Eesti Haigekassa
Estonian Health Insurance Fund

Annual Report 2005

Estonian Health Insurance Fund Annual Report 2005

Name	Estonian Health Insurance Fund
Registration number in the state register of central and local government agencies	74000091
Address	Lembitu 10, Tallinn 10114
Telephone	+372 620 8430
Fax	+372 620 8449
E-mail	info@haigekassa.ee
Web page	www.haigekassa.ee
Beginning of financial year	1 January 2004
End of financial year	31 December 2004
Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman) Arvi Vask Maigi Pärnik-Pernik Eliko Pedastsaar
Auditor	KPMG Baltics
Annexed documents:	Auditor's Report

Table of contents

Relevant statistics 2002-2005

Table 1. Summary of major indicators from 2002 to 2005

	2002	2003	2004	2005	2005/ 2004 %
Number of insured	1 284 076	1 272 051	1 271 558	1 271 354	99,98%
Revenue (in EEK thousand)	5 099 324	5 690 137	6 350 129	7 346 892	115,70%
Expenditure on health insurance benefits (in EEK thousand)	4 647 939	5 292 194	6 136 989	6 983 752	113,80%
Operating expenses (in EEK thousand)	82 954	86 625	80 112	89 385	111,58%
Insured who received special medical care (persons)	919 470	914 611	917 227	919 822	100,28%
Average duration of treatment (days)	7,2	6,8	6,6	6,9	104,55%
Emergency care as a percentage of expenditure on specialised medical care:					
- outpatient	14,4	13,9	15,0	15,2	101,33%
- inpatient	56,4	56,6	60,0	64,6	107,67%
Average cost per case in specialized medical care (EEK)					
- outpatient	275	346	409	468	114,43%
- inpatient	6 264	7 566	8 701	10 079	115,84%
Number of prescriptions	4 050 231	4 012 989	4 775 221	5 000 602	104,72%
Average prescription cost for the EHIF	180,6	171,2	180,0	173,0	96,11%
Days of incapacity covered by insurance	6 411 107	6 717 278	7 321 490	7 685 148	104,97%
Cost of incapacity benefit per day	128	138	151	165	109,27%

Corporate overview

Short history of the Health Insurance Fund

The Health Insurance Act took effect in Estonia in 1992. In 1994, the centralization of the health insurance system and the foundation of the Central Health Insurance Fund took place, whose function was to provide compulsory health insurance coverage through its regional departments. Since 2001, the Estonian Health Insurance Fund (EHIF) is a legal person governed by public law which main objective is laid down in the Estonian Health Insurance Act: "The objective of the Health Insurance Fund is to ensure the payment of health insurance benefits pursuant to the Health Insurance Act, other legislation and health insurance costs prescribed in the budget of the health insurance fund."

What are the functions of the Estonian Health Insurance Fund?

Each year, the Health Insurance Fund enters into contracts with health care institutions for provision of health services, financing this way general medical care and specialised medical care, as well as dental care and nursing care. Upon payment for health services, the Health Insurance Fund is guided by on the regulation of the Government of the Republic "The list of health services of the Estonian Health Insurance Fund." The Health Insurance Fund shall buy a service from a health care institution, but the owner of the hospital is, as a rule, either the state or a local government, operating as a foundation or a public limited company.

Likewise, quality and providing access to health services are the main activities of the Health Insurance Fund. Harmonisation and development of the quality is one of the main priorities of the Health Insurance Fund. For this purpose clinical guidelines are developed together with specialist societies.

In addition to health services, the Health Insurance Fund also pays for covered prescription drugs. The drugs for which the Health Insurance Fund pays are included in the regulation of the Minister of the Social Affairs "The list of drugs of the Estonian Health Insurance Fund." The Health Insurance Fund shall reimburse at 50 %, 75 %, 90 % or 100 % per prescription, whereat person himself or herself shall bear a co-payment. The Minister of Social Affairs shall establish, by a regulation, reference prices of drugs and shall enter price agreements with persons authorized to market medicinal products.

The better the state of health of people, the less money goes on treatment of diseases and combating health problems. Therefor, the Health Insurance Fund consideres the activites such as health promotion and preventing a human disease to be the most important duties. For example, in the last years, screening of breast cancer and cervical cancer has been carried out actively. New activites launched under several social campaigns are aimed at youth, taking into account the fact that habits acquired during the school time remain for a long time. The youth has been explained of harmful effect of passive smoking, problems arising from alcoholism, healthy nutrition etc.

Corporate structure

The highest body of the Health Insurance Fund is the Supervisory Board comprised of fifteen members of whom five persons represent employers, five insured persons and five the state powers. Until 2006, the Management Board of the Estonian Health Insurance Fund was composed of the three members, but now the number of members is four. Currently, the structure of the Health Insurance Fund comprises four regional departments: Harju, Pärnu, Tartu and Viru departments in addition to the central department.

As of 1 January 2006, the Health Insurance Fund employed 252 employees of whom women accounted for 88 percent and men for 12 percent.
The breakdown of employees by education, length of service and age is shown in the table below.

Table 2. Breakdown of the EHIF employees by education, length of service and age, 2005.

Education		Length of service		Age	
Secondary vocational	22,3%	Up to 1 year	25,9%	Aged 22-30	16,2%
Secondary	20,2%	Up to 3 years	23,9%	Aged 31-40	26,3%
Higher	57,5%	Up to 5 years	6,1%	Aged 41-50	22,3%
		Over 5 years	44,1%	Aged 51-65	35,2%

A number of internationally recognised management approaches have been introduced in the EHIF since 2001-2002 – activity-based budgeting, the balanced scorecard, competence management and business process management. They constitute substantial and extensive development projects involving all employees within our organisation. With reference to the last year, we can confirm that we have managed to successfully deploy the new management systems in the organisation – this is proved by feedback from employees as well as external recognition won by the organisation.
For the third year in a row, the EHIF was awarded the certificate of achievement for excellence in financial reporting in the public sector (Public Sector Accounting Flagship), for the most transparent and best-content annual financial report among Estonian public sector organisations.

„Family Physicians' Advisory Line 1220" of the Health Insurance Fund was awarded the first prize for the best innovation on a competition organised by State Chancellery in 2005. Some twenty inter-authority cooperation projects were put out to the competition. In addition to that, the project was named among the finalists of the United Nations Public Service Award.

Mission

The Estonian Health Insurance Fund is committed to building a sense of security in the insured for facing and solving health problems.

Vision

Through solidarity-based insurance the Estonian Health Insurance Fund finances health care services in a transparent and patient-centred manner, maintaining the sustainability of health care institutions.

Main values

Innovation – we target our activities at sustainable development, relying on competent, committed and result-oriented employees.
Respect – we are reliable, open and responsive. Our decision-making is transparent and considerate of individual needs.
Collaboration - we create a trustworthy atmosphere within our organisation and in relations with our partners and clients.

Statement by the Chairman of the Management Board

Year 2005 was both for whole Estonia and the Health Insurance Fund the first full year as a member in the European Union and the first effects of membership have also reached the health care system. Ever more noteworthy becomes shortage of physicians in some specialities such as oncology, cardiology and oftalmology.
These trends are reflected in decrease of availability, ensuring and monitoring of which are considered the main tasks of the Health Insurance Fund.
It is a pleasure that the University of Tartu and the Estonian Medical Association have entered into a contract which provides for a remarkable increase of admission of students to the Faculty of Medicine in the next years. At the same time the question how to ensure the graduates of the Faculty of Medicine with residency places in our hospitals in order to decrease motivation to leave abroad, is still open.
As before, shortage of operating rooms obsesses big hospitals which extends the waiting time of patients on waiting lists of operation. Extensions to the buildings of Tartu University Hospital and the Reginal Hospital of Northern Estonia will mitigate shortage of rooms in the nearest future. Shortage of funds is not always the reason for long waiting lists.
Upon payment for health services we increased the share of diagnosis-specific funding up to 50 % last year. Diagnosis-specific funding shall increase accuracy in planning health care and enable a fair payment for the results.
The problem concerning activity-based funding of the county hospitals is becoming even more serious because the small number of inhabitants living in the service area does not provide the hospitals with sufficient work load which will ensure sustainable development of the hospitals. In the nearest future, the functions of these hospitals shall be looked through and brought into conformity with the actual needs.
We started a systematic work upon development of the quality of activities of the hospitals. In cooperation with the World Health Organization, indicators of activities on the basis of which the hospitals can compare their activities between themselves and, if they so desire, internationally shall be developed during 2006. Development of the quality of health services shall be considered one of the main tasks of the Health Insurance Fund even during the forthcoming years.
In 2005, General Practitioners' Advisory Line came into operation which quickly found its place among other on-line services. Diagnosis is not identified by phone but shall be consulted how to settle the problems emerged. As the first five minutes are free of charge if the call is taken from table phone, then ringing is not restricted even for economically disadvantaged individuals. Even persons not covered with health insurance can ask for advice from qualified family nurses and physicians both in Estonian and Russian and twenty-four hours a day.
I want to thank everyone who assisted us in our activities in 2005.

Hannes Danilov, *Chairman of the Management Board Estonian Health Insurance Fund*

Annual report 2005

This report is composed of three parts:

- The management report of the Health Insurance Fund.
- The notes to budget implementation and analysis of the utilization of medical benefits 2005.
- The annual financial statements for the year ended 31 December 2005.

Management report 2005

Executive summary

In 2005, the Management Board of the Estonian Health Insurance Fund has been guided by two documents approved by the Supervisory Board of the Fund for corporate management and strategy implementation: the 2005-2007 development plan and the 2005 scorecard.

For the development and implementation of its strategies, the EHIF has been using the balanced scorecard method since 2002, which enables to set up and interrelate strategic corporate objectives in a systemic and comprehensive way and to monitor their implementation in a clear and measurable manner. We are of the opinion that application of the balanced scorecard method in planning and implementing of our activities has been accepted in the Health Insurance Fund. Consistent planning of activities has become a part of mentality of employees and enables a more efficient performance of the tasks and assessment of the results.

Below is an evaluation of the implementation of the objectives set in development plan and the balanced scorecard in 2005 by the Estonian Health Insurance Fund.

The main outcomes of strategic objectives of the EHIF in 2004 are presented below, whereas a more detailed overview of the accomplishment of sub-objectives is provided after this summary and Table 3.

Satisfaction of insured persons with health insurance system – achievement rate was 85 percent.

1. Providing access to health services in the presence of limited resources – achievement rate was 97 percent.
2. Improving efficiency of the quality of health services – achievement rate was 100 percent.
3. The purposeful planning and use of the resources of health insurance, ensuring balance, efficiency and transparency – achievement rate was 80 percent.
4. Ensuring awareness of insured persons of their rights and responsibilities – achievement rate was 91 percent.
5. Improving efficiency of operation of the Health Insurance Fund – achievement rate was 100 percent.

In conclusion, the Management Board evaluates the implementation of the development plan and the scorecard for 2004 as "good". We have succeeded in accomplishing all major tasks planned for the further development of the public health insurance system and our organisation.

