Annual National Report 2010

Pensions, Health and Long-term Care

Estonia

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1 Executive Summary

The economic crisis is felt hard in Estonia, with a decline in real GDP by 3.6% in 2008 and 14.1% in 2009. The employment rate has dropped from its peak 63% in 2008 to 56% by the end of 2009 (in the age group 15-74) and unemployment rate has reached 15.5% in the fourth quarter of 2009. The nominal wages have declined about 5% in 2009. This has resulted in a decline in social tax revenues, the main source for pensions and health care, about 10% in 2009. Both the economic crisis and the Government's concurrent aim of keeping the public deficit within the limit of 3% of GDP in order to join the Euro area have affected the whole public sector, including the pension, health care and long-term care system.

In 2009 and 2010, the following major steps were taken to balance expenditure and revenue of the pension system and protect pensioners. Contributions to the mandatory funded pillar were temporarily suspended from 1 June 2009 until 31 December 2010. This means that there are more social tax revenues for the current state pensions in the short run. In 2009, pensions increased by 5%, less than were stipulated by the indexation rules, but still improving the relative situation of the pensioners compared to other socio-economic groups. In 2010, the pensions remained unchanged. Only some special pensions that depend on earnings in certain occupations, for example in the case of judges, prosecutors, police officers, etc., have experienced a decline. The protection of current pensioners has been achieved by postponing the pension reform transition costs to later years (2014-2017), when additional contributions to the funded system need to be collected.

The economic crisis has also acted as a catalyst for some long-term reforms. In April 2010, the general retirement age was set to increase from 63 to 65 years by 2026. Also, gradual abolishment or amendment of the rules for special pension rights was debated heavily in 2010. The financial crisis and mismanagement of some pension funds resulted in the Financial Supervision Authority issuing stricter rules to investment and pension funds to manage risks and to report on their activities.

Built on sound foundations, the overall health care system has not been heavily impacted by the current economic malaise. However, the limits of the corrective measures which can be taken, and the restraints of the narrow contribution base on which the system rests today, have clarified the key issues of the debate concerning financial sustainability. Policies to increase the role of the primary health care level and to add to the services offered at that level have been continued throughout 2009.

The long-term care system, a mix of health care and welfare services, faces the combined problems of the health care system and the decline in general budget revenues. The choices made here will have to provide for fair and personalised solutions which fit the structures and traditions of Estonian society. More specifically, integration of the services on offer, and of the involvement of state and family, is being sought.

The global economic turmoil is no less disruptive in Estonia as it is in other countries of the European Union. The measures taken thus far, while important, however are not perceived as shocking or revolutionary, and have thus not been responded to with societal upheaval. Though many of the initiatives are pure cost-cutting efforts, many follow the logic of a long-present evolution. For those, the current crisis acts more as a catalyser than a game-changer.

The economic and financial situation however also reveals the boundaries of the pension, health care and long-term care systems, insofar as subsequent measures will almost necessarily have to question current conceptions of desirability, finality and equity. Upcoming general elections in 2011 and a generally positive economic outlook will probably delay further change; the beacons for discussion and further reform have nevertheless been set.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the previous Year

2.1 Pensions

2.1.1 Overview of the system's characteristics and reforms

The Estonian pension system comprises 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 comprises of 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.

In 2010, the statutory pension age was 63 years for men and 61 years for women. For women, it will increase to 63 by 2016, and as from 2017 retirement age will gradually increase both for men and women to 65 by 2026.

As of 1 January 2010, the total number of pension recipients was 389 thousand persons (28.8% of population); out of them 292 thousand persons received old-age pension, 77 thousand incapacity-to-work pensions (disability pensions); 11 thousand were recipients of survivor's pensions, and about 6 thousand received national pensions. Only working age persons (from 16 to pension age) are eligible for disability pensions.

Old-age pensions comprise of three components: the flat-rate base amount, the pensionable length-of-service component (covering periods up to 1998) and the insurance component (covering periods from 1999 onwards). The old-age pension is redistributive through the flat rate base amount, which in January 2010 comprised about 38% of the average old-age pension. Also, the length-of-service component is strongly redistributive, but this takes into account only employment periods up to 1998. 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.

Pensions are indexed annually, on 1 April. The index is a weighted average of past consumer price index and past growth of social tax revenues to the pension insurance system with weights 0.2 and 0.8 respectively. As Estonia had a very high inflation and wage growth in 2008, the index should have been 1.138 (13.8%) in 2009. But due to the threatening economic crisis some ad hoc adjustments were made to the indexation rule, and in 2009, the actual index was only 1.05 (5% increase). The difference of 8.8% has to be compensated in the next years. In 2010, both components of the pension index were already lower than 1. The index of social tax revenues was 0.887, and the annual consumer price index was 0.999 in 2009, resulting in a weighted average index of 0.909, or a 9.1% reduction in pensions. According to the legislation, pensions cannot be reduced and therefore remained unchanged in 2010. This also means that there is no compensation left from 2009, as this non-reduction of pensions by 9.1% in 2010 is already higher (by 0.3%) than the 8.8% part that the Government had to compensate for from 2009.

In January 2010, the average gross old-age pension reached EEK 4,715 (EUR 301), an increase by 8% compared to the average old-age pension at the beginning of 2009, which was EEK 4,356 (EUR 278).

The flat rate national pension, which serves at the same time as a minimum pension guarantee, amounted to EEK 2,008.8 (EUR 128) after indexation in April 2009 and also did not change in 2010. Recipients of the national pension on grounds of age constitute less than 1% of all pensioners receiving an old-age pension.

All pensions are liable to 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 in 2009 (after indexation in April) comprised about 38% of the average gross wage. The average net replacement rate is about 41-44% depending whether the pensioner is at the same time working or not. Since the average wage level is predicted to decline in 2010 and 2011, the net replacement rate will approach 50% in the coming years.

The pay-as-you-go state pension insurance scheme is supplemented by a mandatory funded defined-contribution scheme, which was introduced in 2002. In 2009, first pay-outs started. Participation in the scheme is mandatory for cohorts born in 1983 or later, whereas cohorts born 1982-1942 had the option to join the scheme voluntarily. The funded scheme is run by private fund entities. The total contribution to the funded scheme comprises 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 diverted contributions to the funded scheme imply reduced revenues for state pensions.

Although joining the second pillar was voluntary 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 2009, the scheme covered about 70% of the population aged 18 to 63. From 1 January 2009, persons who joined the funded scheme in 2002 and had meanwhile reached pension age are entitled to withdraw benefits. As in most cases, the accumulated assets are rather small, the benefits are paid out in the form of lump sum payments. However, in the longer term, annuities will be the main form of benefits from the funded scheme.

Expenditures on state pensions amounted to EEK 19.5 billion or 9% of GDP in 2009. That is the highest in past ten years, as GDP dropped and pension expenditures increased. The total revenues from the pension insurance component of social tax (20% of gross earnings) amounted to EEK 16.8 billion in 2010. However, EEK 1.2 billion of social tax revenues were redirected to individual accounts of participants of the funded scheme during the first half of 2009. As a result, of the total expenditures on state pensions EEK 16.8 billion were financed from current social tax revenues, EEK 0.32 billion from social tax reserves from previous years; an additional direct contribution from the state budget for special pensions amounted to EEK 0.62 billion, and the remaining part (EEK 2.9 billion) was financed through state reserves from previous years.

By the end of 2009, the total value of assets in the compulsory funded scheme amounted to EEK 14.8 billion. This was EEK 3.4 billion more than a year earlier, while the total contributions made to the funded scheme in 2009 amounted to EEK 1.8 billion (EEK 0.6 billion of individual contributions plus EEK 1.2 billion of contributions redirected from social tax).

The EPI index, which reflects the weighted average of the net rate of return of all mandatory pension funds, increased by 14.8% in 2009 (in 2008 it dropped by 24%). The index for the conservative funds increased by 9.04% and for the most aggressive funds by 17.1%.

The voluntary funded pension system plays a minor role in Estonia. It had about 53 thousand contributors with assets of about EEK 1.1 billion in 2009. In addition, there were about 71 thousand contracts in the form of life insurances.

2.1.2 Overview of the main reforms, debates and political discourse

The funded pension scheme

The main short-term policy reaction to the deficit in the state pension scheme was the **suspension of 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. 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 later) could, upon submitting a relevant claim, resume individual contributions (2%) from 1 January 2010, in which case also state contributions on account of social tax (4%) are transferred. Other age groups may also continue to pay individual contributions (2%) from 1 January 2010, however, without contributions from social tax being transferred. For any other contributors to the funded scheme (i.e. persons not opting for voluntary continuation of individual contributions), contributions to the funded scheme will be gradually resumed from 2011, when a 1% + 2% scheme will be applied, reverting to the full amount of 2% + 4% in 2012.

