HiT summary

Estonia

Introduction and historical background

Type of government and recent political history

Estonia is a parliamentary republic. It first gained independence in 1918. In 1940, at the beginning of the Second World War, the country was occupied by the Union of Soviet Socialist Republics (USSR). Independence was restored in 1991. The 101 members of the unicameral parliament have been elected every four years since 1992, with governments consisting of two- or three-party coalitions. While none of these coalitions has governed for a full term, they have been stable enough to launch and implement economic and social reforms.

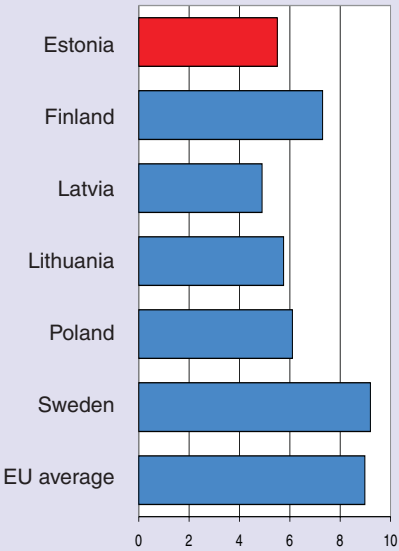
Population

Estonia has a population of 1 356 045 (as of 1 January 2003). A large Russian minority (26%) is concentrated in the cities of north-east Estonia. Since 1989, the population has decreased by about 100 000, due to migration to the east and west and negative natural growth.

Average life expectancy and infant mortality

Between 1959 and 2000, life expectancy increased overall by about one year for men and about four years for women. Life expectancy at birth fell after the political and economic transition of the early 1990s but has risen since, reaching just over 71 years in 2002. There is a marked difference in female and male life expectancy (77 years for women and 65 years for men in 2002). Infant mortality has fallen steadily in recent years, declining from 14.8 in 1995 to 5.7 in 2002.

Fig. 1. Total health care expenditure as % of GDP, comparing Estonia, selected countries and EU average, 2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Leading causes of death

Cardiovascular diseases are the main cause of death (and a significant cause of premature death), followed by cancer and death due to external causes. AIDS is a particular public health

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concern. In 2003, 0.26% of the population was diagnosed as HIV-positive. Studies show that during the 1990s, inequalities in mortality and health behaviour among different socioeconomic groups and ethnic/language groups increased.

Recent history of the health care system

Since 1991, the Estonian health system has undergone two major shifts: first, from a centralized, state-controlled system to a decentralized one; and second, from a system funded by the state budget to one funded primarily through social health insurance contributions. At the same time, there has been a growing emphasis on primary care and public health.

Reform developments

More recent reform activity has included a reconsideration of the initial decentralization envisaged, the re-centralization of some health tasks, the transformation of the Estonian Health Insurance Fund (EHIF) into an independent public body, a legal mandate for all health service providers to operate under private law (even though most institutions continue to be publicly owned by the state or municipalities) and efforts to improve regulation and increase efficiency in health service delivery.

Health expenditure and gross domestic product (GDP)

Total expenditure on health care increased from 4.5% of GDP in 1992 to almost 6.0% in the mid-1990s, followed by a decrease to 5.5% in 2000. Health care expenditure in PPP (purchasing power parity) per capita has increased from a low of US $209 in 1993 to US $559 in 2001. The public share of total expenditure on health care decreased during the late 1990s, from 87.0% in 1997 to 76.3% in 2002.

Overview

The health system underwent extensive reform during the early 1990s, and more recent changes reflect the lessons learned from this initial reform experience. For example, the health system was not equipped to deal with the degree of decentralization that took place in the early stages, but since the late 1990s, the Ministry of Social Affairs has been able to re-establish its responsibility for overall health care planning. Recent reforms have focused on increasing efficiency in health service delivery – including strengthening primary care, introducing gatekeeping and changing provider payment methods – while maintaining access and quality.

Organizational structure and management

Organizational structure of the health care system

Through the Ministry of Social Affairs and its agencies, the Estonian state is responsible for developing and implementing overall health policy, including public health policy, and for supervising health service quality and access. Its main function is regulation. Recently, the role of county governors and municipal governments in health care has been reduced.