Table 3. The balanced scorecard of the Estonian Health Insurance Fund, 2003-2005

Objective	Performance measure	Weighting	Unit of measure	2003 outturn	2004 outturn	2005 target	2005 outturn	Performance level %
	Satisfaction of insured persons with health insurance system *	5%	%	51	51	60	51	85%
1. Access to health services under limited resources		**30%**						**97%**
	Satisfaction with access	7,5%	%			56	49	88%
1.1.	Maintenance of waiting lists							
	Insured having access to primary medical care within established time limits	7,5%	%	100	98	98	99	100%
	Insured having access to specialised medical care within established time limits	7,5%	%	98	99,9	98	100	100%
1.2.	Performance of obligations by partners							
	Quality of contract execution	7,5%	rating		Good	Good	Good	100%
2. Quality of health services		**15%**						**100%**
	Satisfaction with quality	3,75%	%			60	59	98%
2.1.	Development of quality of health care services							
	Approved treatment instructions	3,75%	tk	6	6	5	5	100%
2.2.	Assessment and monitoring of quality of health care services							
	Clinical audits	3,75%	tk	4	5	5	5	100%
	Inspected cases	3,75%	tk	14186	10243	10000	10384	100%
3. Purposefulness, balance, efficiency and transparency in planning and use of resources		**30%**						**80%**
	Satisfaction with range of services paid by health insurance	6%	%			42	46	100%
3.1.	Assessment of needs of health insurance benefits and balance with budget opportunities							
	Agreements with professional associations on the needs of specialities	6%	tk			2	2	100%
3.2.	Efficiency of use of resources							
	Application of price agreements upon medicinal product distributed at a discount not comprised by reference prices**	6%	%			10	30	0%
	Preventing structural rise in price of average cost of a treated case	6%	%			Level to be determined	Level determined	100%
3.3.	Efficiency and quality of service and partnership relations							
	Satisfaction of partners and clients with service***	6%	%	85	86,5	85	94	100%
4. Awareness of insured persons of their rights and responsibilities		**10%**						**100%**
	Awareness of insured persons of their rights	5%	%	61	66	70	70	100%
4.1.	Informing clients and partners							
	Fulfilment of communication plan	5%	mark			4	4	100%
5. Operation of organization		**10%**						**100%**
	Participation in quality competition of public sector organizations	2,5%	mark					
5.1.	Competence and motivation of employees							
	Satisfaction of employees with corporate governance and organization of work of EHIF	2,5%	mark	2,5	3,24	3,4	3,4	100%
5.2.	Modern information systems							
	Transactions in electronic channels	2,5%	%	6	78	90	94	100%
5.3.	Business processes							
	Change in the cost of core processes	2,5%	%	50	50	100	100	100%
	TOTAL	**100%**						**92%**

* Attainment rate for 2003 has been adjusted for comparability

** Upon setting up an objective one could not foresee sharp changes in environment as a result of which a process of conclusion of price agreements with lower prices was launched and achievment of the objective turned out to be formal. Based on this, fulfilment of the results was calculated as 0%.

*** In 2003 and 2004, satisfaction of insured persons, empoyers and partners was assessed separately. The indicator has been summarised for comparability.

Strategic objective. To raise satisfaction of insured persons with health insurance system

Satisfaction of insured persons with health insurance system
The main strategic objective of the Health Insurance Fund is to raise satisfaction of insured persons with health insurance system. The objective for 2005 was to achieve a satisfaction rate of at least 60 percent.
In order to assess general attitude and satifaction with current medical care system, the persons participating in the survey, carried out by the research firm Faktum, were asked to assess the quality of and access to medical care, and satisfaction with current general medical care system. Satisfaction of the insured person with health care system is the total including three above mentioned satisfaction indicators.

On the basis of the survey:

- Satisfaction with the quality of medical care 59%
- Satisfaction with access to medical care 49%
- Satisfaction with the range of health services 46%

Thus, general satisfaction with medical care system 51%.

Table 4. Satisfaction of the insured with health insurance in 2001-2005.

Components	2001	2002	2003	2004	2005
Access to services	56%	50%	52%	52%	49%
Quality of services	70%	62%	56%	59%	59%
Range of services		43%	44%	41%	46%

General satisfaction with access to and range of services has decreased during the years as supplementary funds have been allocated primarily for increase of wages of health care professionals, and not to improvment of access. This forced the Supervisory Board to increase the permitted maximum length of waiting lists in 2005.

Objective 1. Ensure access to health services under limited resources

Pursuant to the Health Insurance Act one of the most important activity areas is to ensure access to health services. We carry out activities which assist to keep access under limited resources on the level of cases of 2004 and cooperate, in order to ensure a correct and transparent maintenance of waiting lists by the provider of health services.

Satisfaction with access

The objective in 2005 was to achieve an assessment on access to medical aid on level good or rather good among 56 percent of persons in survey. On the basis of survey carried out by the research firm Faktum 49 percent of respondents considered the access to medical aid good or rather good.
The following sub-objectives have been set up in order to improve access to health services:

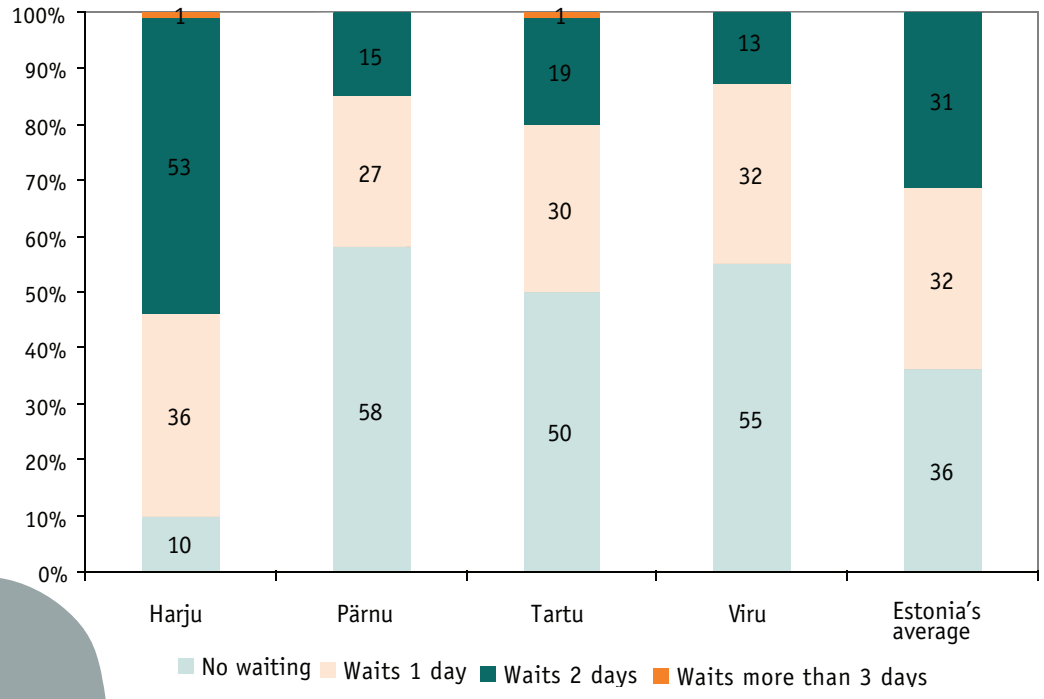
1.1. Improve maintenance of waiting lists

With a view to fulfilling the objective, we assess and analyse access to primary medical care and specialized medical care by regions.

Insured having access to primary medical care within established time limits

The objective of the Health Insurance Fund for 2005 was a timely appointment with the primary care physician of 98 percent of the insured: on the same day for a patient with an acute condition and within three workdays for a patient with a chronic disease. The objective in Estonia is achieved, 99 percent of the insured had a timely appointment with a primary care physician.

Figure 1. Access to general medical care in 2005.



Insured with a chronic disease could not see their family physician within the prescribed three workdays during the second quarter from Harju region of the Health Insurance Fund and during the third quarter from Tartu region.

Insured having access to specialized medical care within established time limits

The objective of the Health Insurance Fund for 2004 was to achieve that 98 percent of the insured have a timely appointment with a specialist doctor during his/her regular reception hours (i.e. under the resources and limited capacity of the health care institution, the maximum length of a waiting list laid down by the Supervisory Board shall not be exceeded).

On the basis of data on waiting lists submitted by health care institutions, access to out-patient specialized medical care was 99.4% and to in-patient specialized medical care was 100% in 2005, taking into account all insured.

With a view to the number of insured in the waiting list who wait longer than the prescribed maximum length under the resources and limited capacity of the health care institutions, then there are problems to ensure access to out-patient medical care in Harju region where the main reason is a smaller capacity compared with the needs of Tallinn health care institutions. The capacity problem has proceeded from a small number of doctors and overload of rooms (e.g. operating rooms).

Table 5. Access to specialized medical care under the resources and limited capacity of the health care institution per the number of insured (%)

	Out-patient				In-patient			
Department	**31.03.**	**30.06.**	**30.09.**	**31.12.**	**31.03.**	**30.06.**	**30.09.**	**31.12.**
Harju	99,0%	99,1%	99,0%	99,1%	100%	100%	100%	100%
Pärnu	99,9%	99,9%	99,9%	99,8%	100%	100%	100%	100%
Tartu	99,5%	99,6%	99,6%	99,4%	100%	100%	100%	100%
Viru	99,5%	99,7%	99,7%	99,8%	100%	100%	100%	100%
Total	**99,4%**	**99,5%**	**99,4%**	**99,4%**	**100%**	**100%**	**100%**	**100%**

Financial resources have caused longer waiting lists than permitted in out-patient medical care concerning such medical professions as rehabilitation treatment, endocrinology and gynecology. In in-patient medical care concerning profession as endovascular surgery and in day treatment concerning profession as otorhinolaryngology.
The main reason for low capacity is shortage of doctors in out-patient care.
The longest waiting lists due to capacity are in out-patient specialized medical care concerning profession as oncology, ophtalmology and cardiology, in in-patient medical care and day treatment concerning profession as otorhinolaryngology.

1.2. Performance of obligations by partners

With a view to fulfilling the objective, we assess the quality of contract execution.

Quality of contract execution

The objective for 2005 was the execution of contracts with health care institutions for the rating of “good” which means that data on waiting lists submitted by all contract partners, providing specialized medical care, nursing care and dental care services, shall be sent in good time and of good quality and that maintenance of waiting lists by partners shall be monitored.

99 percent of contracting parties has submitted data on waiting lists in good time. Partners have not only improved compliance of the waiting lists with the terms of submission, but also the quality and reliability of data. During the reporting period, the Health Insurance Fund has verified data on waiting lists submitted by partners 129 times, including 55 times upon application for an amendment of the contract due to availability problems. The providers of health services who have had problems with the quality of waitning lists have received precepts and terms for elimination of deficiencies.

Objective 2. Improve quality of health services

Pursuant to the Health Insurance Act the role of the Health Insurance Fund is to motivate health care providers, to ensure and improve the quality.

Satisfaction with quality

The objective was to achieve an assessment on quality of medical aid on level good or rather good among 60 percent of persons in survey. On the basis of survey carried out by the research firm Faktum 59 percent of respondents considered the quality to medical aid good or rather good.

The following sub-objectives have been set up in order to improve the quality of health services:

2.1. Improve development of the quality of health care system

With a view to the role of the Health Insurance Fund in connection with quality strategy of health services, the Health Insurance Fund shall assist and motivate health care institutions and professional associations to improve the quality of health services.