Table 1: Contributions to the mandatory funded pension scheme 2009-2017.

	Born 1942-1954		Born 1955 - ...	
Person's decision on individual contributions Year	Continue	Suspend	Continue	Suspend
2009 - 1st half	2%+4%			
2009 - 2nd half	0+0			
2010	2%+4%	0%+0%	2%+0%	0%+0%
2011	2%+4%	1%+2%	2%+2%	1%+2%
2012-2013	2+4			
2014-2017	2%+4%	2%+4%	2%+6%	2%+4%
2014-2017* (optional)	-	3%+6%		

Note: The first number refers to individual contributions and the second number refers to state transfers from social tax. In the period 2014-2017 people may opt for a 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 they continue their individual contributions in 2010. The default option was suspension of the contributions. About 220 thousand persons decided to continue their contributions, which is about 37% of all people who have joined the second pillar. People with riskier funds (aggressive and progressive strategy) and people in smaller pension funds had higher propensity to continue their contributions. In spring 2009, the Ministry of Finance projected that this will be around one quarter, due to the negative public attitude towards the funded pension system in 2008, as many pension funds (in particular the funds with high equity exposure) have had high losses and fund managers have been accused of not behaving in the interests of pension fund members.

Since 2010 many more people than in earlier years, 60,770 people, changed their funds, either by changing all pension fund units or only redirecting new contributions to a new fund.[1] 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.

There were several smaller changes influencing the funded pension scheme. An amendment to the Funded Pensions Act passed in October 2008 **increased the equity investment limit** of so-called progressive (higher risk) pension funds from 50 to 75%. This was based on considerations that in the longer term, higher investment in equities reveals higher yield, and also on the belief in prudent asset management by fund managers. Three fund managers (SEB, Swedbank, Nordea) used the possibility and opened three new funds with aggressive strategies. Since January 2010, people can choose between 22 pension funds managed by six fund managers.

Another amendment introduced **stricter regulation of the administrative fees** of the pension fund in October 2008. The pension fund entry fee, which is charged each time when new pension fund units are issued, is to be abolished from 2011. An upper limit was established on the pension fund management fee – 2% of the net asset value of the pension fund (1.2% in case of conservative pension funds). These changes were expected to increase the transparency of the administrative fee schemes, as regular pension fund participants have often difficulties to compare the total net effect of different fees. Actually all funds abolished the entry fee and all management fees have dropped below 2% since 1 January 2010. This was a result of tougher competition between funds at the time of falling markets.

In 2009, the Estonian Financial Supervision Authority made several **investigations** into the management of funded pension schemes. In several cases they concluded that the fund managers had given preference to their bank's (and owners') capital. Although the details of the investigations were not published in each case, the fund managers were made to compensate the losses of their pension fund investors. For example, at the beginning of 2009 the Authority started to investigate a possible conflict of interest in the case of bonds emitted by the company TR Majad and carried out by the SEB bank. As a result of the investigation the SEB bank agreed to compensate EEK 177 million in December 2009. Various pension funds, mainly managed by Swedbank and SEB itself, received a major share of it – EEK 160 million. In another case, Swedbank Investeerimisfondid compensated for the decline in value (which emerged the third quarter 2009) of their Private Debt Fund shares, which lost 21.19% of their value in one day. This amounted to more than EEK 100 million. The Swedbank's pension funds held about 3%-5% of their assets in the Private Debt Fund. Again, the bank was forced to partly compensate for the losses to the pension funds.[2]

Partly as a result of these cases the Financial Supervision Authority issued **stricter rules** to investment and pension funds to manage risks (since 15 February 2010) and to report on their activities (since 15 November 2009).[3]

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1 "60 770 inimest otsustas vahetada pensionifondi", Press release by the Pensionikeskus, 3 November 2009 http://www.pensionikeskus.ee/?id=3188&year=2009.

2 "Swed tasub PDFi osaku väärtuse vahe 7. detsembril", Äripäev, referred via the Pensionikeskus, 25 November 2009, http://www.pensionikeskus.ee/?id=3207&year=2009.

3 "Nõuded fondi vara investeerimisega seotud riskide juhtimisele" and "Riskide kajastamine investeerimisfondi prospektis" "Finantsinspektsioon kehtestas investeerimis- ja pensionifonidele rangemad riskide juhtimise ja avalikustamise nõuded", Press release by the the Financial Supervision Authority, http://www.fi.ee/?id=3595.

The Ministry of Finance made a **comprehensive analytical study** on the performance of the compulsory and voluntary pension scheme in 2010. Unfortunately it was not available publicly at the time of writing this overview. Based on the study various amendments to improve the schemes have been discussed with major market participants. It has been claimed that the study proposes that investors could change their funds more often, up to four times a year (currently only once a year is allowed), and it also proposes stricter rules to fund management.[4]

The state pension scheme

Pension index change

On 1 March 2009, pension legislation changed, giving the Government the right to implement a lower pension index than stipulated by the pension index formula if the forecasted GDP growth were negative or if the predicted deficit in the state pension scheme were more than 1% of the predicted GDP.

As a result, pensions were increased only by 5% in April 2009, although the formula yielded 13.8% (0.2 times CPI increase 10.8% + 0.8 times social tax revenue growth 14.7%). The unused part, 8.8% in 2009, was supposed to be offset over the next five years. Actually it was offset already in 2010 when the pension index formula yielded -9.1%, but because pensions could not legally be reduced they remained unchanged until 1 April 2010.

In 2009, the organisations representing pensioners' interests disapproved of the reduction of the pension growth rate from 14% to 5%. However, many macroeconomists demanded that pensions be frozen, or even decreased to maintain the fiscal balance in the state pension system and the overall public finance position. In the light of declining wages (-4.6% in 2009 compared to 2008) and prices (-0.1% in 2009 compared to 2008), along with increasing unemployment rates up to 14%, the 5% increase in pensions, although smaller than expected, still improved the relative socio-economic position of pensioners in the society.

Pension age increase

In addition to the suspension of contributions to the funded pension scheme discussed above, which considerably improved the short-run fiscal position of the state pension scheme, the main measure influencing the long-term fiscal position of the state pension scheme was the increase of the statutory pension age.

On 7 April 2010, the Parliament approved, after emotional debates that extended to overnight sessions, an increase of the statutory pension age. The pension age is currently 63 for men and will reach 63 for women by 2016. The amendment of the law increases it further to 65 by 2026 for both sexes.

The discussion about the pensionable age had started already in 2008 and was partly covered in the previous revised version of the asisp Estonian Annual Report 2009 (see section 2.1.3 Public and political discourse in 2008).

The overall process of the 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 already on 17 December and sent it to the Parliament. It was discussed in the Social Committee of the Parliament on 8 February and sent with a 6:5 vote to the Parliament for adoption. The second reading took place on

[4] "Pensionifondi saab tulevikus vahetada kuni neli korda aastas", E24, referred via the Pensionikeskus, 19 February 2010, http://www.pensionikeskus.ee/?id=3238.

17 February 2010, and despite heavy criticism by opposition parties and trade unions it was sent to the third reading and approved on 7 April 2010.

Opposition parties, trade unions and a number of social policy experts proposed that there were other more important issues in the Estonian pension policy that need to be tackled before increasing the pensionable age, for example, implementation of the insurance against accidents at work and occupational diseases, or the reform of special pensions rights which had been on the Government agenda already for several years but never finalised. Trade unions emphasise that the increase in the pension age also requires comprehensive policy how to improve and maintain the productivity of elderly.[5] It was also argued by the opposition parties that the Government should focus their efforts on reducing unemployment and increasing low life expectancy.

The new legislation stipulates that pension age starts increasing in 2017, when the retirement age of men and women will have equalised at 63. The pension age will increase gradually by three-month steps, reaching 65 by 2026. For those younger than 50 in 2010, the retirement age will be 65; for 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.

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

The amendment of state pension insurance legislation also introduced an obligation for government to analyse the impact of the increase in the statutory pension age on the financial and social sustainability by 2019 and, if necessary, government will then propose a new pension age or flexible retirement age.

Another topic that has been heavily discussed in 2009 and 2010 was the reform of the **special pension rights** (e.g. pensions for police or military staff, judges, etc.). On 4 November 2009 the Government announced that they would reform special pensions so that eventually only the special pension for presidents would remain. Special pensions were to remain also for those who already received such pensions or who have fulfilled certain qualifying conditions. Also, special pensions will be indexed similar to old-age pensions in the future. Currently, they depend on the salary level of relevant occupations.

[5] Estonian Trade Union Confederation. “Pensioniea tõstmine eeldab tervislikku töökeskkonda”, Press Release. 18 December 2009. http://www.eakl.ee/?pid=75&lang=5&nid=78.

