to live independently in their own homes for as long as possible, as the cheapest, most effective and most socially accepted option. All action and ideas connected to long-term care face the same direction, and represent a clear choice, fitting the Estonian societal context and the overall goal to provide better services utilising the same resources.

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

[61] Statistics Estonia, "Sotsiaaltrendid - Social Trends", 5, Tallinn, 2010 retrieved on 6 May 2011 at http://www.stat.ee/publication-download-pdf?publication_id=21171.

[62] SOO, K, LINNO, T, "Puuetega inimeste ja nende pereliikmete hoolduskoormuse uuring", Sotsiaalministeerium, Sotsiaalpoliitika info ja analüüsi osakond, 2009 retrieved on 6 May 2011 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 6 May 2011 at http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/VEU2009_FINAL2.pdf.

[63] OECD, "OECD Economic Surveys: Estonia 2011", OECD Publishing, April 2011, 91-99, retrieved on 6 May 2011 at http://www.oecd-ilibrary.org/economics/oecd-economic-surveys-estonia-2011_eco_surveys-est-2011-en.

[64] OECD Public Governance Review "Estonia – towards a single government approach"; expected to be published in June 2011.

However, such a policy is problematic, as it is difficult to reach comprehensive action due to a fragmentation of administrative competencies, service providers, organising capacity and financing possibilities. Measures in one corner of the system have effects in other corners, necessitating coordination and a wider agreement on unified policy[65].

To move forward, a clear and comprehensive direction is needed 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, these differences between stakeholder perspectives are 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 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 much 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.

In the mean while, the focus on home care risks diverting attention away from the immediate 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.

[65] 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.

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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

[R] Pensions

[R1] 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.

[R2] Ministry of Finance, Kohustusliku kogumispensioni kogemused finantskriisist, March 2010, Tallinn

"Experience of compulsory pension insurance from financial crisis"

A comprehensive statistical overview of the performance of the compulsory pension insurance scheme since 2002, including fund management, investment strategies, performance, behaviour of investors, comparison with other countries, etc. The analysis formed a basis for amendment of the Funded Pension Act in 2011.

[R1] Ministry of Finance, 2011. aasta kevadine majandusprognoos, April 2011, Tallinn/retrieved from: http://www.fin.ee/doc.php?107402

"2011 spring 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.

[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.

[R1] 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.

[R2] Seletuskiri riikliku pensionikindlustuse seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde, December 2009/ retrieved from: http://www.riigikogu.ee/?page=pub_file&op=emsplain&content_type=application/rtf&file_id=888057&file_name=Riikliku%20pensionikindlustuse%20seletuskiri%20(655).rtf&file_size=999436&mnsensk=652+SE&fd=

"The explanatory memorandum accompanying changes in the State Pension Insurance Act and other related acts"

Gives a short overview of possible impacts of the increase of the statutory pension age increase. It includes long-run trends of the demographics, fiscal position of the state pension scheme, replacement rates, policy simulations, etc.

[R2] Seletuskiri kogumispensionide seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde/retrieved from: http://www.riigikogu.ee/?page=eelnou&op=ems&emshelp=true&eid=1241326&u=20110513153951

"The explanatory memorandum accompanying changes in the Funded Pension Act and other related acts"

The explanatory memorandum and its annexes, prepared mainly by the Ministry of Finance, give a detailed analysis of the reasons behind changes in the Funded Pension Act approved in January 2011. A detailed statistical overview of the compulsory funded pension scheme is given in Annex 1 and of the voluntary pension scheme in Annex 2. Annex 3 provides a further analysis of possible impacts of planned changes.

[R5] Statistics Estonia, Vaesus Eestis. Poverty in Estonia, 2010, Tallinn/retrieved from: http://www.stat.ee/publication-download-pdf?publication_id=21168&publication_title=Vaesus+Eestis.+Poverty+in+Estonia&id=32392

In the publication the trends of poverty in Estonia's society since the regaining of the independence are analysed. The publication provides an overview on how the nature and the extent of poverty have changed in time and who are the impoverished people in the society. The generational poverty as well as permanent poverty is observed, also different patterns of poverty and the connections between material deprivation and poverty. The influence of current economic recession on poverty compared with the previous periods of economic recession is analysed. The poverty of immigrant population is observed separately, also the ways for reducing the poverty and the measures of social insurance and social welfare will be analysed. It includes statistics on elderly population.