Approved treatment instructions

The objective of drafting treatment instructions was to harmonize, change or improve diagnostics of a certain disease or condition, treatment and general patterns or organization of health services. The Health Insurance Fund shall organise preparation of treatment instructions for professional associations aimed at improving utilization of best cost-effective practice. The role of the Health Insurance Fund is to motivate and assist professional associations in their activities.

In 2005, the objective was to approve 5 treatment instructions which were implemented:

- "Instruction for the treatment of acute ST-elevation myocardial infarction", developed by the Estonian Society for Cardiology
- "Abdominal hernias: instruction for the treatment", developed by the Estonian Association of Surgeons;
- "Instruction for utilization of medicinal products prepared of human blood in Estonia", developed by the Estonian Society for Transfusion Medicine;
- "Diagnostics and treatment algrithms of frequent outpatient infection diseases for family physicians", developed by the Estonian Association of Lab Medicine;
- "Instructions for prevention of cardiovascular diseases in Estonia", developed by the Estonian Society for Cardiology.

In 2003-2005, the Health Insurance Fund has approved 19 treatment instructions in total.

2.2. Improve assessment and monitoring of the quality of health care system

The quality shall be assessed on a regular basis and the results analysed in order to ensure and harmonise the quality of health care system. To this end, we carry out clinical audits for provision of feedback to the providers of services and verify treatment cases in health care institutions.

Number of clinical audits

In 2005, the objective was to carry out 5 audits. The purpose of the audit shall be to monitor the quality of services partly or wholly paid for by the health insurance fund, and determine whether the provision of services has been justified, and pursuant to the feedback to motivate the providers of services to provide services of better quality. The audits shall be carried out by professionals renowned for their experience in the field on the basis of laws in force, treatment

instructions, codes of conduct and good practice. Auditors shall be selected in cooperation with professional associations.

The objective of 2005 was achieved, the following audits were carried out:

- "Practicability of long-term phased treatment by family physicians (consecutive leave for 20-30 days) (Tartu and Pärnu City)", by Professor Emeritus Vello Salupere;
- "Audit of perforations of gastric, duodenum and peptic ulcers in Estonia (in 2002-2003)", by Dr. Marko Murruste;
- "Practicability of long-term home nursing service", by the Estonian Association of Nurses, resposible for the work group Ülle Rohi;
- "Practicability of long-term phased treatment by family physicians (consecutive leave for 20-30 days) (Tallinn and Harju region)", by Professor Emeritus Vello Salupere;
- "Practicability of inpatient operative treatment in connection with general surgical operations of I-IV group", by Dr. Marko Murruste.

The results of the executed audit are exhaustive and shall be used as an input for improvment of work with quality by the providers of health services and for the future activity planning by the Health Insurance Fund.

Inspected cases

The purpose of inspection of treated cases is to ensure that the utilization of medical benefits is accurate and justified. By means of inspection of treated cases the Health Insurance Fund shall assign cost-effective treatment tactics, as one of the options, and developed treatment instructions to the providers of health services for utilization. Inspection of treated cases shall be carried out on the basis of documents (health cards both in general medical care and specialised medical care, dental care cards, health and medical history) certifying the provision of health services.

The objective of inspections made on the basis of random sampling in 2005 was:

- cases of prescribing antagonists for glycocorticosteroid and leukotriene receptors at a higher discount rate for bronchial asthma of children below 18 years;
- cases of prescribing omeprasol at discount rates of 75% and 90% for peptic ulcers;
- assessment of indication of endoprosthesis according to uniform criteria;
- approach to the diagnostics and treatment of male urinary and genital in family physician sector;
- control over the prescription of atypical antipsychotic drugs at a discount rate of 100% in Harju and Tartu regions;
- cases of prescribing hormonal contraceptives at discount rates of 75% and 90% in Pärnu and Viru regions;
- coding of cases of treatment requiring surgery of peripheral veins;
- conformity of prescribing the test strips of clucose meters (medical aids) with the legislation;
- follow-up check of the audit of long-term certificates for incapacity for work (20-30 days of consecutive leave from work) in Tartu and Pärnu regions.

The regional departments of the Health Insurance Fund inspected 10,384 treatment cases in total. As a result of the inspection of treatment records, 990 claims (of them 261 claims on the basis of prescriptions) for EEK 478,728 has been made.

Objective 3. Ensure purposefulness, balance, efficiency and transparency in planning and use of resources of health insurance

We shall presume that all parties connected to the health insurance benefits are interested in highest possible efficiency, clear purposefullness and transparency in use of resources. This will provide the insured persons with services of greater quantity and higher quality and will ensure clarity and uniform rules to the parties of health care system concerning the use of resources of health insurance.

Satisfaction with range of services paid by health insurance

The objective for 2005 was to achieve a satisfaction rate with range of services paid by health insurance of at least 42 percent. On the basis of survey carried out by the research firm Faktum 46 percent of respondents considered the range of services paid by health insurance good or rather good.

3.1. Improve assessment of needs of health insurance benefits by balancing needs with budget opportunities

Agreements with professional associations on the needs of specialities

In order to determine the needs for specialized medical care and prescription drugs, we cooperate with professional associations. The objective of the Health Insurance Fund for 2005 was to agree upon the need for health services with professional associations of pulmonology and for prescription drugs with professional associations of oncology.
The objective was successfully implemented.

3.2. Improve efficiency and transparency of use of resources of health insurance

Entry into price agreements on medicinal products and prevention of structural rise of average cost of a treatment case shall be the main activities in order to achieve this sub-objective.

Application of price agreements upon medicinal product distributed at a discount not comprised by reference prices

Pursuant to the Health Insurance Act reference prices shall be established for or price agreements shall be concluded on medicinal products with a discount rate of 100 or 75 per cent. The Health Insurance Fund shall draft an expert opinion on proposal of price agreement in the course of which it will take into account wholesale purchase prices of medicinal products in reference states and prices of proprietary medicinal products in Estonia upon setting the price of medicinal products, and shall also prepare a reasoned assessment on expected retail capacity of medicinal products.
The objective for preparation of expert opinions and conclusion of price agreements is to improve efficiency of use of resources, to prevent a price increase and to ensure continuous access to medicinal products in the conditions of limited means.
During 2005, the Health Insurance Fund has submitted expert opinions on 59 drafts of price agreements to the Ministry of Social Affairs.
At the time of setting up the objective, rapid changes in the environment could not be forecasted as a result of which a process comprising conclusion of price agreements with lower prices commenced and achievement of the objective turned out to be a formality. It follows that fulfilment of the objective shall be considered 0 percent.

Preventing structural rise in price of average cost of a treated case

The objective for 2005 was to fix the basis for a change concerning structural rise in price of average cost of a treated case in the event of the in-patient type of treatment in respect of which the change can be assessed in the next periods.
Development of technologies and therapies which influences the structure of treated cases and increases the average cost of a treated case is under process in the health care. Likewise, the method of financing of providers of health services shall also have an influence. Service-based financing where the Health Insurance Fund shall remunerate all services provided within a treated case, contributes to increase of the average cost of a treated case. In order to balance this process, the Health Insurance Fund has implemented case-based financing in in-patient specialized medical care and day surgery since 1 April 2004 – DRG system (in English, diagnosis related groups). In the event of DRG-based financing a certain amount of money shall be paid for a treated case which does not depend on the structure of health service provided to the patient. This payment shall motivate the provider of health services to choose a method of treatment and technologies of a similar clinical efficiency but less capital-using. This, however, means that the provider of a health service is interested to keep the price of a treated case as low as possible even if the structure of the treated case shall be changed.

As the change in customary practice and implementation of new treatment methods is a long process then the effect concerning decrease of average structural cost of a treated case can be expected in the next years.

In 2004, increase of average structural cost of an in-patient treated case was three percent and in 2005 six percent (see Table 6). Thus increase of a structural cost of a treated case in 2005, compared to 2004, was 100 percent.

Table 6. Increase of average structural cost of a treated case (hereinafter ASCTC) and its change as regards treatment types of specialized medical care in 2003-2005.

ASCTC and its change in treatment types	**Out-patient**			**Day treatment**			**In-patient**		
	2003	2004	2005	2003	2004	2005	2003	2004	2005
ASCTC in kroons	346	353	352	2 969	3 520	4 152	8 356	8 604	9 078
ASCTC in kroons compared with previous period percentage		2%	-0,3%		19%	18%		3%	6%

3.3. Improve efficiency and quality of service and partnership relations

The objective for 2005 was to achieve a summary figure within the range of 85 percent concerning satisfaction of employers, of partners and with service. Resultant summary satisfaction was 94 percent.

In the relations with their clients and partners the Health Insurance Fund shall observe the principles of a client-oriented organization and shall measure the quality of services as a summary figure of the following target groups:

- Partners
- Employers
- Insured persons or person applying for insurance cover

Satisfaction of partners with service

As to satisfaction of contracting parties with cooperation, the objective was to meet an 80 percent party satisfaction with the Health Insurance Fund.
As a result of the survey the satisfaction rate of the contractual partners with cooperation with the Health Insurance Fund was 97.7 percent. At least 500 evaluations submitted by the contractual partners or representatives of contractual partners were considered representative, actually, 595 filled forms were received.

Satisfaction of employers

The objective of the Health Insurance Fund is to keep the satisfaction rate of employers at 85 percent.

The Health Insurance Fund conducts a survey among employers every year in order to find out employers' satisfaction with the business procedures and service quality in the Fund. The target group is 500 companies from all over Estonia and survey is conducted by the research firm Klaster in a form of telephone survey.

As a result of the survey carried out in 2005, the satisfaction rate of the employers with services of the Health Insurance Fund was 93 percent. 66 percent of the respondents gave evaluations of "generally satisfied"and 27 percent "very satisfied" with the services.

Satisfaction of insured persons or persons applying for insurance cover

The objective for 2005 was to keep the satisfaction rate of insured persons or persons applying for insurance cover at 85 percent. In order to measure satisfaction, the Health Insurance Fund uses inspection purchase or so called Mystery shopping twice a year. This method comprises use of test clients upon assessment of service situations. The look of the service place and the service provider, commencement of a contact, communication with clients and termination of a contact were tested. The testing was conducted by Dive Service Quality Development OÜ.
As a result of the test, the service level in the first half-year of 2005 was at 90 percent and in the second half-year at 91 percent, according to evaluation.

Objective 4. Ensure awareness of insured persons of their rights and responsibilities

Awareness of insured persons of their rights

The objective for 2005 was to achieve an awareness rate of at least 70 percent.

On the basis of a comprehensive survey carried out by the research firm Faktum 70 percent of Estonian residents were aware of their rights and responsibilities concerning health insurance and knows the main terms and facts of the area.

In previous years, the results were respectively 60.5 percent in 2003 and 66 percent in 2004. In 2005, the Health Insurance Fund ordered an ordinary survey together with the Ministry of Social Affairs and therefore, the sample comprised 1500 residents aged 15-74 years instead of 1000.

4.1. Improve informing clients and partners

According to the communication plan of the Health Insurance Fund, informing of clients and partners shall be made through direct meetings, information sessions and e-mails.
The role of preventive health campaigns in public notification has increased in 2005. Such campaigns as healthy nutrition and passive smoking campaign as well as several campaigns and events within the framework of cancer week and heart week have received a positive recognition.
The Health Insurance Fund together with a company OÜ Arstlik Perenõuandla launched „Family Physicians' Advisory Line 1220" on 1 August with the aim of better serving public.