By April 2010, several proposals had been discussed by the Government and some of them were also made public, but no concrete agreements have been reached so far.

Changing pension payment rules

As from 1 February 2009, pension payment rules and procedures were changed. Previously, pensions could be paid out either to a bank account or through post offices, including home delivery, at the choice of the pensioner. From February 2009, as a rule, pensions are transferred to a bank account. Delivery at home is available at the expense of the pensioner; such costs are covered by the state only in case of severely disabled work incapacity pensioners or old-age pensioner with mobility impairment, living in remote rural areas with no access to banking services. It is estimated that abolishing general delivery at home or to post offices saved about EEK 26 million in 2009. While in January 2009 about 111 thousand pensioners (about one third of all pensioners) received their pensions at home or from a post office at the expense of the state, in December 2009 only about 14 thousand exercised this option, and about 16 thousand pensioners received pensions at home or from a post office at their own expense. The remaining 81 thousand pensioners had switched to the use of bank accounts.[6] The implementation of the reform caused some problems in 2009, eventually contributing to the resignation of the Minister of Social Affairs, but from hindsight the overall reform is considered as justified. In January, the Vice Chancellor of the Ministry promised that a deeper analysis of the new system would be carried out in 2010.

Another issue that was debated was whether the pension age or pension size should be **dependent on children**. The Parliament's Social Commission discussed it on 9 November 2009, when Professor Lauri Leppik presented the results of the 2006 study by the Praxis Centre for Policy Studies which investigated policy options on how to make pension more dependent on the number of children raised. The Social Commission has entrusted the Ministry of Social Affairs with working out concrete proposals.[7]

2.1.3 Impact assessment

Both major changes – the suspension of contributions to the funded pension scheme, and the increase of the pensionable age – have been accompanied by impact assessments by the Ministry of Finance.

The formal impact assessment of the pension age increase[8] stated that there were two main interrelated reasons behind the increase of the pension age:

1) declining number of working-age people and deterioration of old-age dependency rates
2) increasing number of pensioners and inability to save average replacement rates from declining

6 "Riik hoidis pensionide kojukande lõpetamisega kokku 26 miljonit", Postimees 3 January 2010, referred via http://www.pensionikeskus.ee/?id=3220.

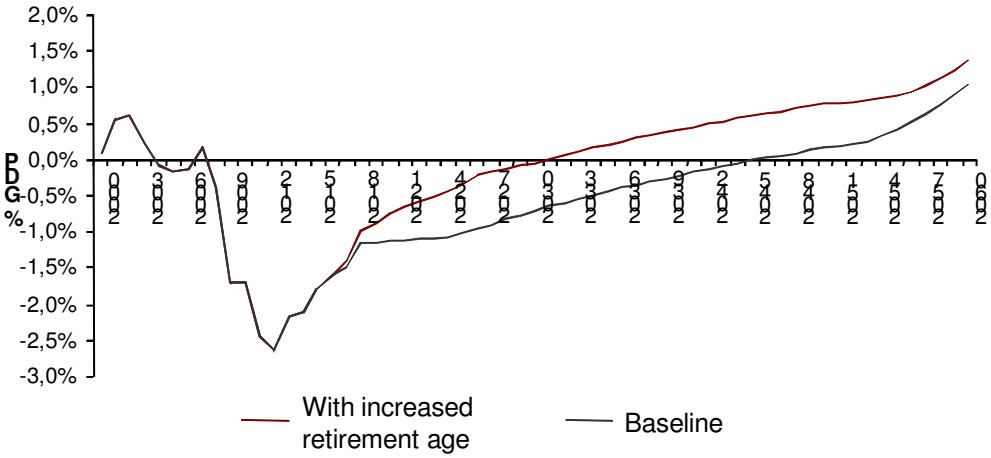
7 "Komisjon: pensionide maksmisel võiks arvestada laste arvu", 9 November 2009, http://uudised.err.ee/index.php?06184040.

8 "Seletuskiri riikliku pensionikindlustuse seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde" 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=.

When fully implemented, the increase of the pension age will influence about 30 thousand persons annually (i.e. two cohorts) starting from 2027.

Figure 1 below shows that the pension increase in 2009 has caused the annual deficit of the state pension scheme to reach about 2.5% of GDP by 2012, and the Ministry of Finance predicted that the annual deficit could persist until 2040 or even longer. The increase of the retirement age would lower the annual deficit by about 0.6% in 2026 (or by about 5%-10% of pension expenditure). The impact assessment also hopes for an additional 15 - 20 thousand employed people.

Figure 1: Impact of the pension age increase on the annual deficit of the state pension scheme.



Source: Ministry of Finance (2009).

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 currently 50% to about 35% by 2050, despite the increasing share of funded pensions. The increase of the retirement age will step up the average replacement rate by 2-2.5 percentage points in the long-run.

There are not many independent impact assessments available. Võrk (2009a)[9] 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,
- 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 the retirement age has raised employment rates by about 20 percentage points for men and by 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

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

elderly by about 25 thousand people, but also increase the number of disability pensioners by 6 thousand, and the number of early retirement pensions by 2000.[10]

The temporary suspension of the contributions to the funded pension scheme in 2009 and 2010 has been predicted to lower the average replacement rate only marginally. Firstly, the period of suspension is short. Secondly, partly it is compensated by higher pensions from the state pension scheme. The Ministry of Finance projected 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.[11]

2.1.4 Critical assessment of reforms, discussions and research carried out

The short-run changes in the pension system experienced in 2009 were a direct result of the economic crisis, and the Government's concurrent aim of keeping the public deficit within the limit of 3% of GDP in order to join the Euro area.

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 choice. Without that even larger transfers from the general budget would have been necessary, but this would have been impossible without further tax increases. To avoid a decline in the mandatory funded pensions in the future, a compensation mechanism was proposed for the period 2014-2017. That 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 be made.

The overall short-run result is that despite the crisis the old-age pensions, disability pensions, and survivor's pensions have increased, both in nominal and real terms. Compared to other socio-economic groups current pensioners are relatively well protected. Only some special pensions that depend on earnings levels in certain occupations, for example in the case of judges, prosecutors, police officers, etc., have experienced a decline, but these pensions are considerably higher than average anyway.

The economic crisis and drop in social tax revenues has clearly acted as a catalyst for some long-term reforms that influence the pension system. In addition to the pension age increase that was approved in April 2010, also the discussion on a flexible retirement age, the abolishment of special pension rights, and the introduction of occupational pensions require labour market policies to be geared towards elderly in Estonia.

The main criticism with respect to the pension age increase has been the speed at which the process was implemented. The opposition parties and various other stakeholders have complained that not all the effects of the pension age increase or alternative options were discussed thoroughly. The Government's urgency can be explained partly again in the light of the Euro process, i.e. in the run-up to the evaluation of the Estonian fiscal position and sustainability in May 2010.[12] Thus, the reforms were to show that measures have been taken to tackle the position of the state pension scheme in the long run.

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[10] Võrk, A. (2009) Kuhu sprindid, pensioniiga? (Where are you sprinting, pension age?) Eesti Päevaleht, 15 September 2009.

[11] Ministry of Finance (2009) "II samba peatamise briifing.ppt", http://www.fin.ee/doc.php?82123.

[12] On 12 May 2010, the European Commission adopted the Convergence Report on Estonia's Euro readiness; the final decision will be taken in July 2010; retrieved on 14 May 2010 from:

2.2 Health

2.2.1 System characteristics and reforms

Health care in Estonia is provided through a system of national health services 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[13]) or by the State (parents on parental leave, persons taking care of disabled persons, non-active parents raising three or more children under 19 years of age with one child aged under eight years, conscripts, and registered job seekers, whether they receive unemployment benefit or not).[14] The latter group makes up 3% of the total of insured persons.

A further group, which amounts to 45% 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. 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% of the population included. The remainder is comprised of unemployed persons not registered as job-seekers, 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, compensation for dental care, and supplementary compensations for pharmaceuticals).[15]

http://ec.europa.eu/economy_finance/articles/eu_economic_situation/2010-05-12-convergence_report_2010_en.htm.

[13] Social taxes are set at 33%. 13% are earmarked for health insurance, while 20% go 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.

[14] 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.

[15] For a detailed overview of the services provided, see the Estonian National Report on Strategies for Social Protection and Social Inclusion 2006-2008, accessible via http://ec.europa.eu/employment_social/spsi/strategy_reports_en.htm.

Health care services in kind are provided free of charge to the citizens irrespective of the amount of contributions paid. Co-payments are required only for some services,[16] for home calls made by family doctors and for outpatient specialised care. The fees are, however, limited[17] and constitute no real impediment. Private hospitals are also available in Estonia, requiring a higher contribution from the patient.