In 2001, the Estonian Health Insurance Fund (EHIF) attained its present status as a public independent legal body, replacing the Central Sickness Fund and 17 regional sickness funds. Its main role is as an active purchasing agency, and its responsibilities include contracting health care providers, paying for health services, reimbursing pharmaceutical expenditure and paying for some sick leave and maternity benefits.

Health care provision has been almost completely decentralized since 2002. Health care providers are autonomous. Services can be provided only by individuals and by institutions operating as private legal entities (limited liability companies, foundations or private entrepreneurs). Most hospitals are either limited liability companies owned by municipal governments, or foundations established by the state, municipalities or other public entities. In this sense they are owned and managed by public institutions, either on a profit-making (limited liability company) or non-profit-making (foundation) basis. Most providers of (non-hospital) outpatient services are privately owned. All family doctors are private entrepreneurs or salaried employees of private companies restricted to providing only primary care services.

Patient/consumer involvement in health care debates has become more significant in recent years.

Planning, regulation and management

National health planning was re-activated at the end of the 1990s. Since 2000, the Ministry of Social Affairs has carried out the general long-term planning of specialist care. The EHIF translates the ministry plans into shorter-term contracting policy. Responsibility for primary care planning is shared by the Ministry of Social Affairs at the national and county levels. Planning of human resources has been a relatively neglected area.

Decentralization of the health care system

The reforms that took place at the start of the 1990s established a significant degree of decentralization in Estonia's health system, particularly given its small population. Planning of primary care and some specialist care was devolved to the municipalities. Deconcentrating health care planning and control to the county level involved the establishment of health care administrator positions in county governors' offices and county offices for health protection. Sickness funds were established as independent public organizations in the counties and large cities in 1992. However, problems arose because some functions had been decentralized too much to ensure efficient performance.

Towards the end of the 1990s, there were three major developments in health system decentralization. First, the responsibility for overall health care planning was firmly re-established at the national level under the control of the Ministry of Social Affairs, while county and municipal responsibilities for planning and administering health services were reduced. Second, organizations such as the EHIF and the Health Protection Inspectorate, which used to be represented in each county, centralized those offices so that they now covered several counties. Third, more rights and obligations have been delegated to managers at EHIF and at the provider level. Health care providers now have legal status as private entities operating under private law, which means direct responsibility for provider performance has been delegated by the Ministry of Social Affairs and the municipalities to the hospital supervisory boards. In the case of primary care, privatization began in 1998 and was completed in 2002. In 2001, the EHIF gained its current status as an independent public organization, and it is no longer subordinate to the Ministry of Social Affairs.

Health care financing and expenditure

Health care financing

Since 1992, earmarked payroll taxes have been the main source of health care finance in Estonia, accounting for approximately 66% of total expenditure on health care over the last five years. In 2002, state budgets, municipal budgets and private sources of funding accounted for 8.1%,

2.5% and 23.7% of total health care financing respectively.

Entitlement to EHIF coverage is based on residence in Estonia and membership in specific groups defined by law. There is no possibility of opting out. Employees and self-employed people contribute to the EHIF via an earmarked payroll tax collected by the Taxation Agency. This "social tax" covers both health and pension contributions (equal to 13% and 20% respectively of employee wages and of self-employed earnings). In practice, employers make contributions on behalf of employees, so employees do not contribute directly to health insurance.

Specific groups are covered by contributions from the state budget, including individuals on parental leave with small children, those registered as unemployed (eligible for up to nine months) and those caring for disabled people. The state's contribution for these groups is defined annually when the state budget is approved. Other groups, including children, pensioners, those receiving a disability pension and students, are eligible for coverage without any individual or state contribution.

People are covered regionally, on the basis of where they live and use health services. In all, the EHIF covers about 94.0% of the population. However, levels of coverage vary among the four regional branches due to socioeconomic reasons, such as differences in levels of long-term unemployment. Those not covered by the EHIF are either the long-term unemployed or those not officially employed and thereby evading taxation. Emergency care for the uninsured is funded by the state budget. Most of the state health budget goes to ambulance services and non-EHIF administration.

The EHIF provides cash benefits (18.5% of expenditure on health insurance benefits) and benefits in kind (81.5%). Overall, the range of health care benefits covered by the EHIF is very broad. The few services excluded include cosmetic surgery, alternative therapies and opticians' services. However, dental care is the main area in which coverage has gradually declined. At the end of 2002, dental care for adults was excluded from the list of benefits in kind and replaced by cash benefits, although the EHIF guarantees free dental care for children and adolescents up to 19 years of age, including preventive and curative services. Conversely, since 2003 the EHIF has introduced cover for long-term care, nursing care and some home care, thereby broadening its benefits package.

