Annual National Report 2009

Pensions, Health and Long-term Care

Estonia

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Authors: Lauri Leppik; Steven Segaert

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1 Executive Summary

Reflecting a high growth of social tax revenues and the consumer price index in 2007, and following a modification of indexation rules, state pensions were increased by 21.6% in April 2008. Total expenditures on state pensions increased by 23.5% (2008 compared to 2007). However, as the economic climate changed in the course of 2008 and the previously high growth rates turned negative (the real GDP growth in 2008 was -3.6%), pension expenditures as a share of GDP increased from 6.1% in 2007 to 7.3% in 2008. Reserves of the state pensions system amounted to 2% of GDP by the end of 2008.

Pension policy changes adopted in 2008, in particular the more generous indexation rules, have applied as from 1 April 2009. Liberalisation of investment regulations of the funded scheme were still largely based on hopes of continued high growth rates. In reality, the economic climate rapidly deteriorated in the last quarter of 2008 and the first quarter of 2009. In the absence of built-in automatic stabilisers, the Government was forced to take some rapid ad hoc policy measures to adjust the two largest social protection schemes – pension insurance and health insurance – with the rapidly changing circumstances.

Given that the reserves are limited and not sufficient to cover the shortfall of revenues over an expectedly prolonged period of crisis, and the unwillingness of the Government even to use the existing reserves (to maintain the overall public sector budget deficit within the 3% limit established by the Maastricht criteria), the main strategy to cope with the crisis has been to cut expenditures to bring these in line with significantly reduced revenues.

Given the political priority of ensuring the stable payment of state pensions this strategy led to a decision to temporarily suspend contributions to the funded scheme from 1 June 2009. In essence, this policy decision acknowledged the inability to finance pension reform transition costs in a situation of economic and financial crisis.

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 care provided to uninsured persons.

From the financing perspective the health insurance scheme operates according to the macro-level defined-contribution principle, with expenditures of the scheme being limited by revenues from the health insurance component of social tax (plus any reserves previously accumulated). However, sickness cash benefits, which are a sub-scheme of the health insurance system, operate according to the defined-benefit principle.

Policies in 2008/2009 aim to increase the role of the primary health care level, and to add to the services offered at that level. Attention also goes to the increase of the coverage rate of the health insurance system. The debate further focuses on the financing and long-term sustainability of the system.

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

2.1 Pensions

2.1.1 Overview of system's characteristics

The Estonian pension system comprises of three main schemes:

- state pension insurance;
- compulsory funded pension scheme;
- voluntary funded pension schemes.

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 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 2008 and 2009 the statutory pension age was 63 year for men and 60.5 years for women. The pension age for women is gradually increased to 63 by 2016.

As of 1 January 2009, the total number of pension recipients was 382 thousand persons (28.5% of population), of them 291 thousand persons received old-age pension and 70 thousand work-incapacity 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 2008 comprised about 37% 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).

At the beginning of 2008, 92% of all old-age pensions were in the bracket between EEK 3000 (EUR 190) and EEK 5,000 EEK (EUR 320). Only 6% of old-age pensioners received a pension that was less than EEK 3,000 EEK, whereas only 2% of old-age pensioners received a pension over EEK 5000 (Võrk 2008).

After indexation of pension in April 2008, the average old-age pension reached EEK 4,554 (EUR 291), an increase by 21% compared to the average old-age pension in 2007, which was EEK 3,763 (EUR 240).

The flat rate national pension, which serves simultaneously as a minimum pension guarantee, amounted to EEK 1,913 (EUR 122) after indexation in April 2008. However, recipients of the national pension on grounds of age constitute less than 1% of all pensioners receiving a pension on the grounds of age.

The average old-age pension in 2008 comprised about 43.5% of the average net wage.

The pay-as-you-go state pension insurance scheme is supplemented by a mandatory funded defined-contribution scheme, which was introduced in 2002. In 2008, the funded scheme was still only in the accumulation phase. 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 managers. The total contribution to the funded scheme comprises of an individual contribution 2% of the gross wage of an employee, supplemented by 4% of the gross wage redirected from the pension insurance part of social tax paid by the employer. The latter element entails transition costs of the pension reform, as the curve-out component of the funded scheme implies reduced revenues for state pensions.