Modern reform[18] 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.[19] Also amongst these core ideas was the development of primary health care that would act as a gatekeeper, as opposed to the role of a mere referral point to specialised care as under the Soviet system.[20.]

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.[21]

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

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16 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.

17 Fees for doctors and specialist are capped at EEK 50 (EUR 3.20); co-payment for hospital stay is capped at EEK 25 (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.

18 For an encompassing review 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).

19 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.

20 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 1,200 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.

21 The latter is enacted through the 2001 Health Services Organisation Act, and the 2002 Health Insurance Act.

sharing, while at the same time protecting patients' rights. The results of tests made by one health care provider, for example, will thus be available to another health care provider who treats the same patient. 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 in 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 is being fine-tuned, doing away with the need of prescription slips and the paper administration it entails.[22]

Already in 2007, an important step to increase the coverage rate was implemented, as now also jobseekers who do not receive unemployment benefits or jobseekers' allowances are insured – an initiative which will under current circumstances surely have become even more significant.[23] Furthermore, a measure to increase the number of insured persons is found in the decision to ease the requirements for pregnant women to be covered by the health insurance system. 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).

Finally, from 1 January 2009 onwards, artificial insemination is now provided almost completely free of charge. Following the coalition agreement, the state budget now covers most of the part that previously had to be covered by the individuals concerned.

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.

2.2.2 Overview of debates and the political discourse

The beginning of 2009 saw the ministerial approval of a Primary Health Care Development Plan, which will shape policy for the period 2009 to 2015. The plan aims to increase the role of the primary health care level, and to add to the services offered at that level. It starts from the premises that, even if the family doctor network at present is of sufficient quality and affordable, the services offered as such lack diversity, and accessibility is imperfect.

Concerning physical accessibility, it is observed that many family doctors' practices at present are solo undertakings, which by nature makes access difficult outside normal operating hours. The existence of a telephone help line[24] alleviates the problem somewhat, but cannot compensate for the fact that there is no network of primary care services at the level of family doctors available in the evenings and during the weekends or holidays, or when one is not near the practice of the family doctor one is registered with. These factors have lead to an

[22] For an overview of these projects, see http://eng.e-tervis.ee/.

[23] 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.

[24] The 1,220 family physician consultation line is a round-the-clock call centre operation where individuals can get advice on medical issues. The help line is popular and well received, as the advice is offered by family doctors who take the calls and is available when the normal family doctor cannot be reached. Answering some 10 thousand calls monthly, the help line has aided to reduce unnecessary emergency interventions.

overconsumption of emergency services[25] as the only medical service to turn to in those circumstances.

In addition to this problem, access to services other than family doctor services is also problematic. Some of these services are now offered through the network of hospitals or specialised institutions, but could just as well be offered through the family doctor network. Meant here are mostly (medical) nursing care, care for pregnant women, and physiotherapy. Nursing care and physiotherapy are less often found in remote areas, and are mostly on offer in bigger health care centres at the county level.

The Primary Health Care Development Plan seeks to alleviate these problems by stimulating the emergence of primary health care centres, where the range of services can be wider, qualified staff can be concentrated, and investment capacity can be pooled. A primary health care centre can then provide primary health care services within a common infrastructure, and be responsible for providing services within a determined territory, making them more available in dispersed settlement patterns. The plan calls for voluntary cooperation between health care providers, through contracting or through setting up joint ventures. The team members may, but are not required to, form a legal entity.

In essence, the emergence of primary health care centres, offering an extended package of health care, can greatly enhance access of health care services outside the cities.

In addition, attention is given to the availability of dispensing chemists. Currently, chemists are in reach within 30 kilometres of travel, but many are seen to be closing, posing a challenge for the future. Revaluating their role as first-hand advisors and integrating them in a primary health care centre setup may help accessibility.

Two elements of the Primary Health Care Development Plan have so far been implemented:

A law enacted in June and taking effect from April 2010 allows midwives to work independently, reducing the take-up of specialist care for routine check-ups and reducing waiting lists.[26] Before this change, midwives could only work in conjunction with gynaecologists. Now, they are allowed to offer services independently, including the prescription of some medication but excluding the competency to act alone during birth.

Furthermore, since January 2010, the definition of a family nurse is now added to the Health Services Organisation Act.[27] The changes result 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, who then has more time to spend on patients who really need to see the 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.

Nurses connected to family doctors are at present not allowed to prescribe medication, but this is under discussion. 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.

Attention also goes to the increase of the coverage rate of the health insurance system. A concept was worked out which should lead to a virtually complete coverage of the population,

[25] 69% of calls made to the ambulance service are of low priority. During the weekend, as much as one third of the total volume of calls is received.

[26] 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).

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

with adaptations in two phases: to give uninsured persons access to primary care and some pharmaceuticals, and later, also to specialist care. This plan has, however, been halted for budgetary reasons. It should be noted that, while the state covers the emergency care given to uninsured persons, access to non-emergency primary health care is in practice given through action from local governments in various ways. However, there is no legal obligation for local governments to provide this assistance.

The debate further focuses on the financing and long-term sustainability of the system. As follows from the description of the system given earlier, some 45% of the insured persons receive health care without paying contributions. This 45% share includes those who receive a state pension; a group projected to grow significantly in the following years, as is the case throughout Europe. More recipients of health care with a higher need, whilst not paying into the system, create a structural imbalance between revenues and expenditures. Where previously no updated projections were available, a recent report, presented by the World Health Organisation (see 2.2.3), constitutes a basis for further discussion.

2.2.3 Overview of published impact assessments

The Estonian Health Insurance Fund commissions regular surveys on the satisfaction level of both employers and contracted health care providers with the services of the fund.

In March 2010, an important report on the financial sustainability of the health care system was presented by the Estonian regional office of the WHO.[28] In this report, projections on increasing costs are coupled with observations concerning the strengths and weaknesses of the current system. The recommendations in the report are formulated taking into account the goals and values of the health system, support by the stakeholders in the system (who were consulted in 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 revnue 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.

2.2.4 Critical assessment of reforms, discussions and carried out research

The impact of the financial and economic crisis on the health care system is described in detail in Chapter 3 of this report. Some changes in the system that are either made because of the financial situation or with this situation as a convenient explanation are better discussed here. Three evolutions draw attention.

[28] 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 (http://www.euro.who.int/document/E93542.pdf). The report was commissioned by the Estonian Ministry of Social Affairs and prepared by the Estonian National Health Insurance Fund.

In February 2009, the Parliament adopted amendments to 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 the day 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, 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%.[29]

It is difficult to assess the impact of this measure. The cost for sickness cash benefits (EEK 2.4 billion in 2008) decreased in 2009 (to EEK 2.2 billion), but this decrease is 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) had already dropped by 17% compared to 2008. Some researchers interviewed for this report voice the suspicion that people more often go to work while sick, but this statement is as of yet not substantiated by objective data.

This leads to a second point of attention, which is the overall level of out-of-pocket payments, calculated to stand at 20% in 2008 (2007: 22%; 2006: 25.6%).[30] The main culprit seems to be the user charges on outpatient prescription medicines,[31] but 2009 also saw an increase in personal financial responsibility for health care. In a direct way, with the introduction of a 15% co-payment rate for (previously free) inpatient long-term nursing care (a co-payment which is however not being implemented by all hospitals). In a more hidden way, by the changes made both to the point of intervention of the sickness cash benefit scheme and the compensation rates it provides.

Finally, the recent WHO report concerning the financial sustainability of Estonia's health care system reveals that the system is essentially underfunded and supported by too small a number of contribution payers and too little government funding. Both issues are connected. Today, some 45% of those who are covered by the system do not contribute to it, which of course puts the financing burden to the remainder of contributors – essentially those who are employed. Roughly speaking, about half of those who are insured without contributions paid are children, and – crucially – about half are pensioners. Given the expected rise in expenditures which goes hand-in-hand with an ageing population, and witnessing the vulnerability of the system to fluctuations of real wages and labour market participation, the challenge for the future will be to broaden the revenue base in a rational and affordable way.

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29 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.

30 Press release by National Institute of Health Development on 8 January 2010, "Tervishoiu kogukulude osakaal SKP-st ületas 2008. aastal 6% piiri" http://www2.tai.ee/TAI/TSO/EST/AA_EKT/TH_kogukulud/THKK_SKPst_08012009.doc; statistical table from their homepage http://www2.tai.ee/TAI/TSO/EST/AA_EKT/TH_kogukulud/Kogukulud_yld_1999-2008_29122009.xls (Excel sheet).

31 For a more in-depth exploration of this topic, see the September 2009 asisp ad hoc report on the impact of the economic and financial crisis on the health care sector in Estonia and WHO, 47-50 and 114-115.