Implementation of communication plan

The communication plan was implemented in the planned capacity and the most important subjects and activities of the year were the following:

- The Estonian Health Insurance Fund Gazette, 3rd edition, circulated as a supplement to the daily Eesti Päevaleht
- A lot of flyers on benefits for incapacity for work, dental benefits, the rights and responsibilities of self-employed persons, European Health Insurance Card etc. A flyer on information concerning prescription drugs together with the Ministry of Social Affairs.
- A campaign to launch and inform about „Family Physicians' Advisory Line 1220" (a flyer in two languages, TV and radio clips, stickers);
- Several speeches mainly made to managers and employees within the framework of cooperation to combat envelope wages;
- Reviews on subjects such as utilization of drugs by family physicians, health insurance cover and benefits for incapacity for work in medical publications aimed at partners.

Object 5. Improve operation of organization

In order to manage to carry out its mission and objectives, the organization shall employ right persons to perform right tasks, develop effective and optimal processes and make communication with clients and partners as quick, comfortable and smoothy as possible.
The following sub-objectives have been set up for this:

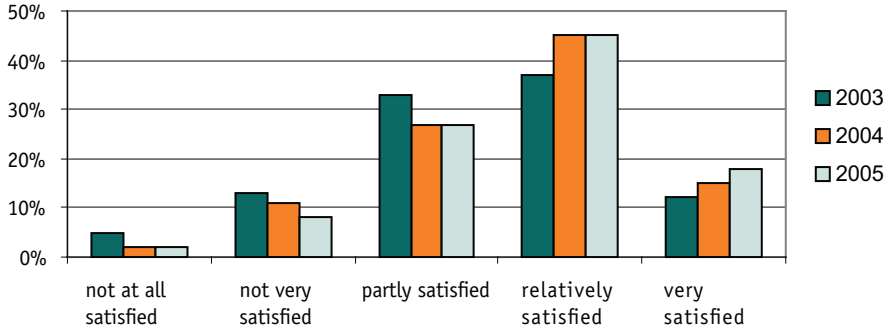
5.1. Develop competence and motivation of employees in a systematic way

We need competent and motivated employees in order to carry out the above mentioned objectives. To this end we plan different development activities and assess work performance of employees on a regular basis twice a year.
The average figure upon assessment of competence on 4-point scale was 2.4 in 2005, 2.3 in 2004 and 2.1 in 2003.
In 2005, training in the area of team design, matrix management, client relationship, negotiations and stress control took place. Many interorganisational advisory days took place in different professional groups.

Satisfaction of employees with corporate governance and organization of work of the Health Insurance Fund

The objective for 2005 was to achieve staff satisfaction with corporate governance and organization of work at level 3.4 or 63 percent. The annual staff satisfaction survey is conducted at the end of each year. Staff satisfaction of 2005 was planned at level 3.4 or 63 percent. The result of 2004 was 60 percent or 3.24. This time 58 percent of the EHIF employees were surveyed (64 percent in 2004 and 47 percent in 2003).

Figure 2. Staff satisfaction in 2003-2005



5.2. Use modern information systems

Use of information systems is subject to the principle that only standard software shall be procured, as far as possible. Standardizing of infotechnological means and systems in the organization shall ensure good operational compatibility and reliability between different parts of the system and enable to manage the whole system more efficiently.
Development/procurement of information systems is subject to the following principles: integrity, security, availability, reliability and maintenance/development.

Development project of the register of insured persons was launched in 2005. The main advantage of the new information system compared with the existing solutions is the high level of integration both with external systems (supports standard data exchange formats) as well as internal systems (other business software systems of the Health Insurance Fund are based on SAP platform) of the Health Insurance Fund, good flexibility, high reliability and security.

Transactions via electronic channels

The objective for 2005 was to process 90 percent of the submitted health insurance benefits (medical bills, covered prescriptions and insurance entries) using electronic means.

In 2005, approximately 1.1 million entries connected with insurance cover were made in the health insurance register. If in 2004 electronic register entries represented 47 percent of all entries, then in 2005 the corresponding figure was 51 percent. 13 percent of electronic register entries were made by employers, 38 percent of insurance data were forwarded by partners – the Ministry of Education and Research, the Social Insurance Board, employment office and the Unemployment Insurance Fund electronically. In 2006 the Tax and Customs Board, the Defence Resources Agency and the Population Register will be added.

In 2005, 100 percent of the volume of medical bills and covered prescriptions were submitted by using electronic means. Thus, the average proportion of transactions submitted electronically is 94 percent.

5.3. Improve work processes for more effective fulfilment of objectives

By the end of 2005, the principles of drafting the processes and procedures of the Health Insurance Fund were regulated. The basic and supporting processes and their content were mapped, and the parties chargeable were determined. Self-assessment of the Health Insurance Fund was carried out in the second half-year in order to prepare the organization for participation in the Estonian Management Quality Award Competition of 2006.

Change in the cost of core processes

The objective for 2005 was that the budget of operating expenses shall not exceed yearly increase of consumer price index. Fulfilment of the objective shall be assessed once a year after the end of financial year.

The aim of the change in the cost of core processes is to keep the increase of operating expenses under 100 percent as of yearly increase of consumer price index. Implementation of the budget of operating expenses was 95.7 percent in 2005.

Explanatory notes to the budget implementation statements and the analysis of the utilization of health insurance benefits 2005

Introduction

Explanatory notes to budget implementation serve as an explanation of the execution of the 2005 budget of the Estonian Health Insurance Fund and
the analysis of the utilization of health insurance benefits.

Table 7. Main indicators for the years 2001-2006 (%)

Main indicators:	2001	2002	2003	2004	2005	2006*
Social tax as a percentage of total revenue	99.5	99.2	98.9	98.9	99.1	99.1
General medical care as a percentage of total expenditure	7.4	7.9	8.0	7.7	8.1	8.4
Specialized medical care as a percentage of total expenditure	47.6	45.3	49.9	51.0	51.6	52.6
Incapacity benefits as a percentage of total expenditure	16.5	16.1	16.2	17.4	17.4	18.9
Prescription drugs as a percentage of total expenditure	14.6	15.2	12.0	13.6	12.0	12.1
Operating expenses as a percentage of total expenditure	1.7	1.6	1.5	1.3	1.2	1.2
Reserves as a percentage of total expenditure	0.0	3.7	9.9	10.1	7.8	8.0
Health insurance benefits as a percentage of GDP	4.3	4.0	4.2	4.4	4.5	4.6

* - approved budget

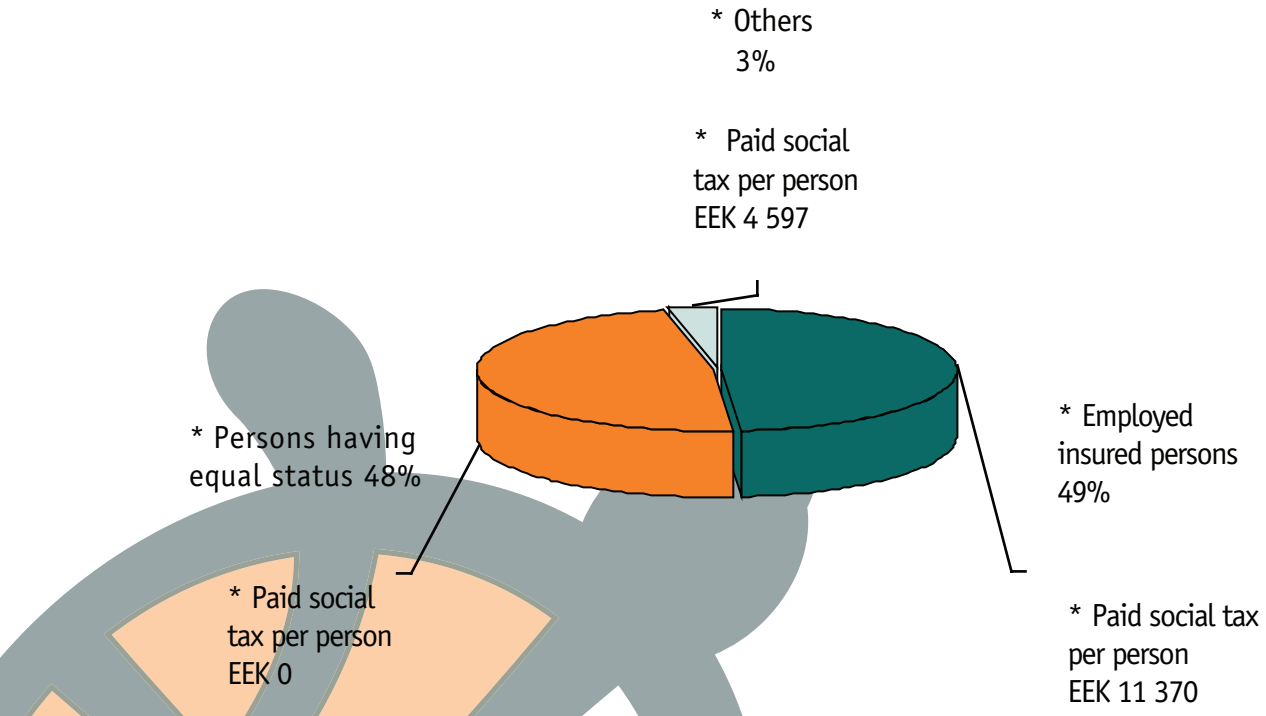
The insured

As of 31 December 2005, the number of people insured by the EHIF was 1,271,354. The number of the insured has decreased by 204 persons as of 31 December 2004 and by 697 persons as of 31 December 2003.

Table 8. Number of the insured

Insured	31.12.2002	31.12.2003	31.12.2004	31.12.2005	Variation 2005/ 2004 %	Proportion of all insured (2005)
Insured persons in employment	578 673	584 885	595 734	617 625	103.67%	48.58%
Government insured persons	48 469	49 119	43 869	38 538	87.85%	3.03%
Persons covered as insured	656 926	631 830	626 438	609 893	97.36%	47.97%
Persons covered by international health agreements	8	6 217	5 517	5 298	96.03%	0.42%
Total	**1 284 076**	**1 272 051**	**1 271 558**	**1 271 354**	**99.98%**	**100.00%**

Chart 3. Proportion of the insured and the social tax paid



Insured persons in employment represent approximately 47 percent of the total number of the insured, and persons covered as if they were insured constitute almost one half of the insured. The working insured pay about EEK 11 370 per person per year as the health insurance portion of the social tax, whereas the contribution of persons covered as insured is nil. The percentage of insured persons in employment has increased gradually in 2003-2005 as a result of increase of employed workforce. In 2003, the corresponding figure was 46 percent and in 2004 47 percent. In the situation where less than half of insured persons pay for about 97 percent of the health costs of all insured, it is ever more difficult to meet the expectations of the society in respect of health care services. Given aging of population, growing awareness of the insured, new and higher expectations and the development of medical technology, on the one hand, and the shortage of financial resources allocated to health care, on the other hand, it is probable that actual possibilities do not allow for meeting our expectations in the future.