Some EHIF benefits in kind are subject to user charges. New legislation gives providers the right to introduce capped fees for specific benefits through a fixed payment per service (a co-payment). Co-payments apply to home visits, outpatient specialist visits and each day spent in hospitals. Children, patients hospitalized for conditions related to pregnancy or childbirth, and patients in intensive care are exempt from the inpatient co-payment. Some services, such as in vitro fertilization (IVF) and termination of pregnancy, are subject to co-insurance rates of up to 50% of the listed price. Outpatient prescription drugs are subject to both a co-payment and co-insurance.

Since 2002, there have been clearer and more explicit rules for adding new services to the benefits package and establishing the appropriate level of user charges. The EHIF and the Ministry of Social Affairs agree upon the benefits package, and the government makes a final decision. The four criteria for including/excluding services from the benefits package include medical efficacy, cost–effectiveness, appropriateness and compliance with national health policy, and the availability of financial resources. Nevertheless, implicit rationing continues to take place at the provider level, and waiting lists are also used to ration health care (see below).

Out-of-pocket payments consist of user charges for EHIF benefits, direct payments to providers for services outside the EHIF benefits package or from non-EHIF-contracted providers, and informal payments. Informal payments have not been common in Estonia and continue to be relatively rare.

Prior to 2002, a commercial market for VHI had not really established itself, largely due to the comprehensive range of benefits covered by the EHIF and the absence of substantial waiting times for treatment. Furthermore, people are not permitted to opt out of the EHIF, and supplementary VHI policies offered to employees by employers are subject to a 33% tax on benefits in kind. Since 2002, one commercial insurer has offered voluntary coverage for those not otherwise eligible for EHIF coverage (for example, the non-working spouses of those insured by EHIF), but the level of cover it provides is significantly more limited than the voluntary coverage provided by the EHIF.

Health care expenditure

The government does not set targets for the overall level of health care expenditure as a proportion of GDP. Rather, the level of health care expenditure is determined mainly by wage levels, which form the basis for EHIF revenues, and rising private expenditure on drugs and dental care. Internationally, spending on health as a proportion of GDP in Estonia is above average for central and eastern European countries and the highest among the Baltic states. However, it is still one fourth of the average for the 15 countries in the European Union (EU) prior to May 2004.

During the 1990s, the public share of total expenditure on health care fell. Figures showing public spending in the mid-1990s may have underestimated the level of private spending on health care, but data collected since 1999 are more reliable. Private spending has increased proportionately due primarily to rising expenditure on dental care and drugs, which are only partially reimbursed by the EHIF, and to the introduction of cost sharing for EHIF benefits in kind. In the next few years, however, levels of private spending may decline in relation to public spending as a result of investments from EU structural funds and increases in EHIF revenue.

Health care delivery system

Primary care, the patient's first contact

Reform of primary care began in 1991 with the aim of establishing family medicine as a medical specialty. There is now a clear distinction between primary care and ambulatory specialist care.

The main services provided by family doctors include diagnostic procedures, treatment of general illnesses, health counselling, health promotion and disease prevention. Patients need a family doctor's referral in order to see most specialists and to be admitted as non-emergency inpatients. However, patients are able to access some specialists directly, without a family doctor's referral (for example, ophthalmologists, gynaecologists, psychiatrists and dentists).

Each family doctor has a list of registered patients. Patients can change their family doctor at any time if they can find a new one to take them on. Survey data show that 88% of those who had visited their family doctor are satisfied with the service, and the percentage of satisfied patients has risen by 6% since 1999 and by 9% since 2001. However, the system of partial gate-keeping is not yet well accepted by the population. The accessibility of family doctors is good: more than 80% of patients are able to see their family doctor on the same day, and only 7% of patients wait more than five days.

