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Analytical support on social protection reforms and their socio-economic impact

Country Document 2013

Pensions, health and long-term care

Estonia

November 2013

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On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
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1 Executive Summary

Developments in the Estonian social policy in 2010-2013 have been affected by the temporary measures adopted during the recent economic downturn in 2008-2010 and their partial reversals in 2013-2017 and long-term concerns about the sustainability of the pension and health care financing.

Regarding the pension system, the last crisis accelerated some pension reforms. The main policy measures implemented during 2009-2011 were ad hoc changes in the pension indexation rule, which smoothed the value of nominal pensions; a temporary suspension of the transfers to the funded pension scheme in 2009-2011, and its compensation mechanism in 2014-2017; an increase of the pension age for the period 2017-2026. In the compulsory funded pension scheme, the crisis has resulted in stricter control and clearer rules over the management of the private pension funds and more flexibility for employees and employers. In 2012, the government has started the reform of special pensions, and first changes were implemented in 2013. In 2013, an additional pension supplement for people who have raised children stepped into force. It will increase pension expenditures in the future, but it is targeted to those who potentially suffer most from career breaks. In 2013, the government also approved the principles and the timeframe of the new disability insurance scheme that should gradually replace the existing work incapacity pension scheme by 2017. It foresees merging the work incapacity pension scheme with active and passive unemployment policy measures, which should encourage the employment of disabled people.

In health care, the main issue has been the 2008 financial crisis and its aftermath. Although Estonia has managed the downturn quite successfully and overall satisfaction with the health system remains high, it is hard to predict the longer-term effects of the austerity package. The main health care issues remain to be health system sustainability and efficiency; availability and quality of health care services, and affordability of pharmaceuticals. Structural issues concerning the funding of the health care system have not been resolved. Faced with the effects of population ageing, a new balance needs to be sought that ensures sustainability, quality and equity.

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

Since the health care and social welfare systems are relatively separate from each other it causes problems in terms of the transfer of individuals between the different systems, which can be regarded as a weakness of Estonia’s health care system.

2 Pensions

2.1 System description[1]

2.1.1 Major reforms that shaped the current system

The Estonian pension system consists of three main schemes: a state pension insurance scheme (a pay-as-you-go system with defined benefit) – the first pillar; a compulsory funded pension scheme (defined contribution scheme) – the second pillar; and voluntary funded pension scheme (defined contribution scheme) – the third pillar. The Estonian pension system resembles the World Bank's general three-pillar framework.[2]

According to Leppik (2006),[3] the transformation of the Estonian pension system occurred in two major waves. During the first one, 1990-92, both the financing and benefit sides of the Estonian pension system were separated from the Soviet system. This was followed by a period of relative stability when the pension system operated under a transitional arrangement. The second wave of transformation took place in 1998-2002, when the new three-pillar pension system was introduced. The reforms in 1998-2002 made changes in the state pension system but, even more significantly, they supplemented the state system with privately managed pre-funded pension schemes. The reform of the first pillar was implemented during 1999-2000; the second pillar, in 2002; and the legal framework for the third pillar was introduced in 1998.

Estonian pension system, partly influenced by the economic crisis of 2008-2010, such as changes in the indexation of state pensions or temporary suspension of compulsory funded pension contributions. There have also been several minor reforms that have affected the regulation of funded pension schemes, such as limits to fees, restrictions of investments, more flexible movement of people between funds, etc.

1 This section draws on previous asisp country reports
VÕRK, Andres/SEGAERT, Steven (2011) "Pensions, Health and Long-term Care", Asisp Annual Report 2011.
VÕRK, Andres LEPPIK, Lauri/SEGAERT, Steven (2010), " Pensions, Health and Long-term Care", Asisp Annual Report 2010.

2 WORLD BANK (1994), Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth, Oxford University Press

3 LEPPIK, LAURI (2006), Transformation of the Estonian Pension system: Policy Choices and Policy Outcomes, Tallinn: Tallinna Ülikooli Kirjastus, 2006, 155 p.

Table 1: Pension reforms that shaped the current system

State pension scheme (I pillar)	**Time**
• Individual recording of social tax	1999
• Introducing a contribution-related element in the pension formula by linking the acquisition of new pension rights to social tax paid on behalf of the person • Replacement of disability pensions with so-called work incapacity pensions • Introduction of qualification periods for work-incapacity and survivors' pensions • Calculation of old-age, work incapacity and survivors' pensions on similar principles; a few minor changes in following years • Provision for early retirement with a reduced pension	Gradual implementation 1998-2000
• Equalisation of the pensionable age for men and women at 63	Men by 2001, women by 2016
• Equalisation of the pensionable age for men and women at 65	Both men and women by 2026
• Introduction of deferred old-age pension	2002
• Introduction of indexation: both pensions in payment as well as components determining the amounts of newly granted pensions. Index: 50% Consumer Price Index (CPI) +50% increase of revenues of the pension insurance part of social tax	2002
• Change in the indexation formula (20% CPI + 80% increase of revenues of the pension insurance part of social tax)	2007
• Differential indexation of base component and pensionable service and insurance component	2007
• Ad hoc changes in the pension indexation during the economic crisis	2009-2014
Compulsory funded pension scheme (II pillar)	
• Introduction of compulsory funded pensions	2002
• Window for voluntary joining (persons born 1942-1982)	Depending on the birth year 2002-2010
• Changes in regulation of fees, investment rules, reporting activities, movement of people between funds	2008-2011
• Additional contributions by those receiving parental benefit (2004-2012) or with children below 3 years old (2013 onwards)	2004-2012 (1%) 2013 (4%)
• Suspension of payments during the economic crisis and the following compensation mechanism	2009-2010 2014-2017
Voluntary funded pension scheme (III pillar)	
• Legal framework for the scheme	1998
• Changes in limits to tax-free contributions to the voluntary pension scheme	2012
• Employers' contributions allowed	2012

Source: Leppik (2006)[4]; Leppik, Võrk (2006)[5]; own compilation

Since the introduction of the three pillars, various parametric reforms have shaped the System characteristics

[4] LEPPIK, LAURI (2006), Transformation of the Estonian Pension system: Policy Choices and Policy Outcomes, Tallinn: Tallinna Ülikooli Kirjastus, 2006, p. 155.

[5] LEPPIK, LAURI; VÕRK, ANDRES (2006) "Pension reform in Estonia" in *Pension Reform in the Baltic States* (edited by Elaine Fultz), ILO, Budapest.

The Estonian pension system consists of three main schemes:

State pension insurance scheme – I pillar

The state pension insurance provides protection against the risks of old age, invalidity and survivorship and counts two separate tiers: employment-based old-age, work incapacity and survivors' pensions, and flat-rate residence-based national pensions. Only working age persons (from 16 to pension age) are eligible for work incapacity pensions.

The purpose of the national pension is to guarantee a minimum income for those who are not entitled to the employment-based pension. National pensions are financed from the general state budget, whereas old-age, work incapacity and survivors' pensions are predominantly financed from an ear-marked social tax paid by employers and the self-employed at the rate of 16% or 20% of gross earnings depending on whether the insured person has joined the funded scheme or not. Additional transfers from the general state budget have been necessary in recent years.

In 2013, the statutory retirement age was 63 years for men and 62 years for women. It will be equalised at 63 by 2016, and as from 2017 it will gradually increase to 65 by 2026.

It is possible to retire up to 3 years earlier than the statutory pension age. For each month the pension is reduced by 0.4%, and it is not allowed to have labour earnings until the person has reached the statutory pension age. It is also possible to defer retirement. For each month the pension is then increased by 0.9%.

Old-age pensions (*P*) are comprised of three components: the flat rate base amount (*B*), the pensionable length of service component (*s*), covering periods up to 1998 and the insurance component that is based on individual social tax payments ($\sum I$), covering periods from 1999 onwards. Both the base amount (*B*) and the cash value (*V*) of one year of pensionable service and the pension insurance coefficient are indexed annually.

1) $P = B + s \times V + \sum I \times V$

The old-age pension is redistributive through the flat rate base amount (*B*), which on 1 April 2013 comprised about 38% of the average old-age pension. In addition, the length of service component (*s*) is strongly redistributive, but as this takes into account only employment periods up to 1998 its role is gradually diminishing for new pensioners. Redistribution is also achieved through crediting pension rights for some non-active periods (incl. caring for children and military service), either adding values to *s* when people retire or by paying social tax (i.e. contributing to $\sum I$) on behalf of some socio-economic groups.

Work incapacity pensions (*WIP*) depend on the same three components, but also on the per centage of a person's work incapacity (*%WI*). To avoid that the people would end up with very low pensions first the higher of the following two amounts is use as a basis:

- the amount of an old-age pension calculated from the individual's years of service and pension insurance coefficients (*POwn*) or,
- the amount of an old-age pension for a person with 30 years of pensionable service (*P30*).

For a work incapacity pension, the calculation base, as derived above, is then multiplied by the per cent of person's work incapacity (*%WI*). To create a floor below which work-incapacity pensions cannot fall, it is further stipulated that the work-incapacity pension may not be less than the rate of the national pension (that is, the minimum old-age pension).

2) $WIP = \max(\%WI \times \max(POwn, P30)\,;\ national\ pension)$

Similarly, survivor's pensions depend on the number of dependants.

3) $SP = \max(\%K \times \max(POwn, P30)\,;\ national\ pension),$

where %K is

100%, in the case of three or more dependant family members;

80%, in the case of two dependant family members;

50%, in the case of one dependant family member.

In addition to common old-age pensions, there are rules for special pensions and pensions under favourable conditions (e.g. pensions for the police, military, judges, etc.), which allow retirement under special conditions.

Pensions are indexed annually on 1 April of each year. The pension index (*PI*) is a weighted average of past consumer price indices and past growth of social tax revenues (*STR*) to the pension insurance system (in a 20-80 proportion).

4) $PI_t = 0{,}2 \times CPI_{t-1} + 0{,}8 \times STR_{t-1},$

Since 2007 a differential indexation of the base component and pensionable service and the insurance component is applied. The index is 10% higher for the flat rate base component and 10% lower for the cash value (*V*) of one year of pensionable service and the pension insurance coefficient.

5) $B_t = B_{t-1} \times [(PI_t - 1) \times 1{,}1 + 1)],$

6) $V_t = V_{t-1} \times [(PI_t - 1) \times 0{,}9 + 1],$

In 2009 ad hoc changes to the indexation rule of pensions were made. The changes allowed smoothing the value of nominal pensions during the crisis without having any long-term impact on the sustainability or adequacy of pensions. It resulted in a smaller increase of pensions than implied by the default index in 2009, no decline of pensions in 2010 and 2011, and predictably smaller increase again in 2012-2015.

Table 2: Development of the pension index 2008-2013

Year	2008	2009	2010	2011	2012	2013
Growth of Consumer Price Index	1.104	0.999	1.030	1.050	1.039	1.034*
Growth of social tax revenues	1.147	0.887	0.939	1.068	1.078	1.072*
Index for next year	1.138	0.909	0.957	1.064	1.070	1.064*
Applied index on 1 April next year	1.050	1.000	1.000	1.044	1.050	1.058*
Difference	0.088	-0.091	-0.043	0.020	0.020	-0.006
Cumulative difference to be compensated	0.088	-0.003	-0.046	-0.026	-0.006	0

* Preliminary estimates. Prediction in 2014 state budget
Source: Statistics Estonia, Estonian National Social Insurance Board, Ministry of Finance

Mandatory funded defined-contribution scheme – II pillar

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

employee pays 2% from the gross wage and the employer another 4% (as part of the 20% pension insurance contribution). The amount of pension benefits depends on total contributions over the working career and yields of pension funds. The scheme covers the risk of old age, but not invalidity.

For parents who receive parental benefits, 1% of the parental benefit was additionally transferred to the funded pension scheme from 2004-2012. Since 2013, 4% of the average taxable wage is transferred to the funded pension scheme on behalf of one parent whose child is younger than 3 years. The latter is part of so-called "parental pension" reform in 2013.