Table 9. Average expenditure in 2005 on medical servicing of an inhabitant of the Republic of Estonia registered in the Health Insurance Fund.

age groups (years of age)	Number of the insured as of 31 Dec.2005	Expenditure of general medical care in kroons	Expenditure of specialized medical care in kroons	Expenditure of prescription drugs in kroons	Total expenditure in kroons
0-9	129 735	447	2 292	395	3 134
10-19	182 342	446	1 860	202	2 508
20-29	170 328	451	1 991	344	2 786
30-39	164 854	461	2 059	365	2 885
40-49	167 729	471	2 335	490	3 296
50-59	159 838	493	3 490	840	4 824
60-69	141 779	488	4 952	1 374	6 815
70-79	109 578	480	6 479	1 738	8 697
80-89	39 390	450	5 729	1 480	7 659
90-99	5 677	423	4 786	844	6 054
100-109	101	403	5 451	247	6 101

Examining the average expenditure on medical servicing of an inhabitant (see Table 9), we can see that the biggest expenditure per person are just in age groups over 60 years of age – the average expenditure is almost twice as high as the average expenditure of age groups of working insured. Health costs of persons over 60 years of age amount to EEK 2 240 million which is 43 percent of expenditure on general medical care, specialized medical care and prescription drugs, at the same time their contribution to cover the expenditure is marginal.

Review of most important development projects

Introducing the software supporting the register of insured

Introducing the software supporting the register of insured is mainly aimed at increase of quality, by applying electronical health coverage administration.
The new solution of the register of the insured will enable to forward information necessary for the insurance cover between the authorities in electronic form without interference of the insured person, to decrease the amount of errors, to decrease the costs on manpower by the Health Insurance Fund. Likewise, application of standard solutions will ensure reliability of information and will save costs on administration and will increase standing of Estonia as an e-state.

E-prescription

The project of e-prescription is mainly aimed at creating a digital processing system for prescriptions in Estonia. The project of e-prescription is planned as a cooperation project of the Ministry of Social Affairs and the Health Insurance Fund. As a result of implementation of the project, a prescription, in addition to a paper prescription, can be issued digitally by a physician and purchased in any pharmacy without a paper prescription by the patient. Issue of a prescription will become more convenient and safe for a physician.

A forecast for 2006-2008

In order to guarantee the transparency of health insurance system, the resources of the Health Insurance Fund shall be planned currently over three years which will ensure comprehensibility of financing principles of the health insurance system and proportions between types of benefits and stability of development for all parties. Table 10 will show the forecast of revenue and expenditure for 2006-2008.

Table 10. A forecast of revenue and expenditure for 2006-2008 (as of 1 March 2006)

In EEK thousand	2006 budget actual	Forecast for 2007	Forecast for 2008
TOTAL REVENUE	**8 012**	**8 744**	**9 546**
EXPENDITURE			
Expenditure on health services	5 290	5 716	6 164
Health promotion	14	14	14
Prescription drugs	966	1 077	1 185
Expenditure on benefits for temporary incapacity for work	1 513	1 713	1 939
Other monetary benefits	91	115	116
Other expenses	40	76	90
Total expenditure on health insurance	7 914	8 711	9 508
Maintenance of the Health Insurance Fund	98	101	103
TOTAL EXPENDITURE	**8 012**	**8 812**	**9 611**
Legal reserve	0	63	64
Legal reserve*	0	48	48
Risk reserve*	0	15	16
TOTAL BUDGET EXPENDITURE	**8 012**	**8 875**	**9 675**
Current difference of revenue-expenditure	0	-131	-129

* In order to follow the rates required by law, a provision in the amount of EEK 72 millions shall be made from retained earnings of 2005.

Summary of budget implementation

Table 11. Summary of budget implementation, 2003-2005

REVENUE (in EEK thousand)	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Social tax	5 629 127	6 276 578	6 675 000	7 277 545	109.0%	115.9%
Premiums paid by persons covered as insured under a contract	17 109	27 493	25 200	29 492	117.0%	107.3%
Amounts due from other persons	16 917	11 005	10 000	10 073	100.7%	91.5%
Financial income	25 531	31 078	22 000	25 475	115.8%	82.0%
Other revenues	1 453	3 975	17 556	4 307	24.5%	108.4%
TOTAL BUDGET REVENUE	**5 690 137**	**6 350 129**	**6 749 756**	**7 346 892**	**108.8%**	**115.7%**
BENEFIT EXPENDITURE						
Health care services benefits	3 583 963	4 059 759	4 733 200	4 716 814	99.7%	116.2%
Disease prevention	45 547	60 480	77 000	74 436	96.7%	123.1%
General medical care	454 694	491 661	607 000	592 155	97.6%	120.4%
Specialized medical care	2 840 898	3 238 607	3 748 000	3 752 783	100.1%	115.9%
Long-term nursing care	75 019	95 177	114 000	113 920	99.9%	119.7%
Dental care service benefits	167 805	173 834	187 200	183 520	98.0%	105.6%
Health promotion expenses	13 800	13 480	10 000	8 564	85.6%	63.5%
Medicinal products compensated for to the insured	682 937	863 847	890 000	871 762	98.0%	100.9%
Expenditure on benefits for temporary incapacity for work	923 929	1 101 980	1 248 273	1 265 063	101.3%	114.8%
Other monetary benefits	67 476	72 437	83 425	79 761	95.6%	110.1%
Other benefit expenses	20 089	25 486	39 851	41 788	104.9%	164.0%
Total benefit expenditure	5 292 194	6 136 989	7 004 749	6 983 752	99.7%	113.8%
OPERATING EXPENSES (in EEK thousand)						
Personnel and administrative expenses	43 960	44 773	52 527	49 140	93.6%	109.8%
salaries and wages	32 940	33 545	39 346	36 827	93.6%	109.8%
incl. remuneration of the members of the Management Board	1 719	1 699	1 833	1,764	96.2%	103.8%
incl. remuneration of the members of the Supervisory Board	3	3	5	2	40.0%	66.7%
unemployment insurance premium	149	158	197	160	81.2%	101.3%
social tax	10 871	11 070	12 984	12 153	93.6%	109.8%
Management costs	15 705	16 236	18 246	16 792	92.0%	103.4%
Information technology costs	12 428	9 096	12 316	12 611	102.4%	138.6%
Development costs	3 103	4 169	3 854	3 778	98.0%	90.6%
training	1 748	1 756	1 697	1 627	95.9%	92.7%
consultation	1 355	2 413	2 157	2 151	99.7%	89.1%
Financial expenses	601	898	1 098	1 699	154.7%	189.2%
Other operating expenses	10 828	4 940	5 365	5 365	100.0%	108.6%
pre-printed forms and publications	1 057	1 082	1 404	1 148	81.8%	106.1%
supervision of the health insurance system	1 066	945	1 425	879	61.7%	93.0%
public relations/ public information	752	914	874	819	93.7%	89.6%
Other expenses	7 953	1 999	1 662	2 519	151.6%	126.0%
Total operating expenses	86 625	80 112	93 406	89 385	95.7%	111.6%
TOTAL BUDGET EXPENDITURE	**5 378 819**	**6 217 101**	**7 098 155**	**7 073 137**	**99.6%**	**113.8%**
Appropriations	311 318	133 028	-418 399	203 755	-48.7%	152.2%
Provision for legal reserve	77 956		-70 000	-70 000	100.0%	0.0%
Retained earnings	233 362	133 028	-348 399	273 755	-78.6%	205.8%
TOTAL	**5 690 137**	**6 350 129**	**6 679 756**	**7 276 892**	**108.9%**	**114.6%**

Revenue

Table 12. Revenue

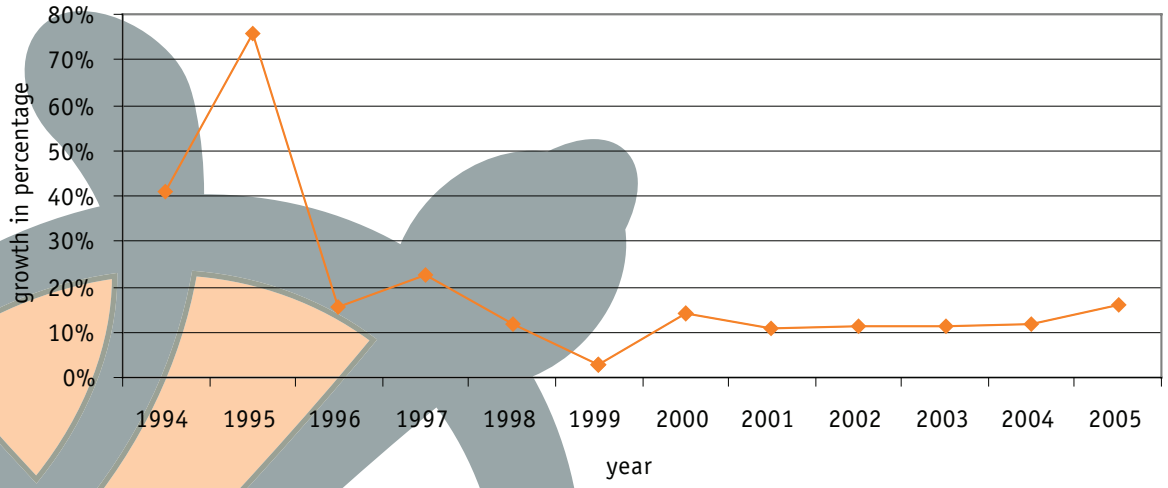
in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Social tax revenue	5 629 127	6 276 578	6 675 000	7 277 545	109%	116%
Premiums paid by persons covered as insured under a contract	17 109	27 493	25 200	29 492	117%	107%
Amounts due from other persons	16 917	11 005	10 000	10 073	101%	92%
Financial income	25 531	31 078	22 000	25 475	116%	82%
Other revenues	1 453	3 975	17 556	4 307	25%	108%
Total	**5 690 137**	**6 350 129**	**6 749 756**	**7 346 892**	**109%**	**116%**

Social tax

Revenue from the health insurance portion of social tax for the 2005 budget was projected to be EEK 6 679 million. The actual inflow was EEK 7 277 545 million. Revenues received in excess of the budgeted amount account for 9 percent or EEK 602 545 million.

Social tax constitutes about 99 percent of the EHIF revenue base. Over the last five years the inflows in social tax have grown by more than 10 percent per year (see Chart 4). Increase in revenue is triggered by a rise in real wages and the consumer price index, as well as by more favourable economic environment and more efficient collection of taxes.

Chart 4. Increase in social tax inflows from 1994 to 2005



Premiums paid by persons covered as insured under a contract

Premiums collected under individual contracts from persons covered as if they were insured accounted for 117 percent of the budget. Persons without medical coverage can insure themselves by making an insurance contract with the EHIF and paying monthly premiums.
242 voluntary insurance contracts have been entered into by 31 December for which the actual inflow during the year was EEK 2,084 million. In addition, premiums for the non-working retirees of the armed forces of the Russian Federation currently living in the Republic of Estonia are transferred to this account. In 2005, the EHIF received 27,408 million for the retirees of the armed forces of the Russian Federation.