Although joining the second pillar is 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 2008, 580 thousand persons had joined the funded scheme. The scheme thus covers 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 18 billion or 6.8% of GDP in 2008. The total revenues from pension insurance component of social tax (20% of gross earnings) amounted to EEK 18.9 billion. However, EEK 2.5 billion of social tax revenues were redirected to individual accounts of participants of the funded scheme. As a result, of the total expenditures on state pensions EEK 16.4 billion were financed from current social tax revenues, EEK 0.95 billion from social tax reserves from previous years and the remaining part (EEK 0.65 billion) from other tax revenues.

By the end of 2008 the total value of assets in the funded scheme amounted to EEK 11.4 billion. This was only EEK 0.4 billion more than a year earlier, while the total contributions made to the funded scheme in 2008 amounted to EEK 3.8 billion (EEK 1.3 billion individual contributions and EEK 2.5 billion contributions redirected from social tax) or 1.5% of GDP. The EPI index, which reflects the weighted average net rate of return of all mandatory pension funds, declined by 24%. Conservative pension funds (investing only in fixed interest instruments) showed net rates of return in the range from +3% to -9%, while so-called progressive pension funds suffered losses in the net asset value of pension fund units in the range from -13% to -32%.

2.1.2 Overview of main changes adopted in 2008

In the state pension insurance scheme, pension indexation rules were modified as from 1 April 2008:

- the relative value of social tax revenues versus the consumer price index was increased in the calculation of the pension index. Previously the relative weight of the components determining the value of the index was 50-50, whereas from 1 April 2008 the weights of 80-20 were applied;
- the relative value of the flat-rate base amount of the old-age pension was increased by means of annual additional indexing of the base amount with the factor 1.1, whereas the employment-related elements of the pension are indexed with the factor 0.9.

Modification of indexation rules had two broad considerations. In a situation of high economic growth rates over 2001-2007 and resulting increases in employment and real wages, additional ad hoc pension increases were annually applied on top of the regular indexation of pensions with the 50-50 index to maintain the replacement rate of pensions and share the raising living standards with elderly population. Raising the relative weight of social tax revenues in the pension index was seen as a measure to reduce the need for additional (political) pension increases. The second amendment aimed at gradually increasing the relative weight of the flat-rate element of state pensions, thereby increasing the degree of redistribution in the public scheme. Applying the modified indexation rules, state pensions were increased in April 2008 by 21.6%.

As from 1 February 2009 the pension payment rules and procedures were changed. Previously, pensions could be paid out either to a bank account or through post office, including home delivery, at the choice of the pensioner. From February 2009, as a rule, pensions are paid to a bank account. Delivery at home is available at the expense of the pensioner, while home delivery costs are covered by the state only in case of a severely disabled work incapacity pensioner or old-age pensioner with mobility impairment and living in dispersed rural location with no access to banking services. This amendment served primarily the purpose of curtailing costs and easing administrative burden related to transfer of pensions as the costs of bank transfers are significantly lower than payment through post office due to a high degree of automatisation. At the same time, the change of payment procedures met high dissatisfaction from many pensioners as many older persons still had not opened banking accounts while access to banking services (incl. ATMs) is limited in many rural areas.

As regards the mandatory funded scheme, amendments to the Funded Pensions Act adopted in October 2008 introduced stricter regulation of the administrative fees of pension fund. The pension fund entry fee, which is charged each time when new pension fund units are issued, will be abolished as 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 are 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.

The amendment also 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 belief of prudent asset management by fund managers. However, in October 2008, at the time of adoption of the legal amendment, financial markets were hit by a severe crisis and the net asset value of higher risk funds dropped by 13% over the course of a single month.

2.1.3 Public and political discourse in 2008

In October 2008, the Prime Minister Andrus Ansip took the issue of pension age into the public debate, claiming that the currently legislated increase of pension age (to 63 years to be reached by women by 2016) is not sufficient and the pension age shall be further increased to the level of 67 by 2035. Subsequently, a number of prominent public figures expressed a similar view about the necessity to raise pension age, including the Chairman of the Board of the Bank of Estonia (J. Männik), the State Auditor (M. Oviir), the Member of the European Parliament (S. Oviir) and several economists (Prof. U. Varblane and Prof. R. Eamets from Tartu University, Prof. J. Leimann from Tallinn University of Technology, Vice President of the Bank of Estonia M. Ross). The public reaction towards raising pension age was generally

negative. Prof. L. Leppik from Tallinn University has suggested to peg any further increase of the pension age to the development of life expectancy by applying a demographic life expectancy factor similar to Finland.