Participation in the scheme is mandatory for cohorts born in 1983 or later, whereas cohorts born in 1942-1982 had the option to join the scheme voluntarily. In 2010, last cohorts, born in 1980-1982, had to make a choice whether to participate in the pension scheme. As of 1 January 2013, 635,893 people had joined the scheme, which are 13,120 people more than at the beginning of the 2012.[6] By the end of 2012, the scheme covered about 75% of the population aged 18 to 63. At the end of 2012 60% of the participants contributed.[7]

Private fund managers run the funded scheme. There are 23 different funds, run by six fund managers. There are four types of funds varying according to maximum proportion of stocks in their asset portfolio.

By the end of 2012, the total value of assets in the compulsory funded scheme amounted to EUR 1.47 billion (about 8.6% of GDP). This was EUR 336 million (about 29.7%) more than a year earlier.[8]

The EPI index (*Eesti Pensioniindeks*), which reflects the weighted average of the net rate of return of all mandatory pension funds, increased 9.5% in 2012. The index for conservative funds (no stocks) increased by 7.06% and for the most aggressive funds (investing 75% to stocks) increased by 12.42% in 2012.[9]

Since 1 January 2009, persons who joined the funded scheme in 2002 and meanwhile had reached pension age were entitled to withdraw benefits. In most cases, the accumulated assets are rather small. By the end of 2012 EUR 13.9 million were withdrawn from mandatory pension funds. At the end of 2012, about 18,000 people (6% of pensioners) had the right to collect benefits from the funded pension scheme. About one quarter had postponed withdrawal of their pensions.[10]

Voluntary funded pension scheme – III pillar

Voluntary funded pension scheme (the third pillar) plays a minor role in Estonia so far. The voluntary funded pension contracts can be made by acquiring pension fund units at fund managers or with life insurers as pension insurance. Two types of pension insurance contracts exist: pension insurance with guaranteed interest and pension insurance with investment risk.

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6 Source: Pensionikeskus, on-line statistics, Table „Kogumispensioniga liitujate arv", retrieved on 12 September 2013 at http://www.pensionikeskus.ee/?id=694&chartSelector=count.

7 Source: Ministry of Finance (2013) „Riikliku vanaduspensioni, kohustusliku kogumispensioni ja vabatahtliku kogumispensioni statistika. Seisuga 31.12.2012", retrieved on 12 September 2013 at http://files.ee.omxgroup.com/pensionikeskus/dokumendid/kogumispensioni_statistika_012013.pdf.

8 Source: Pensionikeskus, on-line statistics, Table „Kogumispensioni fondide maht", retrieved on 12 September 2013 at http://www.pensionikeskus.ee/?id=694&chartSelector=volume; Statistics Estonia on-line database, Table „NAA012: Gross domestic product and gross national income; own calculations.

9 Source: Pensionikeskus, on-line statistics, Table „Kogumispensioni indeksid", retrieved on 12 September 2013 at http://www.pensionikeskus.ee/?id=694&chartSelector=epi; own calculations.

10 Source: Ministry of Finance (2013) „Riikliku vanaduspensioni, kohustusliku kogumispensioni ja vabatahtliku kogumispensioni statistika. Seisuga 31.12.2012", retrieved on 12 September 2013 at http://files.ee.omxgroup.com/pensionikeskus/dokumendid/kogumispensioni_statistika_012013.pdf.

There are 13 pension funds by six pension fund managers; in addition, there are five pension insurance providers.

The voluntary funded pension scheme had about 56,000 participants (7% of people aged 18–62) with assets about EUR 95.5 million (about 0.5% of GDP) at the end of 2012. There were additionally about 68,000 contracts in the form of life insurance at the end of the 2012. The value of reserves of the insurance contracts was EUR 187.2 million (about 1.1% of GDP). Participation in the voluntary scheme has slightly dropped compared to previous year (from 70,000).[11]

Contributions to the voluntary pension system can be deducted from the taxable income up to 15% of the employee's taxable income. As of 1 January 2012 an additional upper limit, EUR 6,000 per annum is set to tax-free contributions to the voluntary pension scheme. The income tax rate on pension payments is also lower, 10% compared to the usual 21%, if conditions regarding investment duration and investor's age at the time of withdrawal are fulfilled.

Since 2012 employers have been able to contribute to the voluntary pension fund of an employee up to the amount of 15% of an employee's annual salary or EUR 6,000 without paying the fringe benefits tax (equal to the sum of income tax and social tax), but only social tax.

2.1.2 Details on recent reforms

Reforms in the past 2-3 years have been influenced by the decisions made during the economic crisis, which had been covered in depth in two previous asisp country reports. Below we outline selection of reforms that we consider most important. The changes in the indexation of I pillar pensions were discussed in the previous section.

Parental pension

Since 1.1.2013 a set of policy measures to increase the old-age pension of those who have raised children has stepped into force. These measures, influencing both the state pension insurance scheme and compulsory funded pension scheme, are jointly referred to as parental pension (*vanemapension*). These additional pension supplements for parents who have raised children were one of the main election promises by one of the coalition partners, Union of Pro Patria and Res Publica (*Isamaa ja Res Publica Liit*) during the last parliamentary election campaign. Although it increases pension expenditures, it is targeted at those who potentially suffer most from career breaks.

Until 1.1.2013 one of the parents who had raised children 8 years before 31 December 1998 (i.e. children must have been born before 1 January 1991) received a pension supplement equal to the value of two years of pensionable length of service. In addition, the actual time of child care leave (up to a child's age of three) was included in the pensionable length of the service component. On 1 January 1999 the system changed and one of the parents received annual pension insurance coefficients that depended on the minimum social tax base on which the state paid social tax. This minimum social tax base used to be considerably lower than the average taxable earnings, varying from 10% of the average earnings in 2005 to 39% in 2010. It means that the pension rights earned by one of the parents were considerably smaller during 1999-2012.

In addition to the pension insurance coefficients, for the parent who received parental benefits, 1% of the value of parental benefit was additionally transferred to the funded pension scheme in 2004-2012.

[11] Source: see previous footnote.

Since 1 January 2013 for one parent of children who will be born after 1 January 2013 the state transfers 4% of the average taxable income to the compulsory funded pension scheme until the child reaches 3 years.[12] If the person has not joined the funded pension scheme (i.e. the parent was born before 1.1.1983 and chose not to join the scheme), he/she will receive an additional pension supplement at the value of three annual coefficients when retiring for each child that he/she has raised at least 8 years.

The amendments made to the parental pension also affected children born before 1 January 2013 to compensate the low pension credits received during 1999-2012. Since 1 January 2013, one of the parents of children who were born between 31 December 1980 and 31 December 2012 receives a pension supplement equal to the value of two years of pensionable length of service when retiring.

The amendments also stipulate that as of 1 January 2015 one of the parents of all children born before 1 January 2013 will receive an additional pension supplement at the value of one annual coefficient. It means that one of the parents whose child was born already before 1991 and who currently already receives a pension supplement equal to the value of two years of pensionable length of service will also receive additional top-up. The value of annual coefficient and one year of pensionable length of service is EUR 4.7 per month in 2013.

It is foreseen that all pension supplements are transferred from the general state budget and not from earmarked social tax revenues. The Ministry of Social Affairs has published a preliminary ex ante evaluation of the reform.[13] It shows that the additional expenditures are initially low, because only few parents whose children were born after 1991 have reached the pension age. In 2013, the additional expenditure will be EUR 2.8 million, but by 2017 it will increase to EUR 44 million. In the long run, the additional cost will reach 0.2-0.25% of GDP. For parents whose children have already been born, the pension supplement will depend on the indexation of state pensions, but for future parents it will depend on the rate of return of the funded pension scheme. It is estimated that on average a parent with two children may receive an increase of their pensions of around 4-10%. Accordingly, this will decrease the gender pension difference, as in most cases it is a mother who is eligible to the pension supplement.

Temporary changes in the funded pension contributions

The main policy reaction to the deficit in the state pension scheme during the recent economic crisis in 2009-2010 was the suspension of the contributions to the funded pension scheme. This was discussed in detail in 2011 and 2012 ASISP annual report. Transfers from social tax revenues to the mandatory funded scheme were temporarily suspended from 1 June 2009 until 31 December 2010 and partly suspended also in 2011 to reduce the deficit of the state PAYG pension system. For 2014–2017, there is a compensation mechanism that will transfer additional social tax revenues to the funded scheme.

By 15 September 2013, people who had joined the second pillar had an option to increase their contributions. About 106,000 people (approx. 16%) increased their contributions to 3%

[12] Initially there was a requirement in the draft law that the parent should not work at the same time, but this was dropped from the final version.

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

of gross wage (from usual 2%) and the share of social tax transferred to the funded scheme will increase from 4% to 6% of gross wage. The transfers operated by the state increased to 6% also for those 180,000 people who continued their contributions in 2010-2011, but did not choose to raise their contributions in 2014-2017.

Table 3: Distribution of people according to their decision to increase contributions to the second pillar and the contribution rates (in parentheses)

Did the person increase contributions in 2014-2017? Did the person continue paying own contributions in 2010-2011?	Yes	No	Total
Yes	40,410 (3+6)	179,943 (2+6)	220,353
No	65,730 (3+6)	359,929 (2+4)	425,659
Total	106,140	539,872	646,012

Note: The first number in parentheses refers to individual contributions and the second number refers state transfers from social tax.

Source: Ministry of Finance, Pensionikeskus, own calculations

Abolishing special pensions

The coalition agreement of the current government foresees a gradual abolishing or amending of the rules for special pensions and pensions under favourable conditions (e.g. pensions for the police, military, judges, etc.), which allow early retirement, reduce flexibility in the labour market, and hide some long-term fiscal obligations.

Since 1 January 2013 the special pensions of the Auditor General and the Chancellor of Justice have been abolished (maintaining the existing pension rights). In addition, the indexation of pensions that are regulated by the Police and Border Guard Act were changed from indexation based on the relevant salary rate to indexation based on the common pension index.

Increase of pension tax allowance

The government has promised to increase income tax allowance for pensions by EUR 18 per month, from current EUR 192 to EUR 210 per month. Together with the general tax allowance (EUR 144) it would mean that for an average non-working pensioner the pension is free from income tax as the average old-age pension was EUR 315 in January 2013.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

The coverage of the state pension insurance system is practically universal. As of end of 2012, the total number of pension recipients was 409,260 (about 32% of the population). Of those, 301,434 received old-age pension (96.3% of the age group 60 and over), 94,418 work incapacity pensions (i.e. disability pensions), about 6,972 families (with about 9,000 persons) were recipients of survivor's pensions and 6,436 received national pensions.

In January 2013, the average gross old-age pension reached EUR 315, an increase by 3.7% compared to the average old-age pension at the beginning of 2012, which was EUR 304. The increase is due to the changing structure of the pensioners, additional insurance components

earned by working pensioners and indexation of pensions. There are very few pensioners who receive second pillar pensions and the pensions are very low. The II pillar pension adds only about 20 cents on average, as only 0.4% of current old-age pensioners have a pension insurance contract from the funded pension scheme.[14]

The average work incapacity pension is about 58% and the average survivor's pension per family about 48% of the average old-age pension. The flat rate national pension, which serves simultaneously as a minimum pension guarantee, amounted to EUR 140.81 in 1 April 2013 (5% increase compared to 1 April 2012 due to indexation). Recipients of the national pension on grounds of age constitute less than 1% of all pensioners receiving a pension on the grounds of age.

All pensions are taxed by income tax, but as there is an additional tax allowance for pensions, the effective tax rate on pensions is very low. The average gross old-age pension comprised about 34% of the average gross wage of a full-time worker in January 2013. The average net replacement rate is about 36-41%, depending whether a pensioner is working or not at the same time.

The employment rate of elderly (aged 55-64 and 65-69) declined during this crisis by about 7-8 percentage points (in 2010) compared to the peak values in 2007-2008, but this drop is similar to the employment rate change of prime-age workers. The employment rates of pensioners have started to increase again in 2011 and 2012 reaching pre-crisis level.

Simultaneously, inflow into the pension system increased substantially in 2009 and 2010, especially via work incapacity pensions and early retirement. In 2010 the inflow into the work incapacity pension scheme was 50% higher than in 2007, and via early retirement scheme 60% higher. High inflow into the work incapacity scheme continued also in 2011 and only 2012 we see a decline again.