2.3 Long-term care

2.3.1 System characteristics and reforms

Long-term care in Estonia is comprised of a mix of health care services and welfare services.[32] Local governments (municipalities) are the main providers of long-term care services, and cover the costs that are not born by the Health Insurance Fund (Haigekassa – which is an independent government agency). They do so by either providing the services themselves, or by administering provision by third parties (which can also be other local governments).

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 local governments via the counties, who can be seen as the "hand of the state" on the regional level. The counties are further also responsible for supervising the quality of care services, provided by the local governments.

While 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.

Home 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. This includes treatment, nursing, raising and development.

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 to help to reimburse the costs related to the care, and to alleviate the families' care burden and 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).

[32] 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.

2.3.2 Debates and political discourse

The challenges the long-term care system in Estonia faces are well-known, and are duly recognised by stakeholders and policymakers alike. The debate focuses on the goal to better integrate the various services provided through the health care and the welfare system, to arrive at a concept of personal assistance to the persons in need of long-term care. Taking into account the policy goal of providing help to a person in his or her own home for as long as is possible, service provision needs to be made more responsive to the individual's needs. More emphasis is put on a thorough assessment of the need for care, and to provide a package of "personal assistance". As the dichotomy found in the current system aggravates a range of different problems and issues, this, above all, requires the development of a better synergy between health care and welfare.

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 thousand. 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 little funding. 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 possibilities), and not those services that are required on the basis of an assessment of what the person would really need. 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.

Access is further impeded by the fact that 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. Residents are therefore visited by family doctors, and/or involve private nursing companies.

Concerning financial accessibility, while the health care system in principle provides for free medical care, the welfare system requires a personal contribution which is borne by the individual or by his or her family.[33] This can amount to up to 60% of the cost and can translate to a personal contribution of 85% of an average pension – for many families a heavy burden to carry. Note, however, that where an individual or his/her family is unable to pay, the local government will have to cover the full cost of the service as part of the provision of social assistance.

In other words, the main problem that transpires from these observations is that it is difficult for a person to move between services. Difficulties in access on the level of geography, finances and quality all lead to inefficient allocation of resources. Persons who do require quality nursing services but not medical treatment are kept in hospital for longer than necessary, because such nursing care would otherwise not be available, or not affordable for the individual. In part, to set right this particular inefficiency, a co-payment of 15% for inpatient long-term care (nursing care) was introduced as from 1 January 2010 onwards.[34] While this may solve a problem from the perspective of the health care system, it can only intensify the evolution of care provision based on a choice of need to a choice of personal financial allocation.

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[33] 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."

[34] Regulation number 42 of the Estonian health insurance fund of 19 February 2009, Riigiteataja I 2009, 16, 99 (https://www.riigiteataja.ee/ert/act.jsp?id=13231527).

To help overcome these issues, proposals to develop an integrated care on the basis of assessed personal needs have repeatedly been tabled,[35] but so far have not been accepted or implemented. A recent policy note recaptures the idea and offers new ways to reach the goal of integrated care.

The system today organises extensive nursing care through nursing care hospitals that are organised by the Estonian Health Insurance Fund. Patients who only require sporadic nursing care are expected to turn to a family doctor. In reality, however, 71 out of the 120 welfare institutions that provide round-the-clock care organise nursing care nevertheless, even though they are legally not allowed to do so. This informal solution, however, also means that no compensation through the health care system is provided so that the bill is passed either to local government or to the patient himself, and that normal checks on quality and qualifications are not implemented. The proposed solution is to legally allow care homes to provide nursing care themselves; a change in the Social Welfare Act is under preparation.

Implementation of this policy will require agreement on the aspect of financing, and on the legal form under which the care homes are allowed to operate. The current laws governing health insurance do only allow agreements between the Estonian Health Insurance Fund and private companies, whereas the majority of care homes is currently owned by municipalities or operate as NGO. This agreement between health care and welfare policy still seems to remain elusive.

2.3.3 Overview of published impact assessments

An extensive review of the system, ordered by the Ministry of Social Affairs and performed by an independent consultancy, was completed in June 2009. 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.[36] Concerning financing and viability of the system, the study essentially proposes to introduce an insurance scheme, with long-term care to be financed through personal contributions.

An assessment of the care burden of individuals who take care of a needy family member can provide insight in the costs (in the broad sense) involved, and a basis for the implementation of the official policy goal to provide adequate compensation.[37] From another study, published in 2008, we know that such need is real.[38] Of the persons receiving assistance for normal daily activities, most do so through family or other informal networks.

A further study, launched in 2010 with assistance of the OECD, looks into the reasons why local governments do not provide the services they should, and attempts to make recommendations concerning the most problematic issues. An output of this activity is expected by the end of this year.

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35 See, for example, the Estonian National Report on Strategies for Social Protection and Social Inclusion 2006-2008, 41-45.

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

37 At the time of writing this report, the paper had been finalised but not yet published. One of the main conclusions, it is said, is that caregivers for the most part are pensioners and older people, no longer active on the labour market.

38 ALTMETS, Katre, KATUS, Kalev, PUUR, Allan, SAAVA, Astrid and UUSKÜLA, Anneli, Toimetulekupiirangud Eesti täisealises rahvastikus – levimus ja tegelik abistamine, 2008, Eesti Arst 87(2), 92-101.

2.3.4 Critical assessment of reforms, discussions and carried out research

The policy goal to better integrate health care and welfare is one that has been formulated already for years. The reason for the lack of agreement and decisive actions mainly seems to be related to worries as to the cost of such a set-up. Indeed, the proposed changes in the current system will lead to an enhanced role of health care in the overall long-term care package, which would put the health care budget under strain. This issue remains to be negotiated, and is of course closely linked with the observations made elsewhere about the narrow contribution base of the health care system.

There is also an important difference in what local governments are legally expected to provide, and what they are providing in reality, as there is between what they provide, and what is needed when looking at the situation of the citizens. The current economic malaise is of course also felt when it comes to long-term care. Municipalities see their incomes diminished because of a decrease in wages and thus in the collected income tax, and are feared to become unable to further finance care institutions with adequacy. Individuals, experiencing individual financial problems are unable to pay for themselves. Families feel the strain of this situation, and can only resort to taking the needy individual into their own homes.

A recently introduced coinsurance requirement for inpatient long-term care (nursing care) only makes this problem more pertinent. Under the new legislation, hospitals are allowed, but not obliged, to ask the patient for a copayment of 15% of the price of a bed-day. In practice, this amounts up to a maximum of EEK 3 thousand per month – a little under the amount of the average pension. Hospitals can also ask for less, and many do as the compensation provided by the Estonian Health Insurance Fund for the price of a bed-day seems to be sufficient to cover more than 85% of the real cost. While the measure partly solves the problem of unjustified use of hospital resources, the added cost for the individual can create grave problems in the long run. Indeed, where copayment, generally speaking, is designed in such a way as to be bearable by all, this idea ignores the specific impact on specific groups and income classes. The added burden does not leave much room for paying other costs, such as the costs connected with ownership or rent of a house or apartment. This may very well result in increased poverty rates as a side effect.

All this makes the case for changes that emphasise quality home care as the “first line of defence” and the most cost-efficient and patient-friendly service – a logical and reasonable choice given the Estonian tradition, culture and social policy system. Such a system can, however, only work when caregivers are empowered to provide this quality care, which means education on the one hand, and systems that make it financially feasible to provide services themselves, or to purchase certain services on the open market, on the other.

Much is done to make this a reality. For example, a handbook for people providing home care is being elaborated. The fragmented financing of the long-term care system, however, remains problematic. Instituting contribution-based long-term care insurance could prove one way to deal with these problems, but this idea seems to have been abandoned in favour of a model where financing is provided through partnership between citizens, local communities and state support. What shape this partnership is to take, and how the specific situation of needy elderly will be taken into account, particularly with regard to co-payments and the ability to pay them, is yet undecided.

Funding through the European Social Fund plays a decidedly important and positive role in the development of the long-term care system in Estonia. It not only assists in collecting the necessary policy supporting studies, but also in very tangible activities such as trainings and financial intervention in the system. Further projects are planned with the financial assistance

of the European Social Fund, such as the replacement of nursing homes with family living units (housing up to seven persons), and the construction of nursing homes where the need is highest. A concrete measure currently being implemented (2010-2011) allows caregivers to engage outside help financed through ESF projects, to allow combining the care for a needy family member with professional activity.[39]

3 Impact of the Financial and Economic Crisis on Social Protection

Responding to the rapidly declining tax revenues, the Parliament adopted in February 2009 a revised state budget, cutting public expenditures in total by about 8% compared to the earlier adopted budget for 2009. On 21 May 2009, the Government approved another revised budget, further cutting public expenditures in total by EEK 3.4 billion (about 1.5% of GDP). According to the forecast of the Ministry of Finance, the annual GDP was expected to decline by 10% in 2009, whereas the 2009 budget had earlier assumed a GDP growth of 2.6%. In reality the GDP dropped by 14.1% and social tax revenues dropped by 10%. For 2010, the Ministry of Finance predicts that GDP will increase by 1%, but the social tax revenues will decline further by 5%, due to low employment rates.