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 care provided to uninsured persons.

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[1] 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.[2] 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 made. These are children under 19 years of age, students aged under 24, pregnant women from the 12th week of pregnancy, 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 95.6% of the population covered under the system in 2008. 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, pharmaceuticals, and for cash benefits (benefits for temporary

1 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.

2 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.

incapacity to work, compensation for dental care, and supplementary compensations for pharmaceuticals).[3]

Health care services in kind are provided to the citizens irrespective of the amount of contributions paid, and are provided free of charge. Co-payments are required only for some services,[4] for home calls made by family doctors and for outpatient specialised care. The fees are however limited[5] and constitute no real impediment. Private hospitals are also available in Estonia, requiring a higher contribution from the patient.

Modern reform[6] 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.[7] Also amongst these core ideas was the development of a primary health care that would act as a gatekeeper, as opposed to the role of a simple referral point to specialised care it had under the Soviet system.

More recent evolutions build on the experiences of the initial reforms, and are meant to optimise the system. Amongst these more recent initiatives are a re-thinking of the initially planned decentralisation (and a subsequent re-centralisation of some tasks), the transformation of the Estonian Health Insurance Fund into an independent public body in 2000, and the mandating of all health providers to operate under private law.[8]

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

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[3] 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.

[4] 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.

[5] 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.

[6] 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).

[7] 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.

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

Currently, updates rather than fundamental changes can be detected. Nevertheless, some changes in the system, introduced during the reporting period, are noteworthy.

At the end of 2007, a legislative framework for a Health Information System was established by way of amendments to the 1994 Health Services Organisation Act. The aim of the new digital database is to improve the quality of health services through efficient information sharing, while at the same time protecting patients' rights. 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 starting from September 2008.

Already in 2007, an important step in the increase of 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. 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.

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, easily accessible and affordable, the services offered as such are not that diverse, 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[9] 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 overconsumption of emergency services,[10] as the only medical service to turn to in these circumstances.

9 The 1220 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 10,000 calls monthly, the help line has aided to reduce unnecessary emergency interventions.

10 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.

In addition to this problem, access to services other than family doctor services is also problematic. 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 nursing care, care for pregnant women, and physiotherapy. Nursing care and physiotherapy are less often found in remote areas, and are only on offer in bigger health care centres at the county level. Follow-up of pregnancies is mostly done by midwifes, who are not allowed to set up an independent practice, but can work only in conjunction with gynaecologists. This is now changing – a law enacted in June allows midwives to work independently, reducing the take-up of specialist care for routine check-ups and reducing waiting lists. More main primary care services could be added, which at present are only offered outside the family doctor network.

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 centres via voluntary cooperation between caregivers, 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 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.

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, 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 different 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. Within this 45% are 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 in to the system, create a structural imbalance between revenues and expenditures. One of the main problems today is that nobody has insight of how important this imbalance will be – currently, there are no updated projections available.[11]

11 For a discussion of other recent and current policy debates, see Estonia: Health system review, Health Systems in Transition, 2008, 10(1), 190-195.

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.[12] A 2008 sample survey of 1,512 persons, commissioned jointly by the same organisation and the Ministry of Social Affairs also examined self-assessments of the population in the age group of 15 to 74.[13] These surveys are summarised in chapter 4.

Other impact assessments are published by the Estonian office of the World Health Organisation, amongst which a comprehensive review of the Estonian health system.[14] This report provides a detailed description of the health system and of policy initiatives in progress or under development. Different approaches to the organisation, financing and delivery of health services are examined, as well as the role of the main actors in the system. The institutional framework, process, content and implementation of health and health care policies is described, and challenges and areas that require more in-depth analysis are highlighted.

2.2.4 Critical assessment of reforms, discussions and carried out research

To understand the challenges the health care system faces, a closer look is required at the way expenses are paid for. The health insurance system is financed almost exclusively from the health insurance component of social tax,[15] which is 13% of gross earnings. In 2008, revenues totalled EEK 12.9 billion, while health insurance expenditures reached EEK 12.3 billion or the equivalent of 4.9% of GDP – an increase by 20.4% compared to 2007.[16] Specialist care is the biggest expenditure item, amounting to EEK 6.6 billion (53.6% of total expenditures), while general practitioner care expenses amounted to EEK 1.05 billion. Sickness cash benefits amounted to EEK 2.4 billion, while compensations for pharmaceuticals EEK 1.3 billion and other types of expenditures (other cash benefits, dental care, nursing care, prevention, health promotion, administration) EEK 0.9 billion.