Public health services

The Public Health Department in the Ministry of Social Affairs is responsible for public health policy planning, health promotion, disease prevention, environmental health and communicable disease control. National public health programmes have been established to address four key public health challenges – AIDS,

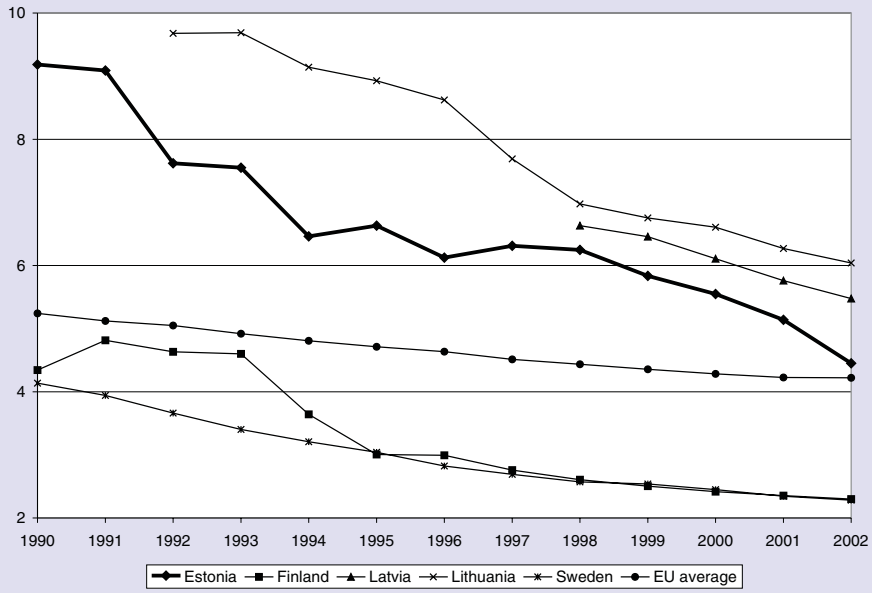
tuberculosis, alcohol and drug abuse, and child and adolescent health – and to facilitate public health research. They are funded from the state budget, coordinated by the National Institute for Health Development and implemented by various government agencies. The EHIF also funds some national disease prevention activities, including screening programmes. The Health Protection Inspectorate is responsible for inspection and enforcement of health protection legislation as well as surveillance and control of communicable diseases, national and local epidemiological services, the national immunization programme (carried out by family doctors), the national environmental health programme and the development of an environmental health information system. Occupational health is coordinated by the Occupational Health Centre, a subsidiary of the Ministry of Social Affairs, and enforced by the Labour Inspectorate, a state agency responsible for occupational safety and labour relations.

Secondary and tertiary care

Specialist care in Estonia is divided into two kinds: ambulatory specialist care and inpatient care. Ambulatory specialist care is provided by polyclinics, health centres, hospital outpatient departments (OPDs) and specialists practising independently. Some independent specialists, particularly dentists, gynaecologists, urologists, ophthalmologists and ear, nose and throat specialists, practise privately, but most other specialists work in hospital OPDs. Both public and private specialists can hold contracts with the EHIF.

Inpatient acute care is provided by regional, central and general (or local) hospitals, as well as some specialist hospitals. All hospitals must be licensed by the Health Care Board and operate under private law as joint-stock companies or non-profit-making foundations. Most hospitals are owned by municipal governments. Private hospitals only provide specific services such as gynaecology, obstetrics and cardiology, with

Fig. 2. Hospital beds in acute hospitals per 1000 population, Estonia, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Finland	2.3	19.9	4.4	74.0[g]
Sweden	2.3	15.1	6.4	77.5[f]
Estonia	4.5	17.2	6.9	64.6
Latvia	5.5	18.0	–	–
Lithuania	6.0	21.7	8.2	73.8
EU average	4.2	18.1[a]	7.0[a]	77.1[a]

Source: WHO Regional Office for Europe health for all database, June 2004.
Notes: [a] 2001.

one exception that provides internal medicine and general surgery services. Hospitals have considerable autonomy in making decisions about renovation, employment, staff salaries and obtaining loans from financial institutions.

Acute care performance has improved over time. The number of inpatient beds and the average length of stay have fallen and the number of admissions has remained stable. The hospitals aim to increase bed occupancy and to lower the average length of stay even further, while the Ministry of Social Affairs recommends that the number of acute hospitals and beds continue to be reduced to 21 acute hospitals and 2 acute beds per 1000 population by 2015.

Waiting lists for inpatient care are an issue in Estonia. They are mainly caused by financial constraints and lack of provider capacity. Since 2001, the EHIF has set waiting time targets for ambulatory specialist and inpatient care.