The Estonian pensioners' situation relative to the working age population before retirement is comparable to other EU countries. The adequacy indicators are at slightly below the EU-27 average values. For example, the aggregate replacement ratio is 50% (EU-27 average is 54% in 2010 income year). The at-risk-of-poverty rate of those older than 65 is 17.2% (EU-27 average is 15.9% in 2010). The severe material deprivation rate of those older than 65 is 7.1% in 2012 (EU-27 average is 7.2% in 2011). The median relative income of people 65+ as a ratio of income of people 0-64 is 72% in 2012 (EU-27 average is 89% in 2011). Both the median relative income of elderly and aggregate replacement ratio have worsened slightly compared to 2010 values, reflecting the fact that pensions did not increase in 2010 and increased at slower rate that wage growth in 2011.

There is a considerable remarkable difference in the at-risk-of-poverty rate between elderly men and women (11.2% versus 20.1% respectively in the age group 65 or over, and even greater difference among those aged 75 or more). The main reason is simply that men statistically enjoy a shorter life-expectancy (14 years for men and 19 years for women at the age of 65 in 2010) and therefore tend to live in couple households, where the risk-of-poverty is lower by definition (through equivalence scales). The at-risk-of-poverty rate of single people older than 65 was 31.4% in 2011.

[14] Source: Ministry of Finance (2013) „Riikliku vanaduspensioni, kohustusliku kogumispensioni ja vabatahtliku kogumispensioni statistika. Seisuga 31.12.2012", retrieved on 12 September 2013 at http://files.ee.omxgroup.com/pensionikeskus/dokumendid/kogumispensioni_statistika_012013.pdf .

Table 4: Selection of indicators of poverty and employment of elderly, 2008-2012

Year	2008	2009	2010	2011	2012
Employment rate, %					
Age group: 25-54	83.7	76.2	74.6	78.1	79.1
Age group: 55-64	62.2	60.4	53.8	57.1	60.5
Age group: 65-69	24.2	19.6	18.2	19.5	26.5
Inflow into the pension system					
Old-age pensions (*vanaduspension*)	7,583	9,312	10,934	8,675	7,750
Of which early retirement (*ennetähtaegne vanaduspension*)	1,372	2,327	2,590	1,656	1,470
Work incapacity pensions (*töövõimetuspension*)	6,726	8,650	10,280	10,370	8,925
At-risk-of-poverty rate (60% of median equivalent income), total*	19.7	15.8	17.5	17.5	
Age group: 65+	33.9	15.1	13.1	17.2	
Men	18.9	8.0	7.2	11.2	
Women	41.3	18.6	15.9	20.1	
Single	71.3	28.5	21.6	31.4	
Relative median at-risk-of-poverty gap, %, total*	17.0	23.2	26.0	23.8	
Age group: 65+	11.4	9.0	8.7	8.1	
Severe material deprivation (%), total	4.9	6.2	9.0	8.7	9.4
Age group: 65+	5.8	5.6	6.6	5.8	7.1
Relative median income of elderly (65+ versus other age groups)*	0.66	0.73	0.75	0.72	
Aggregate replacement ratio (income of pensions of 65-74 to income from work of 50-59)*	0.52	0.55	0.54	0.50	
Quintile ratio (S80/S20)	3.2	2.9	2.9	3.0	

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

The current income distribution of Estonian elderly is considerably narrower (S80/S20 ratio is 3.0) than among younger population (5.9) or elderly in EU-27 (4.1). This is because of the redistributive flat rate base amount, which is about 38% of the average old-age pension. In addition, the length of service component is strongly redistributive, but as this takes into account only employment periods up to 1998 its role is gradually diminishing for new pensioners. Redistribution is also achieved through crediting pension rights for some non-active periods (incl. child care and military service). In the future, when contributions matter more both in the state pension scheme and in the funded pension schemes, the distribution of pensions will be considerably wider.

A majority of old-age pensioners are located near the relative poverty line of the income distribution. Small changes either in the distribution of the labour income or in old-age pensions may change the poverty line and shift a large proportion of old-age people either above or below the poverty line, with no significant change in their actual living conditions. For example, at-risk-of-poverty rate of those older than 65 was 39% in 2008 but only 15.1%

in 2009 and 13.1% in 2010, but 17.2% again in 2011. Therefore, it is crucial that other indicators, such as material deprivation rate or absolute poverty rate are used to evaluate the current situation of the Estonian elderly either over time or relative to other socioeconomic groups. For example, the absolute poverty rate, that is the share of people with income less than the absolute poverty line, set equal to the subsistence minimum, was only 2.3% among the age group 65+, while it was 18.1% among children younger than 15, and 11.7% in the total population in 2010.

Those receiving a national pension may have a higher risk of poverty, but because there are not many of them (about 1.6% of all pensioners), there are no official poverty measures for them. The level of national pension has been about 20-23% of the medium income in 2004-2011, much below international standard of 40% and even below the national subsistence minimum (69% in 2012).

Another large group of pensioners that faces high risk of poverty, which is not well represented in regular indicators, are those receiving work incapacity pensions. There are about 94,000 people receiving work incapacity pension. The average work incapacity pension was about 58% of average old-age pension in 2012. About half of work incapacity pensioners do any work, but even then, their average annual earnings are less than half of the average wage.

Statistics on applications for subsistence benefits confirm that work incapacity pensioners are more likely to be in households that are eligible for subsistence benefits. There were 23,518 pensioners in approved applications in 2012. Of those 76% were work incapacity pensioners and only 10% were old-age pensioners (remaining 10% must be other categories).[15] It shows that work incapacity pensioners face considerably higher risk of being in the households with very low income.

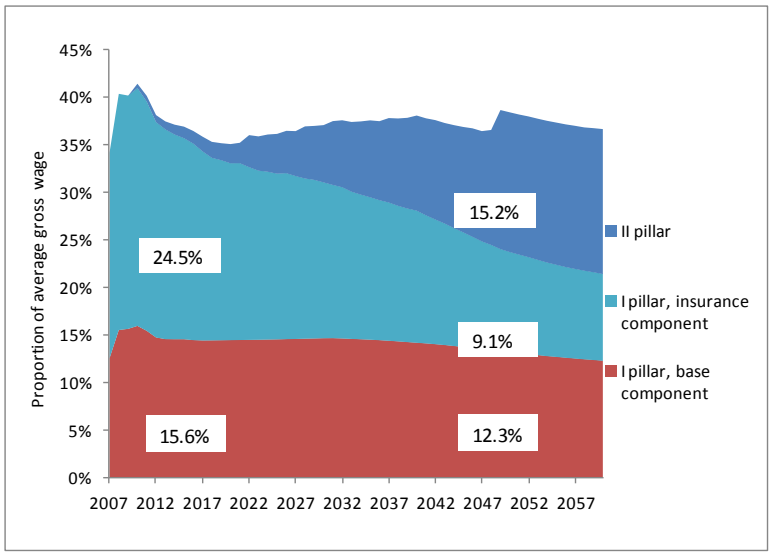
[15] Ministry of Social affairs (2013), "Toimetulekutoetus kohalike omavalitsusüksuste lõikes. 2012", Table '*Tabel 3. Leibkonnaliikmete arv rahuldatud taotluste järgi, 2012'* retrieved on 12 Septembet 2013 at http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalsektori_statistika/Toimetulekutoetus_2012._aastal.xls; own calculations.

Pension adequacy in the future

Regarding the future adequacy of pensions, simulations of gross replacement rates either using numerical calculations of typical workers[16] or cohort-based models by the Ministry of Finance or by the Praxis Center for Policy Studies [17] indicate that the average gross replacement rate from the statutory pension scheme does not change much, staying around 35-40%. Pension benefits from statutory funded scheme are projected to offset the fall in the replacement ratio in the public scheme to a certain extent.

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

Figure 1: The average gross replacement rate of pensions for the new old-age pensioners at the time of retiring in the retirement age



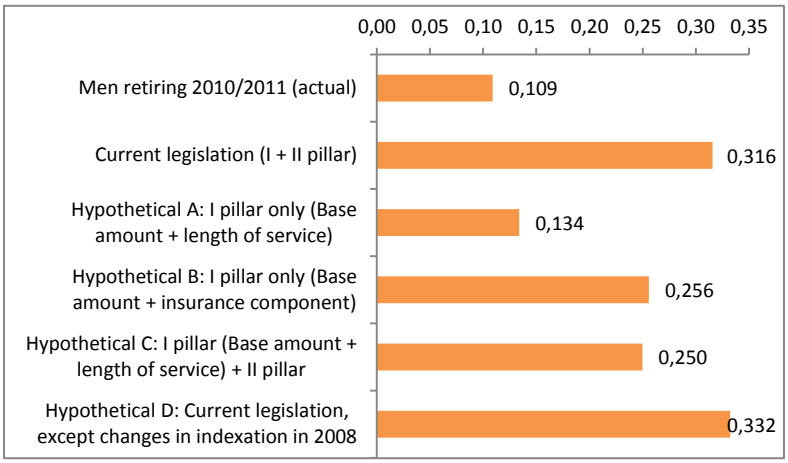
Source: The model of the social budget by Praxis, own calculations

With her analysis Jõgi (2013) shows that recent reforms have considerably increased future inequality of pensions. While the current Gini index of pensions is low (0.11 among men who retired 2010-2011), it will be around 0.32 in the future, as both variation of unemployment experience and of lifetime earnings contribute much more to pensions than earlier. Therefore, the risk of poverty among pensioners will increase considerably in the future.

[16] Interactive pension calculator is available at http://www.minuraha.ee/kasulikud-abivahendid/?popup=pensionikalkulaator_tulevik, which is run by Finantsinspektsioon.

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

Figure 2: Gini index of pensions, men born 1980, retiring 2046, actual and hypothetical pension reforms



Source: adapted from Jõgi (2013)[18]

2.2.2 Sustainability

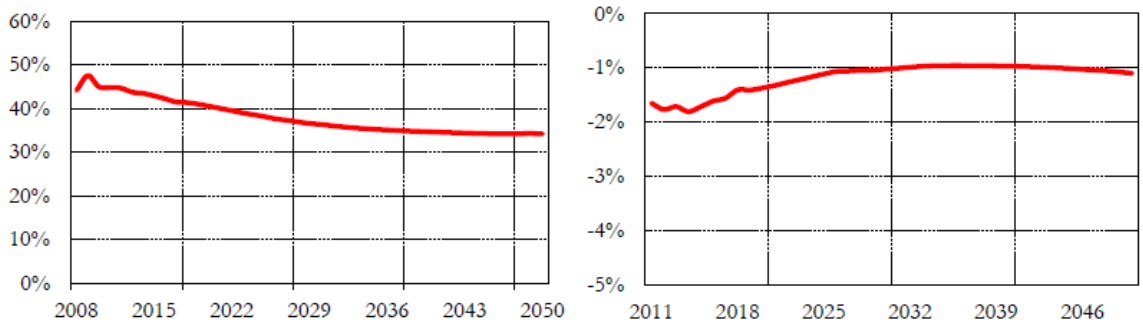
Expenditures on state pensions amounted to EUR 1.36 billion or 7.8% of GDP in 2012. The total revenues from the pension insurance component of social tax (20% of gross earnings) amounted to EUR 1.16 billion (6.8% of GDP). However, EUR 153 million of social tax revenues were redirected to individual accounts of participants of the funded scheme in 2012. As a result, of the total expenditures on state pensions EUR 1.007 billion were financed from current social tax revenues, additional earmarked contributions from the state budget for special pensions were EUR 43 million and the remaining part (EUR 310 million or 1.8% of GDP) was additionally transferred from the general state budget.

Forecasts both by the Ministry of Finance and the Praxis Center for Policy Studies[19] predict that given the current pension rules and the Eurostat (Europop 2010) forecasts about the life expectancy, then social tax revenues may not cover the expenditure on state pensions for next decades. Additional transfers required from other tax revenues are about 1% of GDP in the long run, and around 2% of GDP in the next few years due to additional transfers to the funded pension scheme.