Seen differently, health services make up 68% of expenditures, against 22% for cash benefits and 10% for pharmaceuticals. Looking only at the composition of the 68% used for funding the health services, 79% is spent on specialist care, and 13% on primary health care.

From the financing perspective the health insurance scheme operates according to the macro-level defined-contribution principle, with expenditures of the scheme being limited by revenues from the health insurance component of social tax (plus any reserves previously accumulated). However, sickness cash benefits, which are a sub-scheme of the health insurance system, operate according to the defined-benefit principle.

The impact of the economic and financial crisis is sure to reflect in the amount of real revenues collected in 2009. While the full impact will not be known until the final tally at the end of the year, it seems a certainty that revenues will decrease. The problem might be alleviated by using the reserves that are legally derived from the system (in 2008, EEK 0.6 billion were added to the reserves; by the end of 2008, the combined reserves of the Health

[12] Klaster Uuringukeskus, Haigekassa lepingupartnerite rahulolu, and Tööandjate rahulolu haigekassaga, Tartu, 2008.

[13] Faktum & Ariko, Patsientide hinnangud tervisele ja arstiabile, Tallinn, 2008.

[14] 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), http://www.euro.who.int/document/e91372.pdf.

[15] Revenue from social tax amounted up to 96.9% of total revenues in 2008.

[16] Estonian Health Insurance Fund, Annual Report 2008, 33-34. See http://www.haigekassa.ee/eng/ehif/annual.

Insurance Fund reached EEK 4.1 billion or 1.7% of GDP[17]). However, it has been decided not to use the available reserves. The reason for this is the Governments' ambition to join the single European currency as soon as possible. Reserves that can be shown when calculating compliance with the Maastricht criteria are therefore deemed to be untouchable.

It is difficult to predict where this prioritisation will lead to, both in societal and in political terms. The simple fact remains that less funding must translate in less expenditure and therefore less services provided, as the health insurance system is not allowed to go "over budget". Decreases in revenue are therefore met with restrictive supplementary budgets, of which a first was issued in February 2009, with further cuts expected. Apart from the previously described defined-contribution principle, cost cutting in government expenditure also has more topical impacts on the health insurance system. For example, as of 1 July 2009, the sickness benefit will be paid from the fourth day of sickness (previously the second day), while the employer is then obliged to pay for the fourth to eighth day of sickness. Beyond the eighth day, the sickness benefit is paid by the Health Insurance Fund. In addition, the incapacity benefit has been decreased from 80% to 70% of the salary in case of temporary relief from the performance of duties of employment or quarantine.

It remains to be seen how a hoped-for revival of the economy, a rumoured but fiercely denied upcoming devaluation, or more fundamental measures such as the expansion of (cheaper) primary health care to alleviate the costs resulting from an over-consumption of specialised health care will affect an assessment of 2009

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,[18] so that some services are covered by the health care system, while the responsibility for others is born by the local governments (municipalities). Local governments are the main providers of long-term care services, and cover the costs that are not born by the Health Insurance Fund (which is an independent government agency).

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, 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.

17 The combined reserves are composed of the legal reserve (6% of the budget; EEK 300.3 million at the end of 2008), the risk reserve (2% of the budget, EEK 266.8 million in 2008) and the retained earnings (EEK 3.1 billion in 2008).

18 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.

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).

2.3.2 Debates and political discourse

The debate concerning long-term care 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.

Current problems can be summarised as having relevance to the access, quality and sustainability of the system.

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 227 municipalities have a population of less than 3,000. The main source of income of any municipality is a share of the income tax, collected by the central government and forwarded to the municipality on the basis of the number of registered inhabitants. Small municipalities therefore receive 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 really needs. Basic services are available in every county, but not in all municipalities.

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 services.[19] Services are provided in the same way

19 Welfare institutions do not have in-house physicians or other health professionals. The decision to provide them anyway was mainly a reaction to the Soviet system of health care, where each place – big or small – had its own doctor or nurse.

and on the same principles as would be provided to people living at home. Inhabitants are therefore visited by family doctors, and/or involve private nursing companies.

Concerning financial accessibility, while the health care system provides for free medical care, the welfare system requires a personal contribution which is borne by the individual or by his or her family.[20] This can amount up to 60% of the cost and is 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 cover the full cost of the service.