Amounts due from other persons

The budget has been implemented at 101 percent. The low implementation rate compared with the previous business years can be attributed to the decision of the Supreme Court en banc in 2004. Until the adoption of the decision of the Supreme Court, the EHIF made claims on entities liable for social taxes but in arrears with the tax payments, if the employees insured by these entities had received medical benefits during the period of tax arrears. The Supreme Court holds that § 4(2) of the Estonian Health Insurance Fund Act restricts the freedom of an individual to decide how to use the income belonging to him and therefore also restricts the individual's statutory right to freely possess, use and dispose of his property.

Financial income

Financial income received in excess of the budgeted amount account for 116 percent. Interest income amounted to EEK 8.108 million in 2005 and income from the revaluation of bonds to fair value totalled to EEK 17,344 million.
The liquid resources of the EHIF are divided into two: liquidity portfolio and investments in legal reserve.

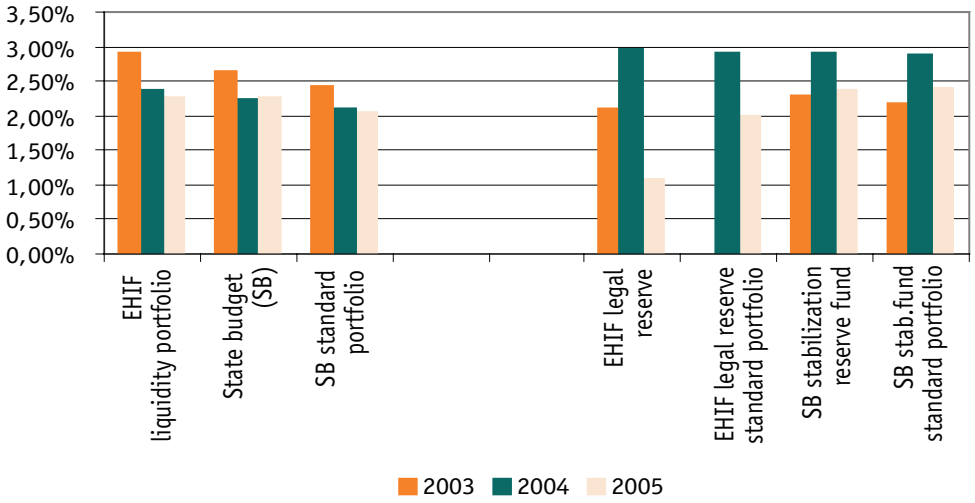
Table 13. Main indicators for liquidity portfolio and investments in legal reserve, 2005

	Liquidity portfolio	Investment in legal reserve
Fund volume at cost	1 080 167 791	441 102 232
Fund volume at market value:	1 086 926 309	437 840 196
Realized gain/loss from beginning of year:	22 005 800	12 790 011
Gain/loss on revaluation:	6 758 518	-3 262 036
Annualized 30-day yield	2.50%	-2.48%
Annualized 90-day yield	2.12%	-3.55%
Yield from beginning of year (on a yearly basis)	2.27%	1.08%
Average duration of investment (on a yearly basis)	0.146	1.216

The objectives of the liquidity portfolio and the legal reserve are somewhat different. If the liquidity portfolio is to ensure that daily cash flows are managed smoothly and easily, investments in legal reserve are a longer-term investment with definite investment constraints for the reduction of risks arising from macroeconomic changes.
That is why the average duration of either investment portfolio differs greatly – there is a short time horizon for the liquidity portfolio, 0.146 years and a somewhat longer time horizon for the legal reserve - 1.216 years.
The utility of investment portfolios is therefore not strictly comparable.

In order to compare the utility of portfolios, the standard portfolios and other similar investment portfolios– the National Treasury reserve, the stabilization reserve and their standard portfolios – are set as the calculation basis.

Chart 5. Utility of the EHIF liquidity reserve, the National Treasury reserve and its standard portfolio as well as utility of the EHIF legal reserve, the stabilization reserve and its standard portfolio in 2003, 2004 and 2005.



Other revenues

Other revenues consist mainly of payments for the bills of the medical services rendered to the persons insured by other EU member states made by the other states in the amount of EEK 2,791 million. Likewise, it reflects revenue received from sale of prescription forms in the amount of EEK 1,516 million.

Expenditure

The EHIF divides expenditure into:

- Expenditure on health insurance benefits
- Costs associated with health insurance administration or the operating expenses of the EHIF.

Table 14. Breakdown of expenditure by year (in %)

	2003	2004	2005	Variation 2005 / 2004
Benefit expenditure	93.01%	96.64%	95.97%	-0.67%
Operating expenses	1.52%	1.26%	1.23%	-0,03%
Retained earnings	5.47%	2.09%	2.80%	0.71%

I Expenditure on health insurance benefits

2005. Substantial changes took place in the expenditure on health insurance benefits in 2004:

Spending on medical services

- Pursuant to the wage settlement, the EHIF has met the necessary requirement on keeping the level of cases treated at the level of 2004 and, in specialized medical care, financing of cases has increased by 87,143 cases or 3 percent.
- In specialized medical care the number of out-patient surgeries (including day surgeries) has increased by 15 percent and the number of in-patient surgeries by 5 percent in 2005.
- Overspending on nursing care services in 2005 is mainly due to the conditions established in the wage settlement entered into between the Government of the Republic, the Estonian Hospitals Association and the Estonian Medical Association which specified rise in the reference prices, including reference prices of a nursing day by 18 percent.

Prescription drugs

- The total amount of drugs reimbursed for the insured in 2005 was EEK 871,762 million, accounting for 98 percent of the budgeted amount. Compared to 2004, spending on drug benefits grew by EEK 7,915 million.
- Quite a moderate rise in prescription drug benefits in 2005 has been achieved due to 1st quarter of the year as a result of considerable decrease in drugs consumption after the drug-buying fever that took place in December 2004.
- Change in methodology for calculating the reference prices since January 2005 resulted in decrease in average price of covered prescriptions to a certain degree. At the same time, average price of covered prescriptions shows upward trend since the second quarter, amounting to the level of 2004 in the fourth quarter.

Benefits for incapacity for work

Spending on benefits for temporary incapacity for work increased by 15 percent in 2005, as compared to 2004.

The continued growth in spending on benefits for temporary incapacity for work from 2002 to 2005 has been caused by:

- Increase in average daily earnings;
- Increase in the number of certificates and days of incapacity for work.

1. Health benefits

Table 15. Implementation of the health benefits budget in 2003-2005

Health benefits (in EEK thousand)	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Disease prevention	45 547	60 480	77 000	74 436	97%	123%
General medical care	454 694	491 661	607 000	592 155	98%	120%
Specialized medical care	2 840 898	3 238 607	3 748 000	3 752 783	100%	116%
Nursing care	75 019	95 177	114 000	113 920	100%	120%
Dental care service benefits	167 805	173 834	187 200	183 520	98%	106%
Total	**3 583 963**	**4 059 759**	**4 733 200**	**4 716 814**	**100%**	**116%**

In 2005, financing of out-patient health care services increased by 3 percent, compared to 2004. Of the total health expenditure, 44 percent was paid for out-patient services (incl. day cases) and 56 percent for in-patient services (incl. 2 percent emergency response expense) for the insured.

Table 16. Expenditure on out-patient and in-patient health services

Benefits for out-patient and in-patient services (in EEK thousand)	2004 actual	2005 actual	2005 actual/ 2004 actual %
Disease prevention	60 480	74 436	123%
General medical care	491 661	592 155	120%
Outpatient specialized medical care	973 238	1 159 411	119%
Centrally contracted outpatient health services	27 431	27 224	99%
Community-based nursing care	13 408	15 435	115%
Dental care service benefits	173 834	183 520	106%
Total benefits for outpatient health services	**1 740 052**	**2 052 181**	**118%**
Centrally contracted inpatient health services	22 836	33 489	147%
Inpatient specialised medical care	2 178 582	2 435 521	112%
Hospital-based nursing care	81 769	98 485	120%
Total benefits for inpatient health services	**2 283 187**	**2 567 495**	**112%**
Expense of emergency response	36 520	97 138	266%
Total benefits for outpatient and inpatient health services	4 059 759	4 716 814	116%

Disease prevention

Disease prevention is concerned with screening for early detection of pre-disease conditions and application of preventive measures. The cause/effect relationship of prevention activities cuts the EHIF expenditure on the treatment of specific diagnoses. Of EEK 77 million budgeted for disease prevention in 2005, the EHIF expended EEK 74,436 million, which accounts for 97 percent of the estimated amount.

Table 17. Disease prevention projects and other prevention activities

Prevention activities in EEK thousand	2005 budget	2005 actual	2005 actual/ 2005 budget %
School health	38 861	38 374	99%
Reproductive health of young people	6 961	6 528	94%
Early detection of breast cancer	8 831	8 938	101%
Screening for phenylketonuria and hypothyrosis	1 103	1 061	96%
Prenatal diagnosis of hereditary diseases	7 892	10 355	131%
Early detection of osteoporosi	1 187	850	72%
Prevention of heart diseases	5 349	2 449	46%
Immunization against hepatitis B	3 041	3 145	103%
Early detection of cervical cancer	2 094	1 558	74%
Hearing screening for newborns	1 527	1 178	77%
Other prevention activities	154	0	0%
Total	**77 000**	**74 436**	**97%**

Need for prenatal diagnosis of hereditary diseases was significantly bigger than planned. This can be explained by increased awareness, coverage level and age of women giving birth.
Lower completion of the project on osteoporosis prevention was due to the specific nature of the target group and the availability of testing opportunities in Tallinn, Tartu and Pärnu.
All family physicians had the opportunity to participate in prevention projects of heart diseases in 2005. The number of family physicians who participated in the project was still moderate, 198 family physicians participated in the project, due to that the capacity of actual activities was significantly smaller.
Immunization against hepatitis B of children born in 1992 (excl. pupils from Pärnu region) has been started. Since 2006, immunization against hepatitis B is financed from the national budget on the basis of national immunization plan.
Underspending on the projects on early cervical cancer detection can be explained by the fact that tests were carried out outside regular office hours on the basis of individual invitations.
Underspending on hearing screening of newborns is due to a smaller percent of false-positive patients and therefore decreased the need for supplementary testing.

Table 18. Results of the disease prevention programmes in 2005

Prevention activity	Target group covered, 2003	Target group covered, 2004	Target group planned, 2005	Target group covered, 2005	Percentage of the planned target group	Results
School health	207 612	193 804	195 131	193 659	99%	School health agreement is missing in some vocational schools
Reproductive health of young people and prevention of sexually transmitted diseases (STD	22 676	23 821, of which 7 736 screened for STD	26 000	26 070, of which 8 900 screened for STD	100%	Primary appointments 18%, male patients 4% and non-Estonians 18%. SDT prevention 34% and sexual consulting 66% of project. An STD detected on 687 occasions (8%), incl. HIV cases, pregnancy detected on 143 occasions and 203 women referred for abortion in the age group 15-19 years.
Early detection of breast cancer	17 457	18 932	18 500	20 165	109%	474 screened women (2.4%) were referred for differential diagnostics. Cancer detection rate was over 5 cases per 1000 women screened, of which early-stage cancer account for over 70%.
Screening for phenylketonuria and hypothyrosis	13 206	14 489	14 500	14 838	102%	An phenylketonuria detected on 1 occasion and 7 children with hypothyrosis.
Prenatal diagnosis of hereditary diseases	1 135	1 293	1 310	2 174	166%	Fetal chromosome abnormality was detected in 53 cases (3%).
Early detection of osteoporosis	1 334	1 616	2 000	1 385	69%	Osteoporosis was detected in 29% and osteopenia in 51% of the screened persons.
Prevention of cardiovascular diseases (CVD)	10 986	9 538	45 100	12 743	28%	CVD risk was observed in one out of every 4 men and in one out of every 5 women; reduction of the CVD risk in the course of the project over 4 %.
Immunization against hepatitis B, 2nd half-year	55 966	15 758	16 464	13 311	81%	Immunization was not made to the pupils of Pärnu region (ca 3000), this will be carried out within the framework of national immunization plan.
Early detection of cervical cancer	3 822	5 339	10 000	6 694	67%	Detection rate was over 1.5 cases per 1000 screened women; early-stage cancer cases accounted for over 70 %.
Hearing screening of new borns	-	516	6 500	7 669	118%	8 deviations from the standard were observed in the course of screening.