Clinical guidelines were introduced in the late 1990s to improve quality of care; there have been fewer than a hundred to date. Most describe best practice rather than providing clear guidance for everyday practice. In cooperation with hospitals, the EHIF has developed a system of performance indicators to be measured on an annual basis, but this system is not yet in routine use.

Recent patient survey data show that only 52% of the general population consider accessibility to be good or quite good, while overall satisfaction with health care quality had fallen by 9 percentage points since 2001 to 56%. At the same time, 84% of those who had actually used health services during the year were satisfied with inpatient care and 91% with ambulatory specialist care.

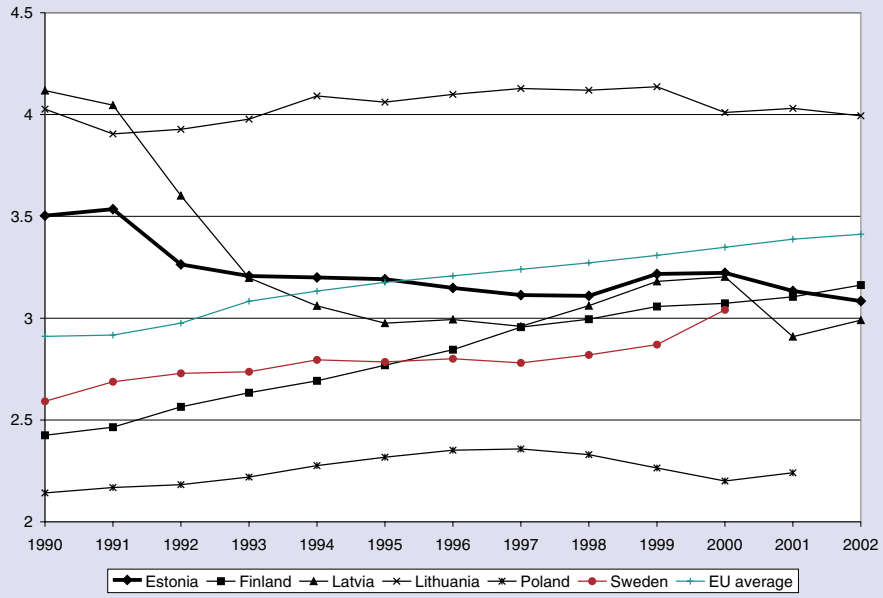
Social care

Social care is the responsibility of municipal governments but financed by transfers from the state budget. It is provided through cash benefits and benefits in kind. The cash benefits include allowances for daily living, personal assistance etc. General services to assist individuals in need of social support continue to be provided mainly in social care homes, although some municipalities have also developed systems of community care. Services provided specifically for people with mental health problems or disabilities are the responsibility of the state and are managed and financed centrally by the Ministry of Social Affairs and the state budget.

Human resources and training

Human resources have been neglected in Estonia in the past, and the quantity and quality of health care professionals is a key issue. After independence in 1991, underinvestment in health facilities and human resources was a major source of cost savings but resulted in low salaries and poor morale among doctors and nurses. More

Fig. 3. Physicians per 1000 population, Estonia, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

recently, the prospect of the free movement of medical professionals within the European Union has put further pressure on this part of the health system. The number of doctors fell by 24% during the 1990s and is expected to fall another 12% by 2010. Currently there is a shortage of nursing personnel and an uneven distribution of specialist services around the country. Recognizing that the nursing shortage threatens the implementation of hospital reforms, the Ministry of Social Affairs has proposed expanding nurse training. However, this proposal may be hampered by lack of training capacity.

Pharmaceuticals

The State Agency of Medicines (SAM) is fully responsible for the control of all pharmaceutical activities and (since 2000) medical devices. All pharmaceutical activities, including manufacturing, wholesale and retail, import/export and hospital pharmacy services, are licensed by the Licensing Board at the Ministry of Social Affairs. In addition to inspecting pharmaceutical services, the SAM provides market authorization based on proven quality, safety and efficacy; approves clinical trials; regulates advertising and promotion of pharmaceuticals; and has responsibility for pharmacovigilance activities.

The EHIF reimburses drugs on a positive list, but outpatient prescription drugs are subject to user charges (see above). A system of reference pricing is in place. A recent legislative proposal for obligatory generic substitution at the pharmacy level was opposed and eventually rejected by both doctors and pharmacists. The regulation was implemented in 2004 in a milder form, in which doctors are generally required to prescribe by active substance, though they are also allowed to prescribe by brand name if they provide a written justification for doing so in a patient's medical notes.