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. Families are financially over-burdened by the cost of nursing care, and the uneven development of day care services and home care services still means that people have to turn to intramural care more often than would be required on the basis of individual needs. All while home care remains a policy priority, and the basis of the concept for the provision of long-term care.

To help overcome these issues, proposals to develop an integrated care on the basis of assessed personal needs have repeatedly been tabled,[21] 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.

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.[22] 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.

A further study is planned, assessing the care burden of individuals who are called upon to take care of a needy family member. The study aims to provide insight in the costs (in the broad sense) involved, and will provide a basis for the implementation of the official policy goal to provide adequate compensation. Another study, published in 2008, demonstrates that such need is real.[23] Of the persons receiving assistance for normal daily activities, most do so through family or other informal networks.

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20 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.”

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

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

23 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 that the Health Insurance Fund, an independent government institution, has reservations 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 further under strain. The possible emergence of a contribution-based long-term care insurance may very well pave the way for a reorganisation and further development of the system. Whether or not this will come to pass remains to be seen.

The current economic malaise is 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 faced with an inability to further finance care institutions. Individuals, equally experiencing this problem, are unable to pay for themselves either. Many families feel the strain of this situation, and can only resort to taking the needy individual into their own homes.

Quality home care, as the "first line of defence" and the most cost-efficient and patient-friendly service, can be a solution, but needs to be further developed. At present, 74 out of the 227 municipalities do not provide such a service at all, which puts further strain on the other types of services. This is a recognised policy priority, and funds are allocated in order to help municipalities to offer these services.

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.

3 Impact of the Financial and Economic Crisis on Social Protection

Following a period of moderate economic decline in the first three quarters of 2008, a severe economic crisis hit the country in the last quarter of 2008. GDP declined by 9.7% in the last quarter of 2008 and by 15.7% in the first quarter of 2009. Decline in the economic output is coupled with declining employment and increasing unemployment. In the first quarter of 2009, the number of employed persons was 6.8% less than a year earlier. At the same time, the average gross wage had declined by 1.5% (first quarter of 2009 compared to first quarter of 2008).

Responding to the rapidly declining tax revenues, the Parliament adopted in February 2009 a negative additional state budget, cutting public expenditures in total by about 8% compared to the earlier adopted budget for 2009. According to the forecast of the Ministry of Finance, the annual GDP is expected to decline by 10% in 2009, whereas the 2009 budget had earlier assumed a GDP growth of 2.6%.

As a part of the package of constraining public expenditures, an ad hoc modification of pension indexation rules was adopted in February 2009. According to the rules which were just adopted in 2008, the pension index depends on increase of social tax revenues and

increase of consumer prices with relative shares respectively 80% and 20%. The ad hoc modification adopted by Parliament in February 2009 allowed the Government to adopt an index which is smaller than that calculated according to the abovementioned formula if the expected GDP real growth for the same year is negative or if the deficit of the state pension insurance budget (the difference between expenditures on state pensions and revenues from social tax) for the given year is expected to exceed 1% of GDP. Applying this modified rule, state pensions were increased from 1 April 2009 by 5%, whereas the earlier indexation formula had foreseen an increase by 13.8% (against the relatively high increase of wages and prices in 2008). Nonetheless, as pension expenditures increase in a situation of declining GDP, the share of pension expenditures in GDP are expected to increase from 6.8% of GDP in 2008 to 8.6% of GDP in 2009, which is the highest expenditure level from the time of regaining independence.

In February 2009, the Parliament has also adopted amendments to the Health Insurance Act (to be implemented from 1 July 2009) as regards 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. Currently the sickness cash benefit scheme entails a waiting period of only one day, and benefits at the rate of 80% of former wage are 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 for the first three days of sickness. The employer is responsible to pay the benefit from the 4th to the 8th day of sickness, hence 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.

In this context it should be taken into account that the Estonian health insurance system operates on the principle of closed budget, its revenues being defined by the health insurance part of the social tax (13% of payroll), while medical services and sickness cash benefits are being financed from the same source. Therefore reducing expenditures on sickness cash benefits will leave in relative terms a larger share of the health insurance budget for medical services. Nonetheless, due to stagnation of the expenditure levels the Board of the Health Insurance Fund decided to extend the acceptable duration of the waiting list for out-patient specialist treatment from four weeks to six weeks as from March 2009 to tackle the increasing demand. This will delay access to specialist care, while the maximum duration of waiting lists for general medical care, hospital treatment and day surgeries remained unaltered.