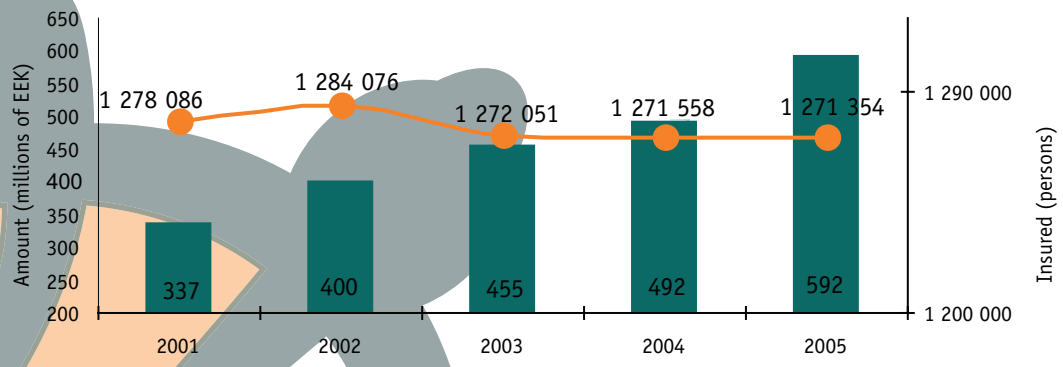
General medical care

Table 19. Expenditure on general medical care in 2005 compared to 2004

Budget for general medical services (in EEK thousand)	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Base fee	62 148	62 525	62 525	100%	101%
Distance allowance	2 022	2 692	2 686	100%	133%
Qualification allowance	9 123	9 432	9 384	99%	103%
Capitation fee (under age 2)	12 845	17 981	17 991	100%	140%
Capitation fee (aged 2 -70)	292 910	356 878	355 877	100%	121%
Capitation fee (over age 70)	46 197	58 335	58 579	100%	127%
Medical tests fund	66 416	94 157	82 710	88%	125%
Advisory Line 1220	0	5 000	2 403	48%	
Total	**491 661**	**607 000**	**592 155**	**98%**	**120%**

Expenditure on general medical care amounted to EEK 592 million in 2005. Compared to 2004, the expenditure has increased by 20 percent or in excess of EEK 100,494 million. Increase in the expenditure was due to rise in the reference prices for capitation fees of family physicians, in conformity with wage settlement with medical professionals, and rise in the reference prices of distance allowance in order to assist family practices located at a greater distance. The number of insured remained in 2005 at the level of 2004.

Chart 6. Number of the insured and expenditure on general medical care from 2001 to 2005



In 2005, a distance allowance was paid to 196 family practices, in 2005, there were 21 practices more who received a distance allowance, compared to 2004.

Capitation fee budget was implemented at nearly 100 percent in 2005, whereas the funds paid in capitation fee increased by EEK 80 million or 23 percent due to a rise in the reference price for capitation fees as compared to 2004.

The budget for medical tests was implemented at 88 percent, financial resources of medical tests fund in the amount of EEK 11,447 million remained unused. Reasons for unused resources of medical tests fund are different and result from location of practices and difference in the content of family physician patient lists and the method of financing of the medical tests fund. It has been set out that the method of financing of the medical tests fund shall be more flexible in the future. Compared to 2004, the use of financial resources of medical tests fund by family physicians increased by EEK 16,294 million or 25 percent.
In 2005, supplementary allowance for family physician qualifications was paid to 782 physicians or 99 percent of the family physicians with a patient list.

Table 20. General medical care in 2004-2005

Number of family practices and patients	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget	2005 actual / 2004 actual
Base fee (practices)	783	788	788	100%	101%
Distance allowance (practices)	175	197	196	99%	112%
Qualification allowance (practices)	761	788	782	99%	103%
Capitation fee for under age 2 (persons)	23 890	26 224	25 187	96%	105%
Capitation fee for aged 2-70 years (persons)	1 099 346	1 093 430	1 093 993	100%	100%
Capitation fee for over age 70 (persons)	150 351	151 931	153 002	101%	102%
Patients (insured) in total	1 273 587	1 271 585	1 271 354	100%	100%
Average patient list (persons)	1 627	1 616	1 613	100%	99%

The average list size per family physician was 1,613 persons in 2005, which has decreased by 14 persons or 1 percent compared to 2004.
At the end of 2005, there were 51 lists with fewer than 1,200 patients (incl. 8 lists with less than 1,000 patients due to the size of the area) and 195 lists with above 2,000 patients (incl. 50 lists with above 2,300 patients and 2 lists with over 3,000 patients). Most of the the biggest family practices are in Pärnu region.

Table 21. Appointments by family physicians in 2000-2005

	2000	2001	2002	2003	2004	2005
Appointments by family physicians (total number)	2 572 076	4 338 268	3 987 121	3 935 504	4 194 373	4 513 223
Total family practices	482	668	813	820	783	788
Appointments per family physicians per year	5 336	6 494	4 904	4 799	5 357	5 727
Appointments per family physicians per month	430	546	413	400	446	477

In 2005, average number of appointments made by a family physician was 22.13 (primary, subsequent and preventive), plus 3.62 home visits per week or 0.78 home visits per day. On the basis of information concerning appointments of family physicians in 2005, it should be noted that independent work of family nurses are applied to a less extent by family physicians.

Specialized medical care (excl. centrally contracted health services)

The expenditure of the EHIF for specialized medical care services (excl. centrally contracted health services) amounted to EEK 3,692,070 million in 2005, of which outpatient (incl. day cases) health services accounted for 31 percent and inpatient health services for 69 percent. Thus the 2005 budget for specialized medical care has been overspent by EEK 3,240 million.

During 2005, the EHIF assumed an obligation to pay for 2,716,579 treated cases, of which outpatient cases (incl. day cases) account for 91 percent and inpatient cases for 9 percent. Since 2004, the budgeted and actual expense of emergency response by hospitals is reported under outpatient and inpatient specialized medical care.

Pursuant to the decision of the Supervisory Board of the EHIF concerning the development plan of 2005, the EHIF entered into agreements with 6 hospitals on payment for services provided to the insured in exceed of contractual capacity with coefficient 0.3 which shall cover variable expenses of the service provider.

Table 22. Expenditure on outpatient and inpatient specialized medical care by specialty (incl. emergency response expense)

Total specialized medical care by specialty (in EEK thousand)	2004 actual	2005 budget	2005 actual	2005/ 2004 %	2005/ 2005 budget %
Surgery	692 436	796 151	785 370	113%	99%
outpatient	95 724	109 353	112 857	118%	103%
day cases	18 446	22 172	27 677	150%	125%
inpatient	578 266	664 626	644 836	112%	97%
Othorinolaryngology	102 884	111 349	111 512	108%	100%
outpatient	38 272	42 678	43 157	113%	101%
day cases	9 915	12 677	12 554	127%	99%
inpatient	54 697	55 994	55 801	102%	100%
Neurology	112 389	112 673	111 877	100%	99%
outpatient	40,272	45 436	49 312	122%	109%
day cases	18	9	1	6%	11%
inpatient	72 099	67 228	62 564	87%	93%
Ophthalmology	122 512	142 893	137 028	112%	96%
outpatient	78 600	64 112	60 695	77%	95%
day cases	30 642	61 846	65 533	214%	106%
inpatient	13 270	16 935	10 800	81%	64%
Orthopaedics	289 233	318 648	320 784	111%	101%
outpatient	54 650	63 612	65 119	119%	102%
day cases	12 708	14 801	16 662	131%	113%
inpatient	221 875	240 235	239 003	108%	99%
Oncology	222 520	251 554	251 918	113%	100%
outpatient	86 918	99 978	100 114	115%	100%
day cases	55	0	0	0%	
inpatient	135 547	151 576	151 804	112%	100%

Total specialized medical care by specialty (in EEK thousand)	2004 actual	2005 budget	2005 actual	2005/ 2004 %	2005/ 2005 budget %
Obstetrics and gynaecology	343 367	389 416	398 778	116%	102%
outpatient	144 199	161 164	173 735	120%	108%
day cases	16 621	18 629	24 042	145%	129%
inpatient	182 547	209 623	201 001	110%	96%
Pulmonology	84 873	93 127	97 696	115%	105%
outpatient	28 715	32 613	34 507	120%	106%
inpatient	56 158	60 514	63 189	113%	104%
Dermato-venerology	38 745	40 906	41 085	106%	100%
outpatient	29 061	30 773	31 809	109%	103%
day cases	907	1 120	577	64%	52%
inpatient	8 777	9 013	8 699	99%	97%
Paediatrics	146 334	167 994	167 965	115%	100%
outpatient	31 504	34 451	36 967	117%	107%
day cases	4 730	3 825	3 863	82%	101%
inpatient	110 100	129 718	127 135	115%	98%
Psychiatrics	148 023	164 233	161 241	109%	98%
outpatient	31 106	34 571	34 874	112%	101%
day cases	956	1 197	877	92%	73%
inpatient	115 961	128 465	125 490	108%	98%
Infectious diseases	38 163	46 967	51 101	134%	109%
outpatient	8 030	9 775	11 747	146%	120%
inpatient	30 133	37 192	39 354	131%	106%
Internal diseases	737 144	871 645	880 692	119%	101%
outpatient	156 234	176 689	182 910	117%	104%
day cases	24 320	28 181	35 709	147%	127%
inpatient	556 590	666 775	662 073	119%	99%
Primary follow-up care	10 004	11 342	7 354	74%	65%
inpatient	10 004	11 342	7 354	74%	65%
Rehabilitation	57 415	65 766	64 977	113%	99%
outpatient	24 857	27 505	28 559	115%	104%
inpatient	32 558	38 261	36 418	112%	95%
Unspecified specialties	5 778	6 051	5 554	96%	92%
outpatient	5 778	6 051	5 554	96%	92%
Total	**3 151 820**	**3 590 715**	**3 594 932**	**114%**	**100%**
Total outpatient	853 920	938 761	971 916	114%	104%
Total day cases	119 318	164 457	187 495	157%	114%
Total inpatient	2 178 582	2 487 497	2 435 521	112%	98%
Emergency response expense	36 520	98 115	97 138	266%	99%
Total specialized medical care (excl. centrally contracted health services)	**3 188 340**	**3 688 830**	**3 692 070**	**116%**	**100%**