Financial resource allocation

Third-party budget setting and resource allocation

About 70% of total expenditure on health is channelled through the EHIF. The EHIF budget is determined by the revenue generated by the part of the social tax earmarked for health. EHIF funds are allocated to the four regional branches on a per capita basis, adjusted for regional differences in age structure in the case of primary care. The regional branches have some flexibility in allocating funds among specialist care, long-term care and dental care. The planning of provider contracts takes place at the regional level, by the regional branches of the EHIF.

The state budget funds approximately 8% of care, mostly through the Ministry of Social Affairs. Budgetary ceilings for each ministry are set by the Ministry of Finance, based on legislative obligations and government priorities.

Payment of hospitals

Hospital payment is based on cost and volume contracts with the EHIF, using the maximum service prices set out in the price list. The price list, which includes about 1800 different items in all, covers both fees-for-service and complex prices for specific procedures. Fee-for-service payment involves per diem and individual units. During the late 1990s, there was a move away from a detailed fee-for-service payment system to a case payment system in order to tackle some of the perverse incentives created by the former, particularly overtreatment, but also undertreatment and selection of patients. Complex prices were introduced in 1998 for several well-defined surgical diagnoses, but their contribution to total inpatient reimbursement is small, and the combined payment methods do not result in significant risk sharing on the part of providers. The gradual introduction of financing based on diagnosis-based groups (DRGs), from 2004, aims to address this issue.

Payment of health care professionals

In primary care, family doctors and nurses contracted by the EHIF are paid via a combination of capitation, fees-for-service and a basic monthly allowance. Independent ambulatory specialists contracted by the EHIF are paid on a fee-for-service basis up to a maximum amount specified in the contract. Health care professionals who provide outpatient and inpatient care in hospitals are usually salaried employees. Other health care professionals, including pharmacists, are also salaried.

Health care reforms

The Estonian health system has undergone significant changes since independence in 1991. Reforms took place in two waves. Reforms in the first wave of "big bang" reforms focused on improving health care financing and increasing the health system's responsiveness to patients. The government introduced a system of funding health care through earmarked contributions for health insurance that were collected and pooled by sickness funds. It also introduced a purchaser–provider split and gave health care institutions more autonomy.

In the second wave, reforms were mainly aimed at increasing efficiency and protecting the public interest through closer and more transparent regulation of health care providers and the health insurance system. Primary care and hospital reforms aimed to increase efficiency and accountability in service delivery by clearly establishing the legal status of providers, making providers share some financial risk and ensuring quality of care. At the same time, the government sought to strengthen its planning and regulatory capacity and strengthen the purchasing power of the Estonian Health Insurance Fund. The second wave also included pharmaceutical reimbursement reform aimed at increasing efficiency through the introduction of a reference pricing system.

Estonia has been fairly successful in implementing the major planned reforms in the context of other major social, economic and political changes. Problems encountered during implementation have not delayed significantly the reform process.

Conclusions

The Estonian health system has been transformed over the last 13 years, undergoing extensive initial decentralization followed by some re-centralization. In recent years, the position of the Ministry of Social Affairs has been strengthened, particularly in creating a national framework for health service provision and policy. Reforms to increase efficiency in health service delivery continue, alongside efforts to ensure responsiveness while maintaining access and equity. Remaining challenges include tackling inequities in health status and health behaviour; gaining control of the HIV epidemic; improving regulation of autonomous hospitals to ensure better public accountability; and boosting health expenditure as a proportion of GDP.

HiT summary

Estonia

The Health Care Systems in Transition (HiT) profile on Estonia was written by Maris Jesse (Health Policy and Finance Analyst, PRAXIS Center for Policy Studies), Jarno Habicht (Liaison Officer, World Health Organization (WHO), and PhD student, University of Tartu), Ain Aaviksoo (MPH student, Harvard University, formerly Head of Public Health Department, Estonian Ministry of Social Affairs), Agris Koppel (Chief Executive Officer, Jõgeva Hospital, and PhD student, University of Tartu) and Alar Irs (Head of Department, Estonian State Agency of Medicines, and Visiting Lecturer, Newcastle University, Australia) in collaboration with Sarah Thomson (European Observatory on Health Systems and Policies). It was edited by Sarah Thomson. The Research Director for the Estonian HiT was Elias Mossialos (European Observatory on Health Systems and Policies).

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.