The financial crisis has also had a severe impact on the value of pension assets in the mandatory funded pension scheme. In 2008, the weighed average rate of return of the mandatory funded pension scheme was minus 37.5%. For pension funds investing in equities, the decline in the value of pension fund assets was particularly severe in October 2008. In response, the fund managers have re-shifted assets in fund portfolios from equities more towards deposits and government bonds. At the same time, the impact of the financial crisis on conservative pension funds investing only in fixed-interest instruments (no equity exposure) has been rather minor, the net asset value declining by 2.2% over 2008.

From 1 January 2009, withdrawal of funded pensions is available for persons who joined the new funded scheme in 2002 and meanwhile have reached the pension age. However, retirees who had invested in higher-risk pension funds would face a significant loss as compared to the value of contributions paid into the funds, if they decide to withdraw a pension in the current situation. While most of the fund managers and custodian banks had recommended lower-risk pension funds for older persons, this is not a legal requirement and the investment risk of pension funds is entirely on fund participants.

Social tax revenues in April and May 2009 comprised only 89-90% of the revenues level in respective months of 2008. At the same time, expenditure levels in April and May 2009 were

5% higher than the year before following indexation of pensions. Over the first five months of 2009 expenditures on state pensions had exceeded social tax revenues by nearly EEK 1 billion. To secure continuous payment of state pensions, the Government decided to suspend temporarily contributions to the mandatory funded pillar. The negative rate of return of pension funds was used as an additional argument to justify suspension. On 14 May 2009, the Parliament adopted respective amendments to the Funded Pensions Act and the Social Tax Act. Contributions to the mandatory funded 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. However, persons with ten years from retirement (born 1954 or later) may, upon submitting a relevant application, resume individual contributions (2%) from 1 January 2010, in which case also state contributions on account of social tax (4%) are transferred. Other age groups may continue to pay individual contributions (2%) from 1 January 2010, but no contributions from social tax are transferred (i.e. the scheme applied is 2+0%). For any other participant of the funded scheme (i.e. persons not opting for voluntary continuation of individual contributions), contributions to the funded scheme are gradually resumed from 2011, when a 1+2% scheme is applied, and from 2012 in full amount of 2+4%.

On 21 May 2009, the Government approved another negative additional budget, cutting public expenditures in total by further EEK 3.4 billion (about 1.5% of GDP). These additional cuttings are motivated by a desire to introduce the European common currency Euro from 1 January 2011, with the resulting need to meet the Maastricht criteria, whereby government sector budget deficit shall not exceed 3% of GDP. The additional negative budget does not reduce expenditures on state pensions, but includes an additional reduction of health insurance expenditures by EEK 0.6 billion reflecting decline in actual social tax revenues. The main controversy in respect of the latter proposal relates to the possibility of using reserves accumulated in previous years to cover the shortfall of revenues. While the medical community largely advocates for making use of the existing reserves (as noted above, these amount to EEK 4.1 billion), the Government is opposed to using reserves as these reserves help to maintain the public sector balance within the Maastricht limits. To put it in other words, if reserves of the social protection systems were taken fully into use, other areas of public expenditures would need to be cut more severely to meet the budget deficit criteria. On the other hand, of course, as the duration of the crisis is still unknown, the accumulated reserves may turn to be insufficient to cover the shortfall of revenues over the full period of crisis.

To contain the costs of the health insurance scheme, the current coalition parties have made a proposal to reduce the rate of sickness cash benefit from current 80% to 70%, and the rate of benefit in case of caring for a sick child at home from current 100% to 80%. This proposal along with the second negative budget for 2009 is still pending in the Parliament. It is expected that the second negative budget is adopted before the end of 2009.

Some economic experts (incl. the Vice President of the Bank of Estonia) as well as journalists have also suggested the policy option of reducing the nominal value of state pensions in payment, but so far most of the political parties (incl. coalition and opposition) have claimed that despite declining wages, increasing unemployment and resulting decline in social tax revenues, state pensions will not be reduced.

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.

[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?eID=tx_mm_bccmsbase_zip&id=17421468174a2ca6e531cb0

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.

[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.

[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
[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

[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.

[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"

[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) co-operative 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.

[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/aruanne2008.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%.

[L] Long-term care

[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.

[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] 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.

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 programs 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 co-ordination 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.

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

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

For more information see:
http://ec.europa.eu/employment_social/progress/index_en.html