[R1, R3, R4, R5] Statistics Estonia, Sotsiaaltrendid. Social Trends. 5, 2010, Tallinn/ retrieved from: http://www.stat.ee/publication-download-pdf?publication_id=21171

The publication is a collection of articles on social trends and population ageing. The collection provides a comprehensive overview of the reasons leading to population ageing, a longer-term effect of population ageing on the society and labour market. The collection also discusses the ability of the elderly to cope with working life, their material welfare, health and expenditure on social services, the activeness of older population and their social cohesion. The collection includes the following chapters: Population Ageing in Demographic View; Older People on the Labour Market; Material Welfare and Economic Coping Capacity of Older People; Social Welfare Services of Older People; Health of Older People; Cohesion of Older People.

[R1] 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.

[H] Health

[H1, H5] Eesti Haigekassa, Eesti Haigekassa majandusaasta aruanne 2009, 2010, Tallinn, 88p/retrieved from:
http://www.haigekassa.ee/uploads/userfiles/HK_majandusaasta_aruanne_2010(1).pdf

Annual report of the Estonian Health Insurance Fund for the year 2009.

[H] Estonia health system performance assessment. 2009 snapshot, WHO and Ministry of Social Affairs, 2010, Copenhagen, 131p/retrieved from:
http://www.euro.who.int/__data/assets/pdf_file/0015/115260/E93979.pdf

This report presents the main findings of an assessment of the performance of the Estonian Health System, carried out jointly by the WHO Regional Office for Europe and the Ministry of Social Affairs of Estonia in 2008 and 2009. This assessment was part of the biennial collaborative agreement between the Ministry of Social Affairs of Estonia and the Regional

Office. The initial objectives of this evaluation were to: present international evidence supporting the use of health system performance measurement for performance assessment and improvement; propose an initial set of performance indicators with related findings; and put forward ideas about how to strengthen accountability in order to stimulate performance improvement. According to the analysis, the main weaknesses of the health system include low disability-free life expectancy, gender and regional inequality and risk factors challenging recent progress in population 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.

[H] National Institute for Health Development, Health statistics in Estonia and Europe 2007, 2010, Tallinn/retrieved from:
http://www.rahvatervis.ut.ee/bitstream/1/1782/1/TerviseArenguInstituut2010.pdf

Collection of statistics on population dynamics, health status, morbidity, and utilisation of health care resources.

[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.

[H4, H5] National Audit Office of Estonia (Riigikontroll), Haiglavõrgu jätkusuutlikkus, 2010, Tallinn, 74p/retreived from:
http://www.rahvatervis.ut.ee/bitstream/1/1721/1/Riigikontroll2010.pdf

"Sustainability of the hospital network"

The National Audit Office of Estonia (NAO) audited whether the existing network of active treatment hospitals is optimal, sustainable and structured in line with the Estonian Hospital Network Development Plan of 2002. The NAO acted based on the presumption that the hospital network is optimal and sustainable if all hospitals have enough patients and qualified

medical staff as well as funds for improving the hospitals and buying medical equipment now and in the future. The audit finds that the active treatment hospital network set out in the hospital network development plan is too big and non-sustainable, because not all hospitals will have enough patients, qualified doctors or money for improvement of the hospitals in the future.

[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.

[H2] PERTEL, Tiia, KOPPEL, Agris, KALDA, Ruth, TÕEMETS, Tiina, VAASK, Sirje, VIILUP, Janika, Mapping the status of disease prevention and health promotion at primary health care level in Estonia, 2010, Tartu, 74p/retrieved from:
http://www.rahvatervis.ut.ee/bitstream/1/1781/1/Perteljt2010.pdf

The study was initiated to identify the needs of primary health care (PHC) professionals such as family doctors, family nurses, school nurses and occupational health doctors in their routine work in disease prevention and health promotion, and the possibilities to strengthen their role in preventing non-communicable diseases. The results show the level of readiness of the PHC professionals to practise health promotion and disease prevention in the current settings. The study also determined aspects that could be improved to enhance disease prevention at the PHC level in Estonia. A number of recommendations have been made as an outcome of the study.

[H2] REILE, Rainer, MARKINA, Anna, Healthy inclusion. Migrants' perspectives on participation in health promotion in Estonia, 2010, Tartu, 61p/retreived from:
http://www.rahvatervis.ut.ee/bitstream/1/1842/1/Reilejt2010.pdf

"Healthy Inclusion" is an international project carried out within the Public Health Programme 2003-2008 and co-funded by the European Commission, DG Health and Consumers, Public Health (EAHC). This report is an Estonian country analysis. This report provides the perspectives of migrants on their perception of health, health status and attitudes towards health promotion, on explored barriers and supporting factors when accessing health promotion interventions. It includes analysis of the interviews with migrants from selected countries with and without access.