[18] JÕGI, EVELIN (2013). Eesti pensionisüsteemi reformide jaotuslike mõjude hindamine kohordisimulatsioonimeetodi abil. (*Assessment of the distributional impact of Estonian pension reforms based on the cohort simulation method*). Master Thesis. University ot Tartu. Estonia, retrieved on 12 September 2013 at https://dspace.utlib.ee/dspace/bitstream/handle/10062/31778/jogi_evelin.pdf

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

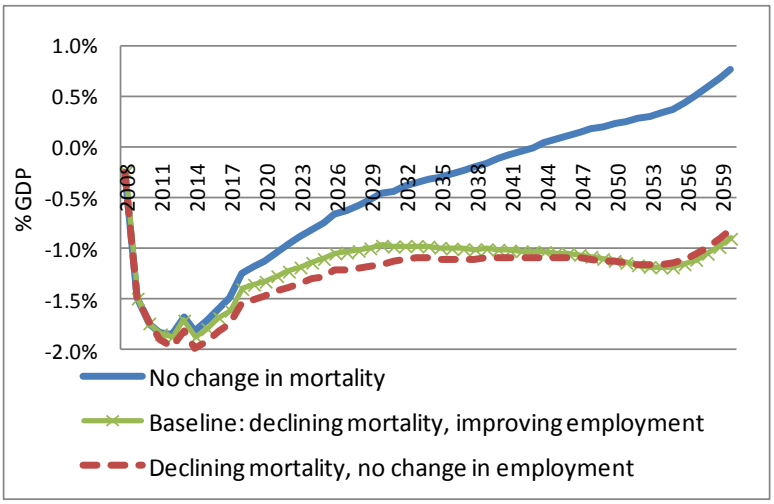
Figure 3: Predicted average replacement rate (%) of pensions from I and II pillar (left chart) and the deficit of the I pillar (% of GDP)



Source: Ministry of Finance, "Riigi eelarve strateegia 2014-2017", updated 26 June 2013, Tallinn/retrieved on 12 October 2013 at http://www.fin.ee/doc.php?109291

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

Figure 4: Difference of the revenues and expenditure of the state pension scheme (I pillar), according to main demographic and labour market assumptions



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

2.2.3 Private pensions

The voluntary funded pension scheme (the third pillar) plays a minor role in Estonia so far. It has about 56,000 participants (7% of people aged 18–62) with assets about EUR 95.5 million (about 0.5% of GDP) at the end of 2012. There were additionally about 68,000 contracts in the form of life insurance at the end of the 2012. The value of reserves of the insurance contracts was EUR 187.2 million (about 1.1% of GDP).

2.2.4 Summary

The Estonian three-pillar pension scheme survived the recent crisis pretty well. Although temporary measures were taken to reduce the deficit in the public pension scheme, most of them have been reversed by the end of 2013.

Unlike some new member states (Poland, Hungary), who have reformed their funded pension schemes, the Estonian compulsory funded pension scheme (II pillar) seems to continue in good health. On the one hand, the government has strengthened the supervision and regulation of the scheme, but on the other hand allowed additional flexibility for investors and increased public awareness of the details of the Estonian pension system via on-line pension calculators. Membership in the voluntary funded pension scheme declined during the recent crisis, but it has stabilized now and has started to grow again.

Current old-age pensions are low compared to other EU countries, but the relative situation of the poverty of the Estonian elderly compared to the other social groups in the society is quite similar to the EU average situation. Low pensions (compared to wages) mean also that the Estonian pension system does not face threat to sustainability; the predicted share of public pensions does not increase much in the future.

It has been a political decision to raise the pension supplement for people who have raised children. This increases pensions of those who have plausibly suffered most from career breaks. As these supplements will hardly lead to any behavioural changes regarding labour supply or fertility behaviour, it must be seen as redistribution from those pensioners who have not raised children to those who have.

The government has finally started to reform the work incapacity pension scheme (see the following section), which should eventually lead to improved situation of disabled people, who currently face the highest risk of absolute poverty in Estonia.

2.3 Reform debates

There are not many debates on the old-age pension system. The main discussion focuses on the planned reform of the work-incapacity pension scheme. On 6th of June 2013 the government approved a reform paper that outlines the principles and the timeframe of the new disability insurance scheme.[20] The purpose of the reform is to help disabled people to find and maintain a job, increase the employment rate of the disabled and to guarantee financial sustainability of the support system of disabled people. The reform paper foresees a change in the methodology of the assessment of work capacity. The new disability benefit will be combined with the current unemployment insurance benefit and those with partial loss of work capacity need to be registered at the Unemployment Insurance Fund and may be required to participate in active labour market measures to receive their benefit. The reform package also includes the introduction of the new work accident insurance scheme, and an occupational disease insurance scheme, the latter in a later phase of the reform. These reforms would lead to a gradual abolishment of superannuated pensions and old-age pensions under favourable conditions.

[20] "Töövõime toetamise süsteemi põhimõtted ja ajakava", retrieved on 12 October 2013 at http://www.sm.ee/fileadmin/meedia/Dokumendid/TVK/T%C3%B6%C3%B6v%C3%B5ime_toetamise_s%C3%BCsteemi_p%C3%B5him%C3%B5tted_ja_ajakava.pdf .

3 Health care

3.1 System description[21]

3.1.1 Major reforms that shaped the current system

Health care in Estonia is provided through contracted private entities and financed by social insurance contributions and through the general budget. Since its independence in 1991, Estonia has been undergoing extensive reforms to expand insurance coverage and availability of services (both public health and health care). The aim is to increase the responsiveness to patients and to change various other elements of the health system. Chronologically, the Estonian health system reforms can be divided into four development phases: the early 1990s, the mid-1990s, the late 1990s/early 21st century, and the current phase. The first two periods introduced a radical new direction for the health system to move away from the Soviet system and laid the foundation for the current organisational structure (including the Ministry of Social Affairs (MoSA), the Estonian Health Insurance Fund (EHIF)). The first reforms were not prepared down to the very last detail, leaving the possibility to consider and fine-tune details and provided for independence for regional innovation in implementation. The third phase aimed to clarify and strengthen the regulatory structure, setting the strategic objectives, setting the functions and responsibilities of the stakeholders and exploring different work strategies. In 2001/2002 this phase culminated in an update in health care legislation, that has ever since been the basis for further health system development.[22]

In 1994, the Central Sickness Fund was established on the basis of the ineffective Estonian Health Insurance Association in order to strengthen central functions such as planning, centralised pooling and allocation of revenues. The social tax rate (13% earmarked payroll tax for health insurance and 20% for pension insurance tax) was introduced. The State Health Insurance Council, which consisted of 15 members, governed the Central Sickness Fund: five representatives of state organisations, 5 members from employers' organisations and 5 representatives of insured individuals' groups. In 1999, the Estonian Tax and Customs Board became solely responsible for the collection of the social tax. Social tax is collected with the aim of receiving the income necessary for state pension and sickness insurance. The revenues from social tax consist of the payments made during employment and service relationships, payments made to the member of the management or control body of a legal person, payments made to a natural person on the basis of a contract under the law of obligations entered into for the provision of a service, also from fringe benefits, and the income tax paid on them.[23]

In 2001, the EHIF obtained its present status as a public independent legal body, replacing the Central Sickness Fund and the 17 regional sickness funds. Its main role is to act as an active purchasing agency and its responsibilities include contracting of health care providers, paying

[21] This section draws on the previous country report VÕRK, Andres, SEGAERT, Steven (2012) "Pensions, Health and Long-term Care", Asisp Annual Report 2012.

[22] KOPPEL A, KAHUR K, HABICHt T, SAAR P, HABICHt J and van GINNEKEN E. Estonia: Health system review, Health Systems in Transition, 2008; 10(1): 1-230.

[23] In the aforementioned cases, the payer shall pay social tax and the period of taxation shall be a calendar month. In general, social tax shall be paid at a rate of 33% on wages actually paid, but for each employee/worker at least from the monthly rate established by the state budget, which is EUR 290 in 2013.23 Social tax covers both health and pension contributions (equal to 13% and 20%, respectively, of employee wages and of self-employed individuals' earnings).

for health services, reimbursing pharmaceutical expenditure and paying for temporary sick leave and maternity benefits.[24]

The Health Services Organisation Act defines four types of health care: primary care provided by family doctors, emergency medical care, specialized (secondary and tertiary) medical care and nursing care. Health care providers are autonomous. Individuals or institutions operating as private legal entities can only provide services: a limited liability company, a foundation or a private entrepreneur. Most hospitals are either limited liability companies owned by local governments, or foundations established by the State, municipalities or other public agencies. In this sense, they are owned and managed as public institutions, either on a profit-making (limited liability company) or non-profit-making (foundation) basis[25].

Reform of primary care began in 1991, with the aim of developing a family medicine-centred PHC system and establishing family medicine as a medical specialty. In 1997, changes in health service regulations required people to register with a particular family doctor (compulsory practice lists and now family doctor can be freely chosen). The same year, family doctors were contracted by the EHIF to provide PHC services. The Health Services Organisation Act, which came into force in 2002, established the regulatory framework for primary care and family medicine, whereby primary care is organised as the first level of contact with the health system and provided by independent family doctors practising on the basis of a practice list. Most family doctors with a practice list are contracted by the EHIF.

At the end of 2007, a legislative framework for a Health Information System was established by way of amendments to the 1994 Health Services Organisation Act. The aim of the new digital database is to improve the quality of health services through efficient information sharing, while at the same time protecting patients' rights. Digital information further allows doctors to consult with specialists, without the need for the patient to make extra visits or undergo additional testing. Under the new act, health care service providers are obligated to enter medical data into the system, including what health services were provided to patients, information on their health status, digital recordings and information concerning waiting lists. This obligation was implemented starting from September 2008. Today, patients and doctors alike can see the results of tests online, via a secured access.[26]

3.1.2 System characteristics

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.

[24] KOPPEL A, KAHUR K, HABICHT T, SAAR P, HABICHT J and van GINNEKEN E. Estonia: Health system review, Health Systems in Transition, 2008; 10(1): 1-230.

[25] KRUUS P, AAVIKSOO A, HALLIK R, UUS M. Strategic Intelligence Monitor on Personal Health Systems, Phase 2: Country Study Estonia. 2013. http://ftp.jrc.es/EURdoc/JRC71154.pdf

[26] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVET R, van GINNEKEN E. Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

All hospitals need to be licensed by the Health Board. Differences in requirements according to hospital levels are mainly in the form of a minimum set of medical specialties that certain levels of hospitals must represent. Each acute care hospital covers a certain area or region. The location has been chosen so that acute care services are available to everyone at a distance of 70 km or 60 minutes' drive; the government approved the Hospital Network Development Plan (HNDP) based on this principle. In order to ensure equal availability of specialist medical services, the HNDP foresees the existence of 19 acute care hospitals, including 11 general, 4 central, 3 regional and 1 local hospitals.[27]

In 2004, the EHIF implemented a DRG-based payment system for inpatient services. The DRG system goal is to increase productivity and efficiency. Another motivation for introducing DRGs was that the old fee-for-service and per diem payment systems had led to volume inflation.[28]. The importance of the DRG system has increased gradually with the increase (from 10% up to 70% since July 2009) in the share of the DRG payment system since the introduction of the system. In addition, over time the DRG system has become a tool for benchmarking and analysis. Since 2005, the EHIF has been providing hospitals with regular information updates regarding average length of stay, case mix index (CMI) (since 2008), use of some DRGs, share of outliers and so on, in order to give them the opportunity to compare with other hospitals, as well as to follow the trend of certain indicators across time.[29]

Providers that operate under private law build the Estonian health system around a basis of compulsory, solidarity-based insurance and universal access to health services made available. 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) or by the State (parents on parental leave, persons taking care of disabled persons, no 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, example students).

Coverage is high, in 2013 with around 95.7% of the population included.[30] The remainder is comprised of unemployed persons not registered as job-seekers, persons insured abroad, persons avoiding taxes, and persons living on sources of income that are not subject to taxation (such as dividends). Uninsured persons are entitled to emergency services in case of need. Some municipalities cover also primary care of uninsured people.