Pensions

The short-run changes in the pension system were a direct result of the economic crisis and the Government's concurrent aim of keeping the public deficit within the limit of 3% of GDP in order to join the Euro area.

Despite the crisis, the old-age pensions, disability pensions and survivor's pensions have increased, both in nominal and real terms. Compared to other socio-economic groups current pensioners are relatively well protected. The increase of the statutory pension age and also the suspension of the contributions to the funded pension scheme means that, to some extent, current pensioners were given a preferential status compared to future pensioners.

Regarding other areas of social protection, the number of recipients of unemployment benefits or subsistence allowance (*toimetulekutoetus*) has increased drastically in 2009 compared to 2008, and it continues to increase.

In 2009, about 2.8% of the Estonian population received subsistence benefits, nearly double as many as compared to 2008 (1.5%). The number of recipients of the unemployment benefits quadrupled in 2009 compared to 2008 (from 15 thousand to 58 thousand). Because the length of entitlement to unemployment benefits is short (up to 270 days), there is also some effect on the pension system. For example, in 2009, the growth rate of disability pensioners increased. Although a more detailed research is needed this suggests that disability pensions may be serving as a pathway to early retirement. A similar pattern could be seen in the 1990s when unemployment was very high.

Also, pensioners are affected indirectly by administrative price increases. In 2009, the general VAT rate increased from 18% to 20%, and on drugs from 5% to 9%. As drugs constitute a large share in pensioners' budgets, this increases the risk of impoverishment of pensioners.

[39] See http://www2.sm.ee/esf2007/.

Health and long-term care

The budget of the Health Insurance Fund is set on the basis of revenue forecasts prepared by the Ministry of Finance. These forecasts are made in August, and estimate how much social tax will be collected in the following calendar year. The forecasts are regularly revised in spring, leading to budget revisions and corrective measures.

In August 2008, the projected 2009 revenue[40] for the health care sector was optimistically estimated to amount up to EEK 13.6 billion. However, at the end of 2008, the severity of the current economic and financial crisis became apparent, as only EEK 12.9 billion were effectively collected for the whole of 2008.[41]

The 2009 budget took this reality into account and projected the revenue for 2009 to be EEK 12.23 billion. A subsequent revision lowered the projection even further, with an estimated revenue of EEK 11.8 billion. To match the decreased income, prices of health care services were frozen,[42] the maximum waiting times for out-patient specialist treatment were extended from four weeks to six weeks, more outpatient services were financed to reduce uptake of the more expensive specialist inpatient care, and certain training activities were delayed to the following year.

The final tally of 2009 reveals a revenues of EEK 11.4 billion; a 11% decrease compared to 2008. Total expenses were at EEK 12.1 billion, which constitutes a decrease by 2% compared to 2008. Since revenues covered only 95% of expenditures, EEK 590 million of reserves were used to cover the difference.[43]

The 2010 budget of the Estonian Health Insurance Fund is based on conservative economic forecasts, taking into account a possible decrease of the total volume of contributions by 9%. On this basis, revenues are estimated to amount to up to EEK 10.9 billion, while costs are estimated at EEK 11.5 billion. This means that reserves will have to be used, to a maximum amount of EEK 570 million. In a bid to maintain the access to health services while balancing the budget, prices of these services have been decreased by 6%.[44]

While the budgetary measures taken are important and can be felt throughout the system, there is (as of yet, at least) no evidence that this has lead to a decrease in services. Earlier prudent reforms of the health insurance system have, as it seems, rendered it primed to deal with economic recession, and drastic cuts seem to be avoidable. Nevertheless, some recent

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40 Social taxes are set at 33% of gross income. 13% is earmarked for health insurance, while 20% goes to the national pension insurance. The rate of the Estonian Kroon (EEK) is pegged at 15.6466 to the Euro.

41 The weaker growth can be attributed to a decrease in contributions collected in the last months of 2008. There has been no change in the contribution collection mechanism or in the contribution rates; increases and decreases of the collected contributions are therefore fully attributed to changes in the total amount of wages.

42 Services are provided by health care professionals or associations (companies) who operate under private law, and who have concluded a contract with the Health Insurance Fund. Services, their prices, and the part that is compensated for by the health insurance system are regulated by the Estonian Health Insurance Fund.

43 The health insurance system holds a financial reserve, comprised of a legal reserve, the risk reserve, and "retained earnings" (the surplus of collected revenues that is not locked into these two legally defined reserve funds). In 2008, the combined reserve was calculated to be EEK 4.1 billion, of which EEK 3.1 billion were retained earnings, and thus readily available to compensate for a budget deficit. In 2009, the risk reserve of EEK 59 million and EEK 577 million of the available retained earnings were used, which leaves a remaining total reserve of EEK 3.5 billion. See also: Haigekassa, annual report 2008 (http://www.haigekassa.ee/uploads/userfiles/Majandusaasta%20aruanne%202008_ENG.pdf) and Haigekassa, annual report 2009 (only in Estonian language: http://www.haigekassa.ee/uploads/userfiles/file/Eesti_Haigekassa_majandusaasta_aruanne_2009.pdf).

44 For the detailed budget, see http://www.haigekassa.ee/uploads/userfiles/EHK_eelarve_2010_seletuskir_kodulehele.pdf.

changes may raise concern, especially where they influence the personal cost of health care and the financial sustainability of the system (see above, 2.2.4).

As mentioned, the health care system receives marginal funding from the general budget, relevant for the provision of emergency care and the development of topical prevention and promotion programmes. Here too, measures are evident. But as is the case with the contributions-funded part of the health care system, there is no evidence that cuts are leading to a reduction in the quantity or quality of services.[45]

[45] More details and background information is provided in the September 2009 asisp *ad hoc* report on the impact of the economic and financial crisis on the health care sector in Estonia.

4 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

[R1] MINISTRY OF FINANCE, "2010 aasta kevadine majandusprognoos", 2010, Tallinn, accessible at: http://www.fin.ee/doc.php?105048
"The spring 2010 forecast of the Ministry of Finance of Estonia"

It is main forecast of the economy for years 2010-2014 by the Ministry of Finance. It includes predictions of the social tax revenues.

[R1; R2; R3; R4; R5] "Seletuskiri riikliku pensionikindlustuse seaduse ja sellega seonduvalt teiste seaduste muutmise seaduse eelnõu juurde", 2009, Tallinn, accessible 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=
"The explanatory memorandum accompanying changes in the State Pension Insurance Act and other related acts"
Gives an short overview of possible impacts of the increase of the statutory pension age increase. Includes long-run trends of the demographics, fiscal position of the state pension scheme, replacement rates, policy simulations, etc.

[R1; R4; R5] AINSAAR, Mare, MARIPUU Lee, "Eakate heaolu Eestis 2007, võrdlus lastega perede ja mitte-eestlaste rühmaga", 2009, Tallinn, Rahvastikuministri büroo, accessible at http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/Eakate_heaolu_Eestis_2009.pdf
"Welfare of elderly in Estonia 2007, comparison of families with children and non-Estonians"

A statistical overview of the various aspects of the everyday life of elderly: health, economic situation, employment, social networks, etc.

[R1; R4; R5; H1; H3; L] MINISTRY OF SOCIAL AFFAIRS, "Health, labour and social sector in 2007.", Tallinn, 2008, accessible at: http://213.184.49.171/www/gpweb_est_gr.nsf/HtmlPages/Ingliskeelne_esinduskogumik_2008/$file/ENG_esinduskogumik_www.pdf

An overview of the main statistical indicators and recent trends on health care, pensions, long-term care and employment.

[R2; R5] LEPPIK, Lauri, VÕRK, Andres, "Transition Costs of Reformed Pension Systems", PRAXIS Center for Policy Studies, Tallinn, 2008, accessible at: http://www.praxis.ee/index.php?id=305&L=1

Research report of a comparative study focusing on transition costs associated with pension reforms entailing a partial transition to a funded pension scheme as part of statutory pension system and implications of such reforms on pension adequacy. The study covers Hungary, Sweden, Poland, Latvia, Estonia, Lithuania, Slovakia and Bulgaria, and also addresses the reforms planned in the UK.

[R2; R5] Mäe, Ülla (2008), "Pensionid", Sotsiaalvaldkonna arengud 2000-2006, Trendide kogumik, Sotsiaalministeeriumi Toimetised, 2/2008.
"Pensions", in "Developments in the social field 2000-2006. Trends. Proceedings of the Ministry of Social Affairs"

An overview of main trends on the number of pensioners by type of pension, age and gender distribution of pensions, distribution of pension amounts, pension expenditures in 2000-2007.