[H1, H3, H4, H5, H6] 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", World Health Organisation, 2010, Tallinn,

150p/retreived from:
http://www.euro.who.int/__data/assets/pdf_file/0003/107877/E93542.pdf

Comprehensive review of the Estonian health care sector with the focus on the sustainability of health care financing. The report includes analysis of the strengths and weaknesses of the current financing system, analysis of stakeholders' views, revenue and expenditure forecasts until 2030, analysis how to improve efficiency in the health care provision, and options to change financing policy. The report concludes that the public revenue base for the health sector should be broadened to ensure that the health system is better able to achieve its objectives now and in the longer term. It also finds that health financing policy can be further strengthened to manage cost pressures better and improve performance.

[H1] VÕRK, Andres, HABICHT, Jarno, XU, Ke and KUTZIN, Joseph, Income-related inequality in health care financing and utilisation in Estonia since 2000, WHO Health Financing Policy Paper 2010/3, 23p/retrieved from:
http://www.euro.who.int/__data/assets/pdf_file/0007/118276/E94130.pdf

This paper summarises recent research on income-related inequalities in health care financing and utilisation in Estonia for the period 2000 to 2007. Quantitative analysis is used to analyse evidence for a number of priority policy issues. Considering prefinancing and out-of-pocket payments (OOPs) together, overall health care financing is mildly progressive. During the period studied about 3% of households (about 15 000) dropped below the national absolute poverty line after making OOPs. The number dropped from 3.7% in 2000 to 2.1% in 2007 due to wages and especially old-age pensions rising faster than the cost of living. For those services more dependent on OOPs, such as outpatient drugs and dental care, there are either more inequalities in utilisation or households face higher risk of impoverishment. Thus the patterns of equity in both the finance and use of services are closely linked to the structure of the EHIF benefit package. Two recommendations are made, first to revise the structure of prescription drug co-payments in order to ensure affordable access, in particular for pensioners, and secondly to improve financial access to adult dental care whilst concurrently maintaining the good protection that exists for other services, such as primary care, inpatient care and emergency care.

[L] Long-term care

[L] KREITZBERG, Mari, MÄE, Ülla, REINOMÄGI, Social protection as a means to alleviate poverty in Estonia, in "Vaesus Eestis – Poverty in Estonia", Statistics Estonia, 2010, Tallinn, 172-197/retrieved from: http://www.stat.ee/publication-download-pdf?publication_id=21168&publication_title=Vaesus+Eestis.+Poverty+in+Estonia&id=32392

The full publication, compiled for the 2010 European Year for Combating Poverty and Social Exclusion, looks at poverty in all its aspects in Estonia. The chapter to which is referred probes the influence of the social security system on poverty and inclusion. It links different provisions together, including services in the field of long-term-care, and offers a view of the practice behind the regulation.

[L] LINNO, Tiina, Coping of Disabled Adults and Care Load Arising from Disability, Policy Analysis (series of the Ministry of Social Affairs), no. 7/2010, 2010, Tallinn, 30 p/retrieved from:
http://www.sm.ee/fileadmin/meedia/Dokumendid/V2ljaanded/Toimetised/2010/series_20107eng.pdf

This article summarises the results of a survey on disabled persons and the care load of their family members, performed by the Ministry of Social Affairs in 2009. Persons with disabilities are also clients of the long-term care system.

Selected figures reveal that the proportion of persons with an officially determined degree of disability in 2009 comprised 8.9% of the total population of Estonia, with the largest proportion over the age of 50. Nearly half (46%) of all adults with disabilities claim that they are financially dependent on some other person. Among the adults with profound disability, the proportion depending financially on some other person exceeds half (56%) and among the age group of 16–29, the proportion is nearly three-quarters (73%). 36% of the adults with disabilities live alone, i.e. they do not have any household members who could give them personal assistance in case of need. 59% of the main caregivers are also the only caregivers of their adult family members with disability, 41% of the caregivers share their care load with someone. 37% of the caregivers of adults with disabilities would need additional assistance for care, while 11% of them would need it to a considerable extent.

[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, 2011, 418p (advanced copy; under publication)

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.

To be published in summer 2011.

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 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.

Klaster uuringukeskus – Klaster Research Center

Address: Kompanii 10, Tartu 51007
Webpage: http://www.klaster.ee

Private research company conducting both qualitative and quantitative studies in the areas of organisation analysis, market analysis (incl. public opinion polls) and media analysis. In 2005-2008, Klaster conducted annual studies (commissioned by the Health Insurance Fund) to analyse satisfaction of employers and contractual partners of the Health Insurance Fund with administrative practices of the Fund.

Poliitikauuringute Keskus PRAXIS – PRAXIS Center for Policy Studies

Address: Estonia avenue 5a, Tallinn 10143
Webpage: http://www.praxis.ee/

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 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.

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(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