The system provides for benefits in kind through a system of family physicians, specialised care and emergency care. Health care services in kind are provided to the citizens irrespective of the amount of contributions paid, and are provided free of charge. Co-payments are required only for some services, for home visits made by family doctors and for outpatient-specialised care. The cost-sharing requirements for outpatient care are as follows. There are no co-payments for visits to a family doctor, although family doctors can charge a maximum fee of €5.00 (until 2013 the maximum limit was €3.20) for home visits. EHIF-contracted providers of ambulatory specialist care can charge a maximum fee of €5.00 (until 2013 the

[27] KOPPEL A, KAHUR K, HABICHT T, SAAR P, HABICHT J and VAN GINNEKEN E. Estonia: Health system review. Health Systems in Transition. 2008; 10(1): 1-230.

[28] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E. Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

[29] BUSSE R, GEISSLER A, QUENTIN W, WILEY M. Diagnosis-Related Groups in Europe. Open University Press in Buckingham; 2011.

[30] Estonian Health Insurance Fund. Statistics 2013. http://www.haigekassa.ee/eng

maximum limit was €3.20) but there is no fee if the patient has been referred within the same institution or to another doctor in the same specialty. Hospitals can charge a maximum fee of €2.50 per day (until 2013 the maximum limit was €1.60) up to a maximum of 10 days per episode of illness. Outpatient prescription pharmaceuticals are subject to a co-payment of €3.19 per prescription. The general reimbursement rate is 50% of the pharmaceutical price (minus the co-payment). A government regulation lists pharmaceuticals for chronic illnesses that are subject to a lower co-payment of €1.27 and can be reimbursed at a rate of 75% or 100%. A reimbursement rate of 90% is applied to pharmaceuticals in the 75% category when these are prescribed to people aged between 4 and 16 years, those receiving disability or old-age pensions, or individuals over 63 years of age.[31]

3.1.3 Details on recent reforms

Latest trends in health care management in Estonia include the target funding for certain services and efforts to improve the infrastructure with providing capital costs of the hospital network using EU structural funds. In recent years, the MoSA has developed concrete plans with a clear consent and financial commitments instead of general policy declarations, based on a broader consultation process for specific health care and public health areas. This has increased accountability and reporting as well as transparency of the MoSA work.

One major health care reform in 2010-2012 was the establishment of the Health Board. The unification of three agencies[32] was motivated by organisational problems among these agencies and the unification seeks to strengthen the implementation of tasks. However, financial support to implement the changes has been rather limited. All three institutions will be consolidated with all respective functions maintained. By law, the new Health Board is the government agency, which carries out the functions of supervision and state coercion prescribed by law. Thus, the future functions of the Health Board include both management and state supervision functions. The Health Board will work in five main activity areas: health care services, communicable diseases surveillance and epidemic control, environmental health protection, chemical safety, medical devices safety. The basic structure of the Health Board will follow the above-mentioned key areas. The basic organisational functions, analysis and development of operational guidelines are in the same structural unit and, therefore, are more consistent. In order to avoid conflict of interests, a separate surveillance unit will be established, whose primary function is the coordination of the monitoring in all activity areas of the agency, resolving disputes, compilation of decisions on general procedures and processing of procedures in regional departments.[33]

In September 2013 a bill of amendments to the Health Care Services Organisation Act that will transpose into national legislation the EU Directive on patients' rights in cross-border health care was sent to the Estonian parliament. The aim of the planned amendments is to

[31] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E. Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

[32] In January 2009 the Cabinet approved a draft regulation for establishing the Health Board by uniting 3 separate agencies: the Health Protection Inspectorate, the Health Care Board and the Chemicals Notification Centre.

[33] PAAT G and AAVIKSOO A. "Consolidation of national supervisory agencies". Health Policy Monitor, April 2009. Available at http://www.hpm.org/survey/ee/a13/3

establish rules facilitating access to health care services in EU countries, advancing health cooperation among Member States and protecting patients' rights. [34]

One of the recent changes in the pharmaceutical sector in Estonia has been the development and introduction of e-prescriptions since 2010, which includes a digital prescription and retail delivery system of pharmaceuticals. This reform was carried out in close cooperation with other major initiatives on e-health. In addition, since April 2013, pharmacies can also distribute pharmaceuticals through the Internet. Any other pharmaceutical distribution channel, such as through doctors, is not allowed so far, but there are increasing discussions on allowing the sale of over-the-counter products outside pharmacies.[35]

About financial crisis, health care workers' salaries also fell because of a drop in available funding. This lack of action combined with discontent about salaries of health personnel, the lack of a collective salary agreement and high workloads formed the main triggers for a national strike of physicians and nurses in October 2012. They also argued that the government had failed to proceed with vital structural reforms for many years, such as restructuring the provider network and addressing issues of sustainability of the health system. An agreement to end the strike was reached in December 2012. Several problem areas and actions to ensure health system sustainability were collectively identified and addressed in a roadmap. However, it is too early to predict whether these structural reforms will actually follow and what the long-term outcomes of the strike will be[36].

3.2 Assessment of strengths and weaknesses

The strengths of the current Estonian system are the universal access to health services and solidarity-based insurance. In addition, Estonia has a well-developed health system and a well-trained workforce. The family-medicine-centred system is well functioning. In recent years Estonia, has managed to reverse the negative effects that resulted from the transition to an independent country on the health of the population and, in this respect, the health status of the Estonian population has moved closer to that of Western Europeans. Radical reforms in the hospital sector have created a sector of autonomous hospitals with their own management structures and clear accountability defined by the law.

The Estonian population is ageing, which affects both financing and expenditure of health care. Life expectancy has increased from 66.5 years in 1994 to 76.3 in 2011. Cardiovascular (circulatory) diseases are the main cause of death, accounting for 46% of deaths among men and 62% among women in 2012. The second largest cause of deaths is cancers (24% of deaths in 2012) while injuries and external causes are the third largest cause (7% in 2012)[37]. Musculoskeletal diseases and mental health problems are becoming gradually more important. A high burden from injuries and deaths from external causes (especially among men), a legacy from the transition in the early 1990s, remains an important public health challenge.[38]

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[34] DIRECTIVE 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011 on the application of patients' rights in cross-border healthcare. http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF

[35] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E, Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

[36] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E, Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

[37] National Institute for Health Development. Health Statistics and Health Research Database. 2012, www.tai.ee/tstua

[38] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E, Estonia: health system review, Health Systems in Transition, 2013; 15(6):1–196

A key weakness of the system is the poor link between primary care, hospitals and emergency care, which has led to fragmentation and often duplicated work. Investment into infrastructure, information systems and human resources is needed in order to create better vertical and horizontal management. According to the patient satisfaction surveys[39], major challenges persist regarding accessibility and quality of health care, as well as patient safety and empowerment issues.

Health expenditure levels in Estonia are one of the lowest in the EU. Even though, the system provides a very good protection to the vast majority of the population, the financing trends are tending to decline in real health expenditure that means increased health risk to the finically insecure population who cannot afford the out-of-pocket expenditures.[40]

3.2.1 Coverage and access to services

The MoSA and the EHIF monitor access and quality of primary care. Family doctors have a gatekeeper function and control most access to specialist care. The referral from a family doctor's is needed in meeting most of the specialists and to be admitted as a non-emergency inpatient. However, some specialist (such as ophthalmologists, dermato-venereologists, gynaecologists, psychiatrists, dentists, pulmonologists and all needed specialist care in case of trauma) are free to access without a referral. Chronically ill have access to specialists without referral.[41]

According to the law, practicing family doctors are required to have at least 20 visiting hours per week, with one evening clinic per week. Furthermore, the practice reception must be open between 08:00 and 18:00 hours every working day and the practice premises of the family doctor must be open for at least eight hours each working day.[42] A patient with an acute condition must be provided with an appointment with a family doctor on the same day, and a patient with a chronic disease within three working days.

The MoSA regulates requirements for geographical accessibility and health services in secondary care. Geographical accessibility was defined in the Hospital Master Plan 2015 according to the criterion that a hospital has to be located within a distance of 70 km or 60 minutes' drive[43]. A regulation of the Ministry of Social Affairs specifies the specialties that have to be provided in a hospital. This includes general surgery, internal diseases, paediatrics, obstetrics and gynaecology.

The law also regulates the maximum waiting times for specialist care: four weeks for ambulatory specialized care, eight months for inpatient care and day surgery and a year and a half for cataract surgery. The appropriate management of waiting lists has led to a situation in which limited capacity of health care providers instead of budgetary constraints are the primary reason for waiting times.

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39 Eesti Haigekassa ja sotsiaalministeerium. Elanike iga-aastased kindlustatute rahulolu-uuringud. 2001-2012.

40 ATUN R, OHOV E, HABICHT J. Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. WHO 2005. http://ee.euro.who.int/SWOT%20Analysis%20of%20the%20Estonian%20Health%20System%20Jan06.pdf

41 LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E, Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

42 The Family doctors guidelines. https://www.riigiteataja.ee/akt/788142

43 HELLERS G, LUNDEGÅRDH G, NYBERG S, et al. (2000). Estonian Hospital Master Plan 2015. Tallinn, Prepared by SC Scandinavian Care Consultants AB and SWECO International AB on behalf of Ministry of Social Affairs.

In 2012, according to the general health service survey by the EHIF about 55% of the respondents assessed availability of health care services to be good. By far the biggest cause for dissatisfaction (45%) in the system and lacking accessibility to medical services is the long queues and long lead time before getting to a doctor.[44]

3.2.2 Quality and performance indicators

Quality monitoring of health care services and providers is left to professional associations and the Health Board. The EHIF regularly carries out audits and randomized controls of service provision and clinical practice to assess compliance with relevant legislation, clinical guidelines and best practice. The findings of the audits are discussed with providers and medical professionals in feedback meetings, which also involve representatives of the ministry and other relevant organizations, enabling them to discuss any problems that emerged in the course of the audit in a wider context.[45]

Estonia has many characteristics, which favour improvement in healthcare quality and safety, including strong northern European culture and social values; high level of computer literacy and use of electronic patient records; many fragments of quality systems at local and national level. Less supportive features include: lack of unifying policy and organisation eg information, patient safety; weak leadership of the quality agenda from Ministry; few incentives for institutions or professionals to improve; shortage of training at all levels (knowledge, attitudes and skills required to improve quality and safety).[46]

Since 2002, five clinical audits have been undertaken each year, costing around €100,000. Topics are identified by consensus of current concerns. The primary aim is to verify that invoice data, on which reimbursements are paid, are complete and accurate. Quality improvement is a secondary aim, focusing on clinical practice, rather than on service organisation and delivery. The implementation of recommendations arising from the audits depends on managers and clinicians whose accountability is often unclear; no financial sanctions or rewards are made by EHIF to provide incentives for compliance. An "audit of audit" could improve the process for future years, including topic selection rationale; stakeholder involvement; underlying standards, requirements, evidence; selection of criteria to be measured; definition of homogenous sample or case mix adjustment; sources and methods of collecting information; training for auditors; analysis and presentation of findings; interpretation and preliminary conclusions; feedback, consultation, learning; action planning, dissemination and follow-up.

In the annual EHIF general survey on health service assessment, in 2012 78% of the population evaluated the quality of health services to be good or rather good and 19% to be bad or rather bad.[44]

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[44] Eesti Haigekassa, Sotsiaalministeerium, GfK Custom Research Baltic, "Elanike hinnangud tervisele ja arstiabile 2012", Tallinn 2013, 130p/retrieved from http://www.sm.ee/fileadmin/meedia/Dokumendid/Tervisevaldkond/Uuringud_ja_analuusid/Feb27_Elanike_hinnangud_tervisele_ja_arstiabile_2012_raport_GfK.pdf

[45] LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E.. Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

[46] Charles Shaw. (2013). Mission report: EHIF and quality of healthcare in Estonia.

3.2.3 Sustainability

Key future challenges for the current healthcare system are the problems caused by the aging population and the increased rate of chronically ill people. This projects an increased rate of financially non-contributing individuals to the system which makes the current system not sustainable. Additional problems are to arise from the increasing urbanization, leaving rural areas more and more sparsely covered and decreasing accessibility to health care for important parts of the population.[47]

The long-term financial sustainability of the Estonian health system was already a concern before the crisis. The population is ageing and health care is largely financed from an earmarked payroll tax paid by a declining proportion of the population. The single-payer system has served well since it was established in the early 1990s. Central revenue collection, national pooling and centrally set prices contribute to efficiency in resource use, while the breadth, scope and depth of coverage result in generally equitable access to primary care and most specialist services. In 2013 recommended keeping in place key elements of the current system: the earmarked payroll tax for health, national pooling of public funds and the single payer. In the long term, revenues should include non-employment-based taxes on capital, dividends and consumption, as well as government contributions to the EHIF on behalf of pensioners[48].