[R3; R4] VÕRK, Andres, "Labour supply incentives and income support systems in Estonia". IFAU Working paper Series, 2009:31, 2009, Uppsala, accessible at http://www.ifau.se/upload/pdf/se/2009/wp09-31.pdf

An overview of labour supply incentives present in the Estonian income support system and how changes during the last ten years in the Estonian benefit system have influenced the incentives. It concludes that the gradual introduction of contribution based and earnings related benefits have increased rewards from employment and are often associated with increased labour supply as well as a reduction in undeclared work. The increase of the statutory retirement ages for men and women have increased average employment rates of the elderly, but also retirement through alternative schemes, most notably disability pensions and early retirement pensions. In a few cases, the Estonian benefit schemes generate disincentives to seek for a job or increase labour effort, affecting people both with low and high earnings. In case of unemployment benefits and early retirement benefits, even marginal income from labour leads to loss of all benefits, thus discouraging part time work.

[R4] MINISTRY OF SOCIAL AFFAIRS. "Employment and working life in Estonia 2008–2009", Series of the Ministry of Social Affairs No 3/2009 eng, 2009, Tallinn, accessible at: http://www.sm.ee/fileadmin/meedia/Dokumendid/Toovaldkond/toovaldkonna_areng_2008-2009_eng.pdf

This collection of trends characterises radical changes of the labour market that took place in 2008 and in the first half of 2009. Relying on abundant statistical data, it tries to analyse the impact of the recession on Estonia's labour market. The main sources used are Eurostat database, data from the Labour Market Board and the Estonian Unemployment Insurance Fund, the Estonian Labour Force Survey and other surveys of Statistics Estonia. It includes also a few statistical data on people close to retirement age.

[R4] MINISTRY OF SOCIAL AFFAIRS, "Employment and working life in Estonia 2007. Trends", Tallinn, 2008, accessible at: http://213.184.49.171/www/gpweb_est_gr.nsf/HtmlPages/series_20085eng/$file/series_20085eng.pdf

An overview of the labour market situation and working conditions in Estonia. Includes a section on the situation of older workers (55-64) in the labour market.

[R4] MINISTRY OF SOCIAL AFFAIRS, "Employment and working life in Estonia 2008-2009", Tallinn, 2009, accessible at: http://www.sm.ee/fileadmin/meedia/Dokumendid/V2ljaanded/Toimetised/2009/series_20093eng.pdf

A collection of trends and data on the Estonian labour market over the years 2008-2009.

[R5] Statistics Estonia "Vaesus Eestis. Poverty in Estonia", 2010, Tallinn, accessible at: 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 Estonia's society. The generational poverty as well as permanent poverty will be 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.

[R5] Võrk, Andres, «Riiklik pension ja tulumaks», 2008, accessible at: http://praxisestonia.blogspot.com/2008/01/riiklik-pension-ja-tulumaks.html
"State pensions and income tax"

Brief policy analysis on distribution of state old-age pensions by amount and the potential impact of changes in the non-taxable allowance for pensions. According to the data of the Social Insurance Board, as of 1 January 2008, 92% of all old-age pensions were in the bracket between EEK 3000 (EUR 190) and EEK 5000 EEK (EUR 320). Only 6% of old-age pensioners received a pension that was less than EEK 3000, whereas only 2% of old-age pensioners received a pension over EEK 5000.

[H] Health

[H] Ministry of Social Affairs, Estonian Health Insurance Fund "Elanike hinnangud tervisele ja arstiabile 2009", 2009, Tallinn, accessible at http://www.sm.ee/fileadmin/meedia/Dokumendid/Tervisevaldkond/Uuringud_ja_analuusid/Patsiendi_rahulolu_uuring_2009.pdf
"Population assessment of health and health care 2009"

This is an annual survey of the Estonian population about their health and health care utilisation, accessibility, satisfaction etc.

[H] National Institute for Health Development "Health statistics in Estonia and Europe 2007", 2010, Tallinn, accessible at 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.

[H1; H3] Eesti Haigekassa, «Eesti Haigekassa majandusaasta aruanne 2008», Tallinn, accessible at:
http://www.haigekassa.ee/uploads/userfiles/Majandusaasta%20aruanne%202008_allkirjadega.pdf

Annual economic report of the Estonian Health Insurance Fund 2008.

[H1; H3; H4; H5] AAVIKSOO, Ain, KIIVET, Raul-Allan, PAAT, Gerli, SALUSE, Janek "Eesti patsiendi minevikuvõidud ja tulevikuvõimalused", 2009, Tallinn, accessible at http://www.rahvatervis.ut.ee/bitstream/1/1149/1/Praxis2009.pdf
"Past wins and future possibilities of the Estonian patients"

Statistical overview and discussion of the main trends and patterns of health care utilisation and out-of-pocket payments in 2000-2008.

[H1; H3] VÕRK, Andres; SALUSE, Janek; HABICHT, Jarno "Income-related inequality in health care financing and utilisation in Estonia 2000–2007. Health Financing Technical Report", World Health Organisation, accessible at http://ee.euro.who.int/E92592.pdf

This paper analyses out-of-pocket payments (OOPs), their impact on catastrophic expenditures and the distribution of the taxation burden to finance health care in Estonia from 2000 to 2007. It also looks at income-related inequality in Estonian health care utilisation in 2006. The results show that out-of-pocket expenditures have increased since 2000. The socioeconomic factors that determine the relatively high household health expenditure relative to capacity to pay are those that describe income level, on the one hand, and health expenditure, on the other hand. Most affected are elderly people whose expenditure for both prescription and over-the-counter drugs increases their risk of impoverishment. The analysis of inequality in health care utilisation shows that after taking into account the need for health care, the use of dental care, phone consultations and other medical specialties are positively related to income. Day treatment utilisation also turns out to be highly related to income, though it is statistically insignificant due to very small number of people it in our sample who have used. The increasing share of OOPs has lead to a decline in the progressivity of overall health care financing.

[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", 2010, Tallinn, World Health Organization, accessible at
http://www.sm.ee/fileadmin/meedia/Dokumendid/ASO/_Tervis_/Responding_to_the_challenge_of_financial_sustainability_in_Estonia_s_health_system.pdf

This is a very 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.

[H2] AAVIKSOO, Ain, PAAT, Gerli "Suitsetamisest loobumise nõustamise hindamine", 2009, Talinn, accessible at http://www.rahvatervis.ut.ee/bitstream/1/1152/1/Praxis2009_1.pdf "Evaluation of smoking cessation advice"

The report analyses the effectiveness of the smoking cessation advice provided by smoking cessation health professionals. It includes survey results of the target group, an economic analysis of the service, and policy recommendations.

[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, accessible at 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 noncommunicable 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, accessible at 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.

[H2; H3] MINISTRY OF SOCIAL AFFAIRS, "An Overview of Health Status in Estonia", Tallinn, accessible at: http://213.184.49.171/www/gpweb_est_gr.nsf/HtmlPages/health_status_eng/$file/health_status_eng.pdf

An overview of the current situation and the main trends in respect of life expectancy, health behaviour and risk factors, self-perceived health, communicable diseases, mortality and burden of disease.

[H3] FAKTUM & ARIKO, «Patsientide hinnangud tervisele ja arstiabile», Tallinn, 2008, accessible at: http://www.haigekassa.ee/uploads/userfiles/Patsientide%20rahulolu%202008.pdf "Patient's evaluations on health and medical care"

Research report. This is a sample survey (N=1521 persons) to analyse assessments of the population in the 15-74 age group about their health status, health behavior, contacts with health service providers, evaluations on access to and quality of health care and contacts with Health Insurance Fund. According to the survey, nearly half of respondents assessed their own health as good or very good, 36% considered it satisfactory and 12% as rather or very poor. About one third of the population suffers from chronic diseases. About 75% of the population has visited doctors over the last 12 months: 70% visited a family doctor, 49% a dentist and 45% a specialist doctor.

53% of respondents regarded access to medical care as good or very good, whereas a year earlier the share of those giving positive evaluation on access to medical care was 7 percentage points higher. The study also revealed that over the last year the waiting time access specialist doctors increased – about two-thirds of those seeking specialist care got an appointment with one month, while 31% had to wait over one month. 73% of respondents consider the quality of medical care in Estonia as good or very good), an increase by 4 percentage points compared to the previous year), while 22% gave negative assessments on the quality of care. The study was commissioned by the Ministry of Social Affairs and the Health Insurance Fund.