3.2.4 Summary

Since independence in 1991, Estonia has been undergoing extensive reforms to expand insurance coverage and availability of services (both public health and health care), to increase the responsiveness to patients and to change various other elements of the health system. A modern provider network based on family doctors as gatekeepers in accessing secondary care has been established and works efficienctly in the current situation. However, regarding the trends in the population, the health care system needs to be revised in near future (primarily financing).

3.3 Reform debates

The long-term sustainability of the Estonian health system financing has become a larger concern over the years. In terms of public financing, the debate has focused on broadening the health insurance revenue base (taxing other incomes in addition to salaries) and persuading local municipalities to increase their financing by expanding their responsibilities[49][50].

One topic under discussion is the fostering and favourable conditions for private insurance providers or increasing out-of-pocket payments. Out-of-pocket payments have already increased in order to activate macro-level cost-containment in public funding. Medicinal products account for the highest share of OOP expenditure (61% in 2011) of which 68% is OOP payments for prescription drugs. Patients' OOP expenses have decreased in Estonia recently: at the end of 2011, insured persons paid 10% less out of pocket per prescription than

[47] MoSA. (2008). National Health Plan 2009–2020. Tallinn: Sotsiaalministeerium

[48] LAI, Taavi, HABICHT, Triin, KAHUR Kristiina, REINAP, Marge, KIIVET Raul, van GINNEKEN Ewout. Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

[49] THOMSON, Sarah, VÕRK, Andres, HABICHT, Triin, ROOVÄLI, Liis, EVETOVITS, Tamás, HABICHT, Jarno (2010). Responding to the challenge of financial sustainability in Estonia's health system. WHO 2010.

[50] LAI, Taavi, HABICHT, Triin, KAHUR Kristiina, REINAP, Marge, KIIVET Raul, van GINNEKEN Ewout. Estonia: health system review. Health Systems in Transition, 2013; 15(6):1–196

in 2010, probably because patients chose cheaper pharmaceuticals because of the promotion of generic prescribing.

Next step should be the evaluation of the out-of-pocket payment impact on different social groups. Patients in Estonia currently cover more than 40% of total costs of prescription medicines, which is the second highest in the EU.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The Ministry of Social Affairs (MoSA) has launched a national strategy with the main goal that by year 2015 operational care network will have been expanded according to the strategy and covers Estonia with demanded care services evenly. The strategy is "The Long-term Care System Strategy of Estonia for 2004-2015". The strategy aims is to increase the number of nursing care beds in nursing care to meet the demand and to facilitate service users moving among different services according to care needs. One of the main goals of strategy is to reach certain proportions of funding for total nursing care expenditures by 2015. This means that 56% of the funding is by health insurance, 31% by local municipality and 13% by service users. The aim is to provide all services free of charge for service users, except services in care homes and nursing homes.[51]

In April 2009, MoSA has launched the regulation "Nursing and long-term care infrastructure development measure" which aims at ensuring better quality and availability of nursing care through building new hospital premises. The general goal was defined as improvement of inpatient and outpatient care services, purposeful usage of health insurance funds, and offering more diverse long-term care services that meet population needs. The European Regional Development Fund (ERDF) financed the measure. The measure aims at increasing capital investments into long-term care hospitals because: 1) state support has so far been relatively small, and 2) several municipalities have undertaken their own steps to improve the situation (e.g. Tallinn Municipality).[52]

The Social Welfare Act sets out the following main goals for welfare services: 1) less state and more individual and local government contributions; 2) the development of case-management methodology; and 3) the development of housing services. (Paat & Merilain 2010).

4.1.2 System characteristics

The long-term care concept in Estonia consists of two main areas: nursing care and welfare. A local social worker, who will take necessary actions considering the needs and wishes of the person and their family, does the assessment of the need for welfare services. A doctor (either general practitioner or a medical specialist) does the assessment of the need for nursing care. The general practitioners only has the role of assessing the need and does not take part in

[51] PAAT, G., MERILAIN, M. (2010), The Long-Term Care System For The Elderly In Estonia, Enepri research report no. 75, contribution to WP1 of the Ancien project.

[52] PAAT, G., AAVIKSOO, A. (2009), Attempts to integrate long-term care, Tallinn: PRAXIS Center for Policy Studies.

service provision. According to the Act of Organization of Health Services *(Tervishoiuteenuste korraldamise seadus)* nursing services include nursing healthcare services and are provided as home-based, day care and institutional services. For more difficult cases of nursing care of the elderly, a geriatric assessment possibility has been available in Estonia since 2004. Interdisciplinary (geriatric) assessment team performs the assessment of the needs of clients and draws up individual plans of nursing care. The team includes a physician (geriatrician or an internist trained in geriatrics), a nurse, a social worker and other specialists if necessary. Geriatric assessment service is part of the nursing services[53].

LTC services can be classified as either community care services (person is supported in her/his own home), or institutional services (care is given in a welfare institution). Home care services are provided within the home, to help persons cope in familiar surroundings. The local governments determine the list of home services and the conditions and procedures through which they can be obtained. Municipalities are required to provide adequate housing for persons and families who cannot afford it, and, where necessary, provide for social housing. Municipalities also assist persons who have difficulties with self-contained living, to adjust the dwelling to their needs or to find more suitable housing.

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

Furthermore, care is provided in welfare institutions that operate during the day or round-the-clock and that provide the persons staying there with appropriate care according to their age and condition. Care homes, as not being part of the health care system, in principle do not offer medical care. Services are provided in the same way and on the same principles as would be provided to people living at home. Inhabitants are therefore visited by family doctors, and/or involve private nursing companies[54].

To support informal care, local governments also grant and pay a caregiver's allowance to caregivers or guardians of disabled persons aged 18 years or older. The aim of the allowance is minimal, and does not meet its goals to help to reimburse the costs related to the care and to alleviate the families' care burden to enable family members to be engaged in paid employment. Informal care plays an important role in Estonia; not only in practice but also from a legal perspective[55].

Medical services that are related to the services listed above are covered by the health care system and financed by an earmarked social tax levied on wages. This includes hospital care, access to physicians, and nursing care. With respect to the latter, a co-payment of 15% for inpatient long-term care (nursing care) was introduced from 1 January 2010 onwards[56], in part to avoid over-use of hospital resources by those not really in need of medical treatment.

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[53] KRUUS, Priit, AAVIKSOO, Ain, HALLIK, Riina, UUS, Maiu. (2012), Strategic Intelligence Monitor on Personal Health Systems phase 2 (SIMPHS 2) Country Study Estonia, European Commission.

[54] VÕRK, Andres, SEGAERT, Steven (2012) "Pensions, Health and Long-term Care", Asisp Annual Report 2012.

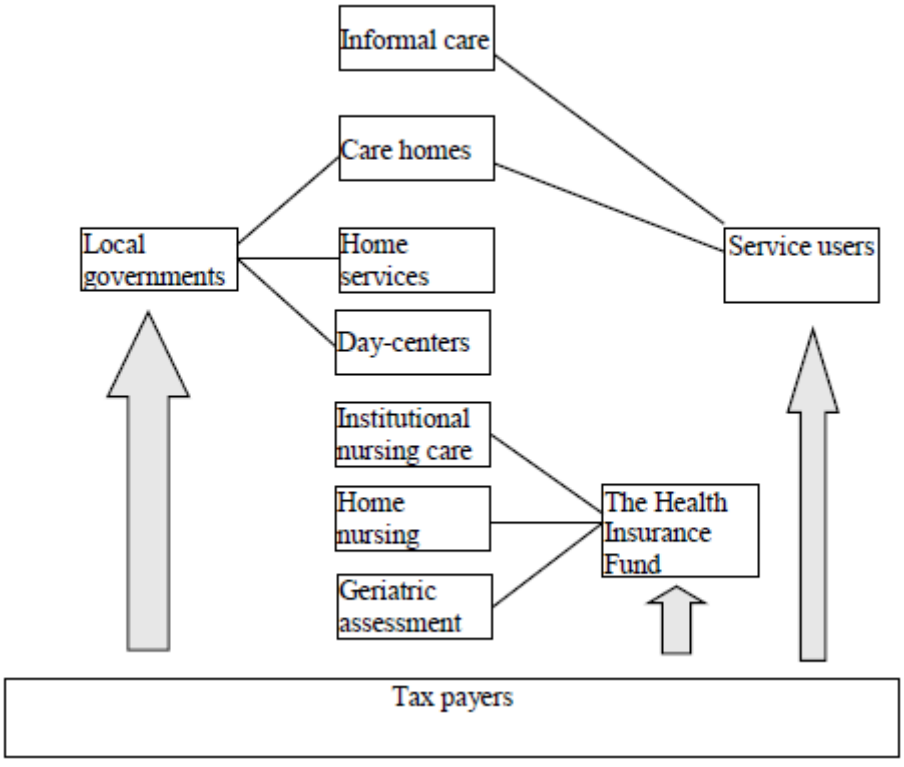
[55] The role of the family in caring for dependent family members is not only factual, but finds a legal basis in the Constitution of the Republic of Estonia. Indeed, Article 27 of the Constitution stipulates that "the family has a duty to care for its needy members."

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

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

Long-term care services are mostly financed by the local government from local government budget and by the person and/or their family, although benefits in cash can in some cases also be provided by the state. At the same time, geriatric assessment and nursing care are mostly paid for by the EHIF indicating a funding scheme that is much more diverse than that of strictly healthcare. Either way, the financial constraints of the service are significant due to very limited local government and EHIF budgets. The care quality is therefore often insufficient and does not meet contemporary requirements and expectations due to inadequacy of premises; there is lack of trained personnel (nurses, caregivers) and a lack of appropriate financing for the services. Many LTC hospitals and welfare institutions are faced with an acute shortage of space and the standards are relatively low. In addition, there is still a shortage of long-term care beds[57]. The financing logic of long-term care in Estonia is presented on figure 6.

Figure 5: Long-term care financing by segments



Source: Integrated Long-Term Care in Estonia[58]

[57] PAAt, G., MERILAIN, M. (2010). The Long-Term Care System For The Elderly In Estonia. Enepri research report no. 75, contribution to WP1 of the Ancien project.

[58] Integrated Long-term Care in Estonia: Providing health care, nursing care and social care services. (2008). Tallinn: [www.egga.ee/Integrated_long-term_care_in_Estonia.pdf]

4.1.3 Details on recent reforms in the past 2-3 years

Over the past two-three years, there have been no legislative reforms in the field of long-term care. However, there have been some changes, which have affected the long-term care. For example, long-term care hospitals have received financial resources from EU structural funds with the aim to strengthen the infrastructure. It was indeed a needed support for infrastructure development, including increase in the number of long-term care beds, but at the same time, there was a lack of agreements with the EHIF to support the services related to these beds. As a result, the occupancy rate for long-termcare beds decreased to 82% in 2012 (in 2008, the corresponding number was 90%).

In addition, in 2010, a 15% co-insurance rate for inpatient nursing care was introduced. This plan was proposed to involve patients in its financing, but it proved unpopular and was not implemented until the financial crisis necessitated tough austerity measures. This, in turn, has led to 4% lower expenditure in the planned EHIF budget for inpatient nursing care in 2011. However, in the end, 1% more patients were provided for than planned[59].

There is no strategy which directly covers the role of ICT in long-term and/or home care. On the national level, the focus is set on public health in general, the framework of which includes goals in providing long-term care but does not state the ICT implications of it. At developing eHealth, the focus has so far been on acute care, the ICT role in which is also covered thoroughly in strategic documents. While some of the points in such documents could be extended to long-term care, in practice they are not. So far, the combination of long-term care and ICT has been slightly out of focus[60]. There are a few pilot projects in the field of homecare but these are still in a raw introductory state that can be described to be happening "despite existing policies" rather than "as a result of existing policies". These few pilot projects currently concern mostly either social care (Virtu) or secondary/tertiary care (DREAMING and Eliko) with very limited impact on primary care institutions. Concerning the role of family physicians, they are the key mediators between the patient and the rest of the medical system, often also the social care system. Referrals are made to specialist doctors, geriatric assessment, nursing care services (etc.) and to the local municipality who is responsible for social care[61].

Finally, strategies to better integrate health care and social welfare are (incl LTC) being developed by interdisciplinary working groups, but as of 2013 have yet to be implemented. A successful implementation requires consensus between the different care sectors, along with legislative support from state bodies. However, work is ongoing and legislative amendments have been prepared and discussed between different parties. Changes are also required in financing to share the burden between the EHIF, municipalities and personal resources; changes are also needed at the service organization level, in terms of descriptions of minimum requirements and quality requirements for all nursing and social care.

59 LAI T, HABICHT T, KAHUR K, REINAP M, KIIVEt R, VAN GINNEKEN E.. Estonia: health system review, Health Systems in Transition, 2013; 15(6):1–196

60 AAVIKSOO, A., HALLIK, R. (2011). Coping with an ageing population - learning from good e-health tele-care practices, Information gathering template for national correspondents – Estonia, Tallinn: PRAXIS Center for Policy Studies.

61 KRUUS, Priit, AAVIKSOO, Ain, HALLIK, Riina, UUS, Maiu (2012), Strategic Intelligence Monitor on Personal Health Systems phase 2 (SIMPHS 2) Country Study Estonia, European Commission.

4.2 Assessment of strengths and weaknesses

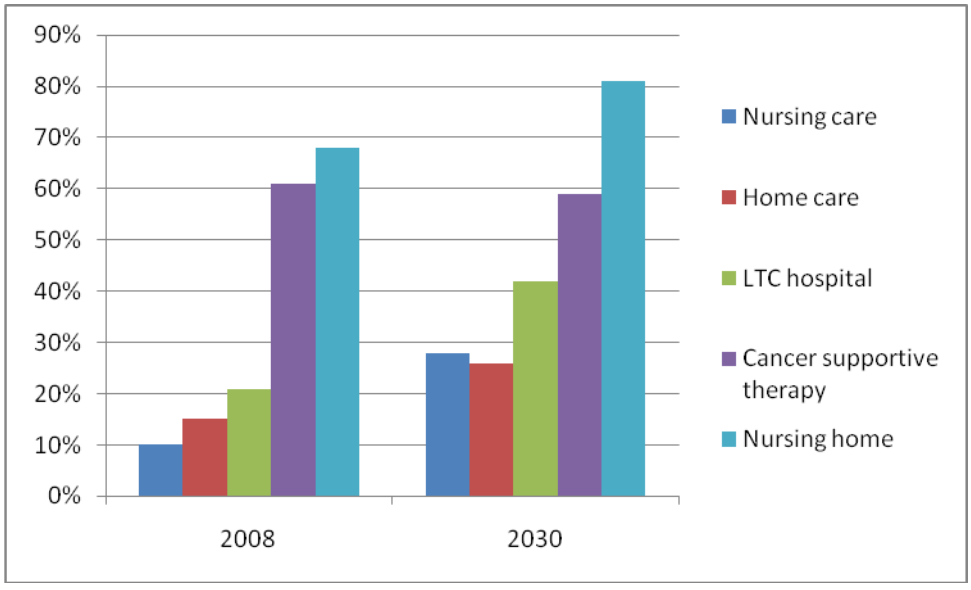
4.2.1 Coverage and access to services

According to an analysis by Price Waterhouse Coopers (PwC) in 2009, total expenditures on LTC services should be about 5 times higher (1.06% of GDP) than they were in 2009. The Institute of Estonian Demography has shown that approximately a quarter of the 65+ population needs formal care services, whereas in 2010 only 5.6% of the 65+ population effectively received it.[62]

The need for LTC is related to a person's degree of disability. Someone who has a need for constant personal assistance, guidance or supervision 24 hours a day is categorised as having a profound disability. Someone with a severe disability needs personal assistance, guidance or supervision in every 24-hour period and someone with a moderate disability requires regular personal assistance or guidance outside his or her residence at least once a week. At the end of 2011 there were 120,000 persons with a disability, representing 9% of the total population, among whom 61% were 63 or older, 34% were aged 16-62 and 5% were younger than 16 (MoSA data, 2012).

Home nursing care has a large financing gap in Estonia (home nurses, home nursing services). The development of such services is still in the embryonic stage. The following table describes the coverage of care services with financial resources. For instance, the home services are financed only at the level of 15% of the total need – the demand for such services is estimated as seven times higher from the volume provided currently. The projections for the 2030 imply that the coverage should increase as due to welfare effects, the need for such services is expected to decrease and the share of local government increases.

Figure 6: The estimated coverage of home care services in 2008 and 2030



Source: Paat and Merilain, 2010

The budget for long-term care for the first half of 2013 was 23% higher than a year ago and reflects a three times higher increase than for other healthcare services. The main driver

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

behind the budget increase were new opportunities for modern long-term care opened up by increased investments into infrastructure which were supported by EU structural funds. At the same time, the number of nursing home visits and the number of persons serviced increased 8% and 11% respectively. Overall, the availability of long-term care has significantly increased – compared to the previous year the number of long-term care cases, financed by EHIF, has increased by 12%.

4.2.2 Quality and performance indicators

Local municipalities (counties) are responsible for ensuring the quality of care services, monitoring the care system (care services, benefits, etc.) and processing the complaints of service users.

MoSA develops national care policy, regulates the legislation of accessibility and quality of care (the quality standards for services). MoSA also collects and analyses care statistics. MoSA develops and applies development programs of care[63].

Great improvements in the quality assurance policies of LTC in creating and monitoring the quality of inputs of services (infrastructure, personnel, planning and funding) have been achieved in Estonia. Some attempts have been made to evaluate the processes of LTC services, but almost nothing is found about the evaluation of the results. Another problem is that quality monitoring is not yet developed, but some steps towards routine monitoring and publishing the results have been included in future plans of social and health care in Estonia. In addition, quality-related databases are expected to be improved and published, which allows patients and clients to find the best practices according to their needs.

National level indicators have been proposed to measure quality of services starting from 2011 (Development Plan of MOSA 2011-2014). These indicators are share of supervisory reports provided in social care (this indicator measures yearly how many county reports are presented out of 15 by the county governors and share of social services, which are covered by service guidelines (this indicator measures how many social services have been covered by service guidelines yearly).

In Estonia, general patient satisfaction has been measured annually since 1999, but the quality of nursing care is hidden in the data on primary and specialist care, as specific LTC questions are not asked[64].

4.2.3 Sustainability

LTC system in Estonia is not sustainable in the long term. As the demand for LTC services grows, because of the ageing population, provision has to increase too. More emphasis should be paid on developing home services and supporting more informal care services. The ageing population significantly influences the development and sustainability of the nursing care and social welfare system. To facilitate the development of the in-patient nursing care to the desired level there is a need to find new funding schemes, where health insurance would be assisted by the contribution of the local government and people themselves (similarly to the funding of care beds). Further, along with the growing revenues from the collection of health

[63] KOPPEL A, PAAT G. Quality Assurance Policies and Indicators for Long-Term Care in the European Union Country Report: Estonia ENEPRI Research Report No. 106/March 2012

[64] KOPPEL A, PAAT G. Quality Assurance Policies and Indicators for Long-Term Care in the European Union Country Report: Estonia ENEPRI Research Report No. 106/March 2012

insurance, the private sector, central government and local municipalities should increase their expenditure on health care in pace with the growth in the GDP, in the future[65].

Problems with LTC in Estonia are the lack of provision and high costs of services, also. For instance, the cost of care home services (i.e. long-term care in an institution) varies according to the institution, from around €319–447 per month to as much as €767–1,086 in some cases.[66]

A large problem is the low salaries in the care sector. Hence, it is important to have enough qualified personnel. However, in recent years the number of specialized personnel has increased. Care workers' (in the public service) salary is one theme that is currently being discussed at state level in the Government. To assess and develop the quality of labour, refresher courses and an employee registration system are being developed[67].

In general, social care and especially long-term care (LTC) in Estonia has received relatively little attention compared to other health care services. There are different development policy documents that might affect the field significantly (but no active progress has been in the last 2 years). Either way, the financial constraints of the service are significant due to very limited local government and EHIF budgets. The care quality is therefore often insufficient and does not meet contemporary requirements and expectations due to inadequacy of premises; there is lack of trained personnel (nurses, caregivers) and a lack of appropriate financing for the services. Many LTC hospitals and welfare institutions face an acute shortage of space and the standards are relatively low.

4.2.4 Summary

Reforms in the healthcare system have close linkages to the social welfare system. Many social care home residents also need long-term care, but the amount of care provided is constrained by limited resources of municipal budgets. As the target group of long-term care and welfare services is largely overlapping, integration and better coordination of services are required to respond more effectively to the varying needs of elderly and chronically ill people.

The LTC system, based on the need for services, is not sustainable in the long term. Important is emphasis should be placed on developing home-based services and supporting more informal care services. LTC services grows year by year, because of the ageing population (provision has to increase too). In addition, less attention is to informal care and financial support is insufficient. Integration between the health care and welfare systems is low and random; consistency and needs-based services are not ensured. Salaries and the number of (qualified) personnel have to increase to improve the quality and provision of care services.

4.3 Reform debates

In general, social care and especially long-term care (LTC) in Estonia has received relatively little attention compared to other health care services. There are different development policy

[65] PAAT, G., MERILAIN, M. (2010). The Long-Term Care System For The Elderly In Estonia, Enepri research report no. 75, contribution to WP1 of the Ancien project.

[66] MoSA Statistics 2009 (precise exact source)

[67] KOPPEL A, PAAT G. Quality Assurance Policies and Indicators for Long-Term Care in the European Union Country Report: Estonia ENEPRI Research Report No. 106/March 2012

documents that might affect the field significantly (but no active progress has been in the last 2 years)[68].

There have been no significant reforms in the long-term care in recent years. The main challenges are still LTC financing and the integrity of the area. Currently, mainly local governments and people themselves bear the burden of LTC, and therefore many of those in need could be left without necessary services and support. Although the Estonian Health Insurance Fund has considerably increased the service capacity of LTC, it is still far behind the needs of all people in need. LTC sector is also highly fragmented and has therefore a somewhat diffused responsibility.

68 KRUUS, Priit, AAVIKSOO, Ain, HALLIK, Riina, UUS, (2012), Strategic Intelligence Monitor on Personal Health Systems phase 2 (SIMPHS 2) Country Study Estonia. European Commission.

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https://dspace.utlib.ee/dspace/bitstream/handle/10062/31778/jogi_evelin.pdf

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MINISTRY OF SOCIAL AFFAIRS (2012) "Töövõime toetamise süsteemi põhimõtted ja ajakava", retrieved on 12 October 2013 at http://www.sm.ee/fileadmin/meedia/Dokumendid/TVK/T%C3%B6%C3%B6v%C3%B5ime_toetamise_s%C3%BCsteemi_p%C3%B5him%C3%B5tted_ja_ajakava.pdf

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PAAT G, AAVIKSOO A. (2009) "Consolidation of national supervisory agencies". Health Policy Monitor, April 2009. Available at http://www.hpm.org/survey/ee/a13/3

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THOMSON, S., VÕRK, A, HABICHT, T, ROOVÄLI, L, EVETOVITS, T, HABICHT, J (2010). Responding to the challenge of financial sustainability in Estonia's health system. WHO 2010.