[H3] TEKKEL, Mare, VEIDEMANN, Tatjana, RAHU, Mati, "Eesti täiskasvanud rahvastiku tervisekäitumise uuring, 2008", Tervise Arengu Instituut, Tallinn, 2008, accessible at: http://www2.tai.ee/TAI/TKU2008.pdf
"Health Behavior among Estonian Adult Population, 2008"

Research report. The study is conducted each even year starting from 1990 and forms a part of the Finbalt Health Monitor (Finbalt) cooperative study where also Lithuania, Latvia and Finland participate. A postal questionnaire survey was conducted, with a simple random sample of 5000 individuals aged 16-64, while the crude response rate was 60%.

According to the survey, 92.6% of respondents had health insurance coverage (note that as the sample covered only population in the active age, the share of insured persons is lower than according to the data of the Health Insurance Fund for the whole population). The coverage rate for women (95%) was higher than for men (89.3%). The share of respondents with no health insurance coverage was highest among men in 25-34 and 35-44 age groups, respectively 14.8% and 12.1%. The most prevalent reason for lacking health insurance was unemployment. 50.7% of all respondents considered their health status as good or reasonably good, 40.5% regarded it as satisfactory, while 8.8% assessed their health status as poor or rather poor.

[H4; H5] National Audit Office of Estonia (Riigikontroll) "Haiglavõrgu jätkusuutlikkus", 2010, Tallinn, accessible at
http://www.rahvatervis.ut.ee/bitstream/1/1721/1/Riigikontroll2010.pdf
"Sustainability of the hospital network"

The NAO audited whether the existing network of active treatment hospitals is optimal, sustainable and structured in line with the Estonian Hospital Network Development Plan 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] Klaster uuringukeskus, «Haigekassa lepingupartnerite rahulolu», Tartu, 2008, accessible at: http://www.haigekassa.ee/uploads/userfiles/HKaruanne2008(2).pdf
"Satisfaction of contractual partners of the Health Insurance Fund"

Research report. The study analyses satisfaction of contractual partners (family doctors, specialist health care providers, dentists, pharmacies, long-term care providers) of the Health Insurance Fund with administrative practices of the Fund. A survey was conducted using a web-questionnaire, replies were received from 601

health care service providers. Most of the service providers give high evaluations to cooperation with and administrative practices of the Health Insurance Fund, 36% of respondents considered these very good, 48% relatively good, 15% satisfactory and only 1% unsatisfactory. On the other hand, 62% health care service providers considered that patients are poorly informed about their rights and obligations in the area of health care. The study has been commissioned by the Estonian Health Insurance Fund annually from 2002.

[H5] Klaster uuringukeskus, "Tööandjate rahulolu haigekassaga", Tartu, 2008, accessible at: http://www.haigekassa.ee/uploads/userfiles/aranne2008.pdf
"Satisfaction of employers with the Health Insurance Fund"

Research report. The study analyses satisfaction of employers with client services of the Health Insurance Fund. A phone survey was conducted with representatives of 505 employers. 81% of employers use regular mail service as the main means of communication to submit relevant documentation (e.g. sick lists) to the Health Insurance Fund, while 68% of employers use a special web portal for registering new employees as insured persons at the Fund. Employers are generally satisfied with the client service of the Health Insurance Fund, the share of unsatisfied employers being less than 5%.

[H6] KANAVOS, P., et al., *Review of the pharmaceutical sector with a view to developing a national medicines policy in Estonia*. 2009, WHO Regional Office for Europe: Copenhagen, accessible at www.euro.who.int/document/e93049.pdf

This report analyses the Estonian pharmaceutical policy. It argues that it is important that a comprehensive medicines policy be developed in Estonia, with clear objectives to address issues of financing, equity in access, protection of vulnerable segments of the population, improvements in rational drug use, macroeconomic efficiency and allocative efficiency. The areas identified in this report for improvement were: (a) The concerns over increasing and significant out-of-pocket expenses for prescription medicines; (b) Streamlining of the process for drug selection for positive list inclusion and subsequent reimbursement; (c) Stimulate the prescribing and dispensing of generics; (d) Facilitate generic substitution; (e) Market incentives for pharmacies to dispense generics; (f) Simplifying and reducing copayments for patients; (g) Implementing a national programme/system to improve prescribing and use of medicines; (h) Monitoring the availability of medicines at pharmacy level; (i) Ensuring adequate and timely distribution of prescription medicines (both wholesale and retail); (j) Reducing VAT on prescription medicines; and (k) Developing a comprehensive medicines policy to include all important areas.

[L] Long-term care

[L] PricewaterhouseCoopers, Etapp I (14 May), II (14 May), III (19 June, 2009), «Hoolduskoormuse vähendamiseks jätkusuutlike eakate hooldussüsteemi finantseerimissüsteemi väljatöötamine», accessible via: http://www.sm.ee/aktualno/kavandatavad-hankelepingud/hange/a/hoolduskoormuse-vahendamiseks-jatkusuutliku-eakate-hooldussusteemi-finantseerimissusteemi-valja.html

An extensive review of the system, ordered by the Ministry of Social Affairs, completed in June 2009. 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. Concerning financing and viability of the Estonian system, the study essentially proposes to introduce an insurance scheme, with long-term care to be financed through personal contributions.

[L] Katus, Kalev, Puur, Allan, Põldma, Asta (2008) «Estonian Family and Fertility Survey: Second Round, Standard Tabulations», Estonian Interuniversity Population Research Centre, Tallinn.

Survey data. This is a large sample survey using the methodology of the European Generations and Gender Survey based on event-history approach. The survey includes data on self-reported health status, activity limitations and need for care. According to the data, by the age of 60, 49% of men and 46% of women have significant activity limitations due to health problems. 20% of respondents in the age group of 55-64 noted a need of regular care in their household. Care needs increase by age, reaching 25% in age group 65-69, 30% in age group 70-74 and 40% in age group 75-79.

[L] ALTMETS, Katre, KATUS, Kalev, PUUR, Allan, SAAVA, Astrid, UUSKÜLA, Anneli (2008), «Toimetulekupiirangud Eesti täisealises rahvastikus – levimus ja tegelik abistamine. Eesti Arst», 87(2), pp.92-101.

"Activity limitations of Estonian adult population: prevalence and real assistance"

Research article. The aim of the study was to provide an overview of the prevalence of daily activity limitations and the need for assistance in Estonian adult population. Analysis was based on a random sample (n=7855) survey data collected in the framework of the Estonian Family and Fertility Survey of the target population from birth cohorts born 1924-1983 (20-79 years old at the time of conducting the survey). The survey used an event-history approach. 18.5% of the adult population in Estonia had some activity limitations. 10.7% needed assistance to cope with these limitations, whereas 8.7% of the population actually received assistance. The care was provided mostly by informal caregivers. The share of formal caregiving (by social workers or nurses) remained low even in the 70-79 age group, were it reached about 8% of cases.

5 List of Important Institutions

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 labor market and social policy, health policy, innovation and economic policy, education policy, governance and civil society policy. Issues regular Working Papers, Policy Analysis Series and Policy Briefs and occasional monographs.

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. From 2005 Klaster has conducted annual studies (commissioned by the Health Insurance Fund) to analise satisfaction of employers and contractual partners of the Health Insurance Fund with administrative practices of the Fund.

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 behavior 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.

Eesti Väärtpaberikeskus AS – Estonian Center of Securities Ltd
Address: Tartu road 2, Tallinn 10145
Webpage: http://pensionikeskus.ee/
Private company administering the central register of securities, incl. units of mandatory pension funds. Provides regular information, news and statistics on funded pension and administers a web portal on the overall pension system.

Tartu Ülikooli Tervishoiu Instituut – Department of Public Health, Univeristy of Tartu
Address: Ravila 19, Tartu 50411
Webpage: http://www.arth.ut.ee/
Public institution of research and higher education, a structural unit of the Faculty of Medicine at the Univeristy of Tartu. The institution provides graduate and post-graduate training (master and doctoral programmes) in public health and conducts research projects in the domain of public health.

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 institution of higher education and research, a structural unit of the Tallinn University. The institution 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.

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. The NGO has developed a concept paper on integrated long-term care in Estonia. Occasional working papers and other publications on long-term care.

Sotsiaalministeerium – The Ministry of Social Affairs

Address: Gonsiori 29, 15027 Tallinn
Webpage: http://www.sm.ee

The Ministry of Social Affairs is concerned with all issues in the field of social affairs, labour and health. The offices of Labour and Health are subordinated to the Ministry of Social Affair., It offers five services: issuing apostils, register providers of labour market services and temporary work agencies, and companies involved in occupational health and safety training, and maintain a database of collective agreements. Additionally researches in the social, labour and health sector are in progress.

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 organisation and coordination of grant and payment of the state pensions, benefits and compensations throughout its local offices. In other words our main objective is to ensure that pensions and benefits according to the national legislation and international agreements are paid to people in due time.

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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