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Annex – Key publications

[Overarching themes]

AAVIKSOO, Ain, KRUUS, Priit, LEPPIK, Lauri, SIKKUT, Riina, VELDRE, Vootele, VÕRK, Andres, "Eesti sotsiaalkindlustuse jätkusuutlikku rahastamise võimalused", 2001, Praxis Center for Policy Studies, Tallinn, retrieved on 12 October 2013 from http://www.praxis.ee/fileadmin/tarmo/Projektid/Tervishoid/Eesti_tervishoiu_rahastamise_jatkusuutlikkus/Eesti_sotsiaalkindlustussuesteemi_jaetkusuutliku_rahastamise_voimalused_taeisversioon.pdf
"Opportunities for sustainable financing of social security system in Estonia"

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

PRAXIS Center for Policy Studies, "Eesti sotsiaalkaitse süsteemi korralduse efektiivsuse analüüs", research report, Tallinn, 2011, retrieved on 12 October 2013 from : http://www.praxis.ee/fileadmin/tarmo/Projektid/Tervishoid/Analyys_loppraport_v1_3_Praxis__01.pdf
"Analysis of the efficiency of the Estonian social protection system"

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

Ministry of Finance, "Stabiilsusprogramm 2013", Updated 26 June 2013, Tallinn/retrieved from: http://www.fin.ee/el-majanduskoordinatsioon-euroopa-semester "Stability Programme 2013"

The Estonian Stability Programme 2013 gives an overview of the recent economic development and fiscal policy and detailed short-run forecasts for 2011-2015. It includes forecasts of the state pension insurance scheme and health insurance scheme up to 2050.

Ministry of Finance, "2014. aasta riigieelarve seaduse seletuskiri", pdf document, September 2013, Tallinn, retrieved on 12 October May 2013 at http://www.fin.ee/riigieelarve-2014 "Explanatory note of the state 2014 budget"

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

Ministry of Finance, "2013. aasta suvine majandusprognoos", September 2013, Tallinn/retrieved on 12 October May 2013 from: http://www.fin.ee/majandusprognoosid "2013 Summer economic forecast"

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

Ministry of Finance, **"**Riigi eelarve strateegia 2014-2017", updated 26 June 2013, Tallinn/retrieved from: http://www.fin.ee/doc.php?109291 "State budget strategy 2014-2017"

State budget strategy 2014-2017 includes an overview of the recent economic development, and detailed forecasts of revenues and expenditures for 2014-2017, including social insurance.

[Pensions]

JÕGI, Evelin, "Eesti pensionisüsteemi reformide jaotuslike mõjude hindamine kohordisimulatsioonimeetodi abil", Master Thesis. University of Tartu. Estonia. 2013, retrieved on 12 September 2013 at:
https://dspace.utlib.ee/dspace/bitstream/handle/10062/31778/jogi_evelin.pdf

"Assessment of the distributional impact of Estonian pension reforms based on the cohort simulation method"

The thesis evaluates the impact of pension reforms on the future average pension and the distribution of future pensions within generation using a cohort-based simulation. The author calculates future pensions under five sets of policy scenarios for the year 2046 for men born in 1980. The study shows how introduction of an earnings-related component into the state pension scheme and the introduction of the funded pension scheme increased variation of individual pensions.

LEES, Kadri, "Pensionile siirdumise otsust kujundavad tegurid Eestis", Master Thesis. University of Tartu. Estonia. 2013, retrieved on 12 September 2013 at: http://dspace.utlib.ee/dspace/bitstream/handle/10062/31779/lees_kadri.pdf

"Factors affecting retirement decision in Estonia"

The thesis analyses retirement decisions of elderly using Estonian data of the 4th wave of SHARE (Survey of Health, Ageing and Retirement in Europe). The author shows that according to the SHARE data over 20% of workers would like to retire as early as possible. The author concludes that the most important factors that affect possible early retirement decisions were health factors and factors that are related to working conditions.

MURAKAS, Rein, TRUMM, Avo, MERILAIN, Merle, JALAK, Annika, "Tööturu- ja muude meetmete vajalikkusest väljateenitud aastate pensioni kaotamisel", Research report. University of Tartu / European Social Fund. 2012, retrieved on 12 September 2013 from: http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/kogumik/VAParuanne_2012.pdf

"On requirement of labour market and other measures when abolishing superannuated pensions"

The study focused on superannuated pensions (pensions for hazardous and arduous work). It includes interviews with employees eligible for superannuated pensions, their representative organisations, employers' representations and overviews of European countries' experience on similar systems and their development. The study analyses various active labour market measures and occupational pension schemes.

University of Tartu, Centre for Applied Social Sciences. Vanemaealised tööturul. Research report. 2012, retrieved on 12 October from: http://www.sm.ee/fileadmin/meedia/Dokumendid/Toovaldkond/uuringud/Vanemaealised_t%C3%B6%C3%B6turul_l%C3%B5ppraport.pdf

"Elderly in labour market"

The report analyses the situation of elderly in the Estonian labour market. The report includes analysis of key legal acts and strategies, overview of previous research, interviews with 1,000 people aged 50-74 and interviews with 201 employers. The report provides a statistical analysis of factors that encourage and discourage employment of elderly people.

MARKSOO, Ülle "Employment and working life in Estonia 2012", Series of the Ministry of Social Affairs, No. 2/2013 eng, 2013 retrieved on 13 October 2013 from: http://www.sm.ee/fileadmin/meedia/Dokumendid/V2ljaanded/Toimetised/2013/Employment_and_working_life_in_Estonia_2012.pdf

The paper gives an overview of the development of the Estonian labour market in comparison with other EU countries, the situation on the Estonian labour market in 2012, the organisation of work and remuneration, labour market policy, and the working environment.

LEETMAA, Reelika, MASSO, Märt, VÕRK, Andres, KARU, Marre, VELDRE Vootele, PAURLUS, Alari, TURK, Pirjo "Sotsiaalkaitsehüvitiste ja -toetuste mõju töömotivatsioonile" Research report, Poliitikauuringute keskus Praxis, 2012, retrieved on 13 October 2013 from: http://www.sm.ee/fileadmin/meedia/Dokumendid/Toovaldkond/TAO/Sotsiaalkaitse_h%C3%BCvitiste_ja_toetuste_m%C3%B5ju_t%C3%B6%C3%B6motivatsioonile_FINAL_V.pdf

"Social benefits and work incentives in Estonia"

The study analyses social benefits in Estonia and their impact on work incentives. The main focus is on unemployment insurance and unemployment assistance benefits and their interaction with other social benefits, such as old-age pensions, early retirement pensions, subsistence benefits, disability pensions. The study includes an overview of different benefits paid during an unemployment spell and their mutual relationships as of 2011. The study uses net replacement rates and marginal effective tax rates to measure work incentives for different family types. The distribution of incentives is calculated using the Estonian SILC data and the micro-simulation model EUROMOD.

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

"Elderly in Estonian labour market"

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

[Health care]

KRUUS Priit , SIKKUT Riina , AAVIKSOO Ain. 2012. Uute ravimite soodusnimekirja lisamise protsess ravimi- ja tervishoiupoliitika kontekstis. PRAXIS Center for Policy Studies. Retrieved on 20 October 2013 from : http://www.praxis.ee/index.php?id=1027

"The procedure of adding new pharmaceuticals into the reimbursement list – goals and practice in the context of pharmaceutical and health policy"

The study aims to analyse whether the process of adding new pharmaceuticals into the reimbursement list is in accordance with stated goals and meets the needs of different stakeholders. For that purpose, an overview of pharmaceutical policy stakeholders, their needs and relationships has been compiled, and the current process of making reimbursement decisions is analysed based on stakeholder interviews. The process analysis includes the description of regulations and practice of different stages in the process, and a synthesis of the assessments made by the interviewees. In addition, a brief overview of the international experience and future trends is given.

LIIV Kristi, LUTSAR Katrin, PALM Eva, KIIVET Raul-Allan. Tervisetehnoloogiate hindamise käivitamine Eestis. Eesti Arst 2012;91(7):350-355. Retrieved on 20 October 2013 from http://rahvatervis.ut.ee/handle/1/5603

"Establishment of health technology assessment in Estonia"

In 2011 the first steps of establishing a specialized Health Technology Assessment (HTA) centre at the Tartu University's Department of Public Health were taken. During the next three years 25 full reports should be completed. The technologies to be assessed will be selected by a HTA council taking into account suggestions from the Ministry of Social Affairs, the Estonian Health Insurance Fund and from other professional organisations and specialists. A single HTA starts with the formulation of research questions relating to a technology of interest, alternatives and target population, as well as the costs and expected health outcomes included in the analysis. The efficiency, effectiveness, safety and cost-effectiveness of the technology are thereafter described on the basis of published research findings. This process includes gathering local data on health conditions, epidemiology and costs for health care systems. The obtained information is used for economic analysis. The method of analysis is selected according to input data and aims of the assessment. As a result, an HTA report is published in which input data and results are described in detail. The discussion part of the report addresses ethical, social and organisational aspects not included in the economic analysis, because of their possible influence on the implementation of using

the technology and final health outcomes. Finalised HTA reports together with the supporting documentation will be available in the public domain at http://www.rahvatervis.ut.ee.

Tervise Arengu Instituut. 2013. Health in the Baltic Countries 2011. 20th edition. Retrieved on 20 October 2013 from: http://rahvatervis.ut.ee/bitstream/1/5587/1/TAI2013.pdf

"Health in the Baltic Countries 2011"

The publication is targeted at health professionals, policy and opinion formers, those involved in research, studies on health and any of the general public interested in the health of their fellow citizens. The most important sources of data for this publication were the annual statistical reports of the various medical institutions as well as health databases and registries. Some data was retrieved from official publications and the web pages of the national statistics offices of the Baltic States. The Health for All database of the World Health Organisation was used as source of information for tables containing data from other European countries.

OECD. 2012. Health at a Glance. Europe 2012. Retrieved on 20 October 2013 from: http://rahvatervis.ut.ee/bitstream/1/5397/1/OECD2012.pdf

Health at a Glance: Europe 2012 presents key indicators of health and health systems in 35 European countries, including the 27 European Union Member States, 5 candidate countries and 3 European Free Trade Association countries. The selection of indicators is based largely on the European Community Health Indicators (ECHI) shortlist, a set of indicators that has been developed to guide the reporting of health statistics in the European Union (ECHIM, 2012). It is complemented by additional indicators on health expenditure and quality of care in the related chapters.

Eesti Haigekassa, Sotsiaalministeerium, GfK Custom Research Baltic, "Elanike hinnangud tervisele ja arstiabile 2012", Tallinn 2013, 130p/retrieved from http://www.sm.ee/fileadmin/meedia/Dokumendid/Tervisevaldkond/Uuringud_ja_analuusid/Feb27_Elanike_hinnangud_tervisele_ja_arstiabile_2012_raport_GfK.pdf

"Assessments of health and health care in 2012"

This is a regular annual population survey about the assessment of health and health care. The report presents the results of the 2012 survey and compares them with 2005-2011 results.

[Long term care]
HANGA, Karin, MAAS, Hille, SÕMER-KULL, Sirli, SCHULTZ, Gert, "Sotsiaalse rehabilitatsiooni, tehniliste abivahendite ja erihoolekande korralduse analüüs", Sotsiaalministeerium, 2013, retrieved on 15 October 2013 from: http://www.sm.ee/fileadmin/meedia/Dokumendid/Sotsiaalvaldkond/Uuringud__anal%C3%BC%C3%BCsid_ja_rahvusvahelised_kogemused/Anal%C3%BC%C3%BCs_TVK_seosed_sotsiaalteenustega__EPIK_juuni_2013_.pdf

"Analysis of organisation of social rehabilitation, provision of technical aids and special care"

The report analyses the organisation of rehabilitation services, special care and the provision of technical aids, their relationship with the planned system of work capacity assessment and

employment support. The report is part of the preparatory work to introduce a new disability insurance scheme.

VELDRE, Vootele, MASSO, Märt, OSILA, Liina, KRUUS, Priit, "Töövõimetuse hindamine, asendussissetuleku võimaldamine ja tööalane rehabilitatsioon Eestis ja viies Euroopa Liidu riigis", 2012. PRAXIS Center for Policy Studies. Retrieved on 20 October 2013 from: http://www.praxis.ee/index.php?id=1043

"Comparative analysis of working capacity assessment practices in Estonia and 5 EU countries"

The aim of the project is to conduct a comparative analysis of work capacity assessment and activation practices in EU/OECD countries and, based on international experience and positive practices, develop recommendations to improve the Estonian incapacity benefit system. The focus is on decision processes and pathways in which eligibility for social security payments or assistive services is decided.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 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-EEA and EU candidate and pre-candidate countries.

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