Table 23. Caseload in outpatient and inpatient specialised medical care

Cases in specialized medical care by specialty	2004 actual	2005 budget	2005 actual	2005/ 2004 %	2005 /2005 budget %
Surgery	340 712	348 383	341 976	100%	98%
outpatient	285 180	290 560	286 826	101%	99%
day cases	6 180	6 535	6 589	107%	101%
inpatient	49 352	51 288	48 561	98%	95%
Othorinolaryngology	192 314	192 362	190 888	99%	99%
outpatient	174 806	175 469	174 446	100%	99%
day cases	3 077	3 638	3 386	110%	93%
inpatient	14 431	13 255	13 056	90%	98%
Neurology	129 390	129 144	129 494	100%	100%
outpatient	119 408	121 209	122 494	103%	101%
day cases	32	18	3	9%	17%
inpatient	9 950	7 917	6 997	70%	88%
Ophthalmology	272 731	274 908	284 314	104%	103%
outpatient	266 767	265 648	275 240	103%	104%
day cases	3 932	6 976	7 611	194%	109%
inpatient	2 032	2 284	1 463	72%	64%
Orthopaedics	216 460	219 440	234 656	108%	107%
outpatient	200 476	203 771	219 973	110%	108%
day cases	2 698	2 787	2 732	101%	98%
inpatient	13 286	12 882	11 951	90%	93%
Oncology	77 959	78 092	75 702	97%	97%
outpatient	68 562	68 664	67 006	98%	98%
day cases	30			0%	
inpatient	9 367	9 428	8 696	93%	92%
Obstetrics and gynaecology	466 949	474 024	484 206	104%	102%
outpatient	415 955	421 602	433 007	104%	103%
day cases	11 857	12 021	13 691	115%	114%
inpatient	39 137	40 401	37 508	96%	93%
Pulmonology	54 531	55 467	54 527	100%	98%
outpatient	50 895	52 150	51 250	101%	98%
inpatient	3 636	3 317	3 277	90%	99%
Dermato-venerology	157 317	153 313	156 561	100%	102%
outpatient	154 799	150 880	154 595	100%	102%
day cases	694	756	358	52%	47%
inpatient	1 824	1 677	1 608	88%	96%
Paediatrics	134 070	134 944	143 088	107%	106%
outpatient	105 054	105 797	114 875	109%	109%
day cases	2 035	1 546	1 628	80%	105%
inpatient	26 981	27 601	26 585	99%	96%
Psychiatrics	181 728	183 055	187 877	103%	103%
outpatient	170 202	171 339	176 511	104%	103%
day cases	294	326	261	89%	80%
inpatient	11 232	11 390	11 105	99%	97%

Cases in specialized medical care by specialty	2004 actual	2005 budget	2005 actual	2005/ 2004 %	2005 /2005 budget %
Infectious diseases	20 620	21 228	22 118	107%	104%
outpatient	11 312	11 705	12 653	112%	108%
inpatient	9 308	9 523	9 465	102%	99%
Internal diseases	329 118	336 233	351 914	107%	105%
outpatient	273 729	277 100	295 237	108%	107%
day cases	2 266	2 207	2 002	88%	91%
inpatient	53 123	56 926	54 675	103%	96%
Primary follow-up care	1 469	1 456	1 123	76%	77%
inpatient	1 469	1 456	1 123	76%	77%
Rehabilitation	37 777	38 182	43 598	115%	114%
outpatient	32 521	32 585	38 069	117%	117%
inpatient	5 256	5 597	5 529	105%	99%
Unspecified specialties	16 291	15 616	14 537	89%	93%
outpatient	16 291	15 616	14 537	89%	93%
Total cases	**2 629 436**	**2 655 847**	**2 716 579**	**103%**	**102%**
Total outpatient	2 345 957	2 364 095	2 436 719	104%	103%
Total day cases	33 095	36 810	38 261	116%	104%
Total inpatient	250 384	254 942	241 599	96%	95%

Compared with the respective budget in 2004, financial resources increased by 16 percent and the caseload grew by 3 percent in 2005. The 2005 budget for specialized medical care expenditure was implemented at 100 percent, but there is a 2 percent overspending for caseload. The overspending is due to the agreements the EHIF entered into with hospitals on payment for services provided to the insured in exceed of contractual capacity. In 2005, the EHIF has financed 7,612 cases in the amount of EEK 4,500 million on the basis of the agreements.

Expenditure has increased over the previous fiscal year in infectious diseases and internal diseases. Rise in expenditure in both specialties is due to increase of caseload and structural cost of a treated case.

Table 24. Major indicators for therapeutic services in outpatient (O) and inpatient (I) specialized medical care (excl. emergency response expense) in 2004 and 2005

Indicator		2004 actual	2005 actual	2005 actual/ 2004 actual %
Treatment cost (in EEK thousand)	O	973 238	1 159 411	119%
	I	2 178 582	2 435 521	112%
Number of cases	O	2 379 052	2 474 980	104%
	I	250 384	241 599	96%
Average cost per case (EEK)	O	409	468	115%
	I	8 701	10 079	116%
Hospital patient days	I	1 660 307	1 677 449	101%
Average duration of treatment (days)	I	6.6	6.9	105%
Persons treated	O	746 165	754 066	101%
	I	171 062	165 756	97%
Outpatient appointments	O	3 152 033	3 411 785	108%
Ratio of outpatient appointments to treated cases	O	1.32	1.38	104%
Ratio of outpatient appointments to treated persons	O	4.22	4.52	107%
Emergency care as a percentage of capacity	O	15.0	15.2	0,2%
	I	60.0	64.6	4,6%
Emergency care as a percentage of treated cases	O	14.4	15.2	0,8%
	I	54.9	59.1	4,2%
Surgeries	O	41 694	47 992	115%
	I	90 628	94 870	105%

Increase in the average cost per case is due to a rise in the reference prices of health services that occurred in 2005 as well as a structural increase in the cost of treated cases, incl. changes in structure of services as well as implementation of DRG within the range of 50 percent. The last one had an effect on the increase of average cost per day case.

Compared to 2004, the average length of stay in hospital as well as the number of hospital patient days have extended, by 5 percent and 1 percent respectively. The amount of simple outpatient and day case services has increased over the previous fiscal year, compared to 2005. Therefore the number of inpatient cases has decreased by 4 percent. As more serious inpatient cases were treated compared with the earlier period, then these cases were more expensive and the average length of stay in hospital was longer.

The total number of outpatient appointments in 2005 has increased by 8 percent as compared to 2004. The number of appointments per outpatient case has increased by 4 percent, referring to rise in subsequent appointments during a course of treatment.

Compared with the previous year, the proportion of emergency care in outpatient services has grown by 0.2 percent and in inpatient services by 4.6 percent. This can be explained by the fact that additional funds of specialized medical care were allocated in 2005 in the reference prices of

health services for implementation of wage settlement with medical professionals, and this was why not enough resources were left over to guarantee access and carry out scheduled treatment. Increase in the proportion of outpatient and inpatient cases subject to emergency care accounts for 0.8 percent and 4.2 percent respectively during the same period.

Compared to 2004, the number of surgeries in 2005 has increased by 15 percent in outpatient services and by 5 percent in inpatient services, the total number of surgeries has increased by 8 percent.
Increase in the proportion of outpatient and day surgeries over the last years can be explained by the DRG system implemented by the EHIF. The upward trend has also continued in 2005 when 34 percent of all surgeries were performed as outpatient and day surgeries. By way of comparison – the respective indicator was 27 percent in 2001, 30 percent in 2002, 31 percent in 2003 and 31 percent in 2004.

Thus, in summary, health services in 2005 were provided, to a certain degree, more efficiently than in 2004 – the number of and spending on outpatient cases as well as the number of outpatient surgeries (incl. day surgeries) has increased.

Special cases

Table 25. Comparison, between 2004 and 2005, of the actual use of funds for special cases and the effective caseload

Special cases	2004 actual		2005 actual		2005 actual/ 2004 actual %	
	treated cases	treatment cost (EEK '000)	treated cases	treatment cost (EEK '000)	treated cases	caseload
Endoprostheses	2 501	110 436	2 461	114 975	98%	104%
Cataract operations	8 161	64 106	7 565	66 223	93%	103%
Cardiac surgeries	843	88 624	767	87 455	91%	99%
Deliveries	13 517	88 906	12 618	91 427	93%	103%

Endoprosthetic surgery is fairly expensive (the average cost per case is about EEK 47,000). As the length of waiting lists for endoprosthetic surgery was very different in different regions, the EHIF drew the management of financing of endoprostheses and cataract together in one department and in a single list since the 2nd quarter 2005. Accordingly, the resources were allocated for fulfilment of therapy needs of the insured within the regions where the waiting lists were the longest. In consequence of incorporation in one department, the EHIF managed to shorten the waiting list of endoprostheses by 0.5 year in 2006. In 2005, the EHIF financed 40 planned endoprosthetic surgeries, which makes 2 percent less than in 2004.

In 2005, financing of cataract surgery was also re-organized alike the waiting list of endoprostheses and despite of lower caseload, the EHIF also shortened the length of the waiting list of cataracts by 0.5 years. In 2005, cataract operations has been financed in the amount of 596 cases or by 7 percent less than in 2004.

In 2005, 9 percent less cardiac surgeries were performed than in 2004, whereas the number of planned cardiac surgeries remained partly unfulfilled due to the capacity of medical institutions. The average cost per surgery case has increased and the total cost of cardiac surgeries was implemented at 99 percent.

Cardiology

In 2005, the number of treated cases in the specialty of cardiology has increased by 6 percent compared to 2004. Expenditure has increased by 22 percent mainly due to a rise in the average cost per case which is 15 percent.

The increase in expenditure and in the average cost per case in the specialty of cardiology is due to preference of a more expensive method of treatment. According to the clinical practice, 2 reperfusion methods are in use, based on the treatment instruction "Instruction for the treatment of acute ST-elevation myocardial infarction", developed by the Estonian Society for Cardiology and approved by the EHIF at the beginning of 2005. Compared to 2004, the number of medical bills with trombolysis has decreased by 24 percent and the proportion of medical bills with coronary angioplastic has increased by 40 percent on the basis of authentic information.

Table 26. Treatment method of acute myocardial infarction in 2004 and 2005

Coronary stenting	2004	2005	2005/2004
Amount*	1 163	1 534	132%
Total in EEK	96 020 706	133 265 820	139%
Bills	850	1 190	140%
Average cost per case	112 966	111 988	99%
Persons	827	1 146	139%

* Number of applications of the health service code on bills.

Centrally contracted health services

The EHIF paid EEK 60,713 million for centrally contracted health services in 2005 (103 percent of the budgeted amounts for the year).

Table 27. Implementation of the budget for centrally contracted health services in 2005

Centrally contracted health services (in EEK thousand)	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Bone marrow transplants	4 958	5 300	5 384	102%	109%
Regular treatment in a foreign state	1 554	8 027	13 094	163%	843%
Peritoneal dialysis	23 280	24 400	22 733	93%	98%
Emergency transportation of the insured (airplane, helicopter)	1 742	2 700	1 733	64%	99%
Medical check-ups for young athletes	4 151	4 860	4 491	92%	108%
Haematological treatment sessions	9 241	10 200	9 708	95%	105%
Antidotes and serums	200	200	200	100%	100%
Risk balance	0	670	0		0%
Artificial urinary sphincters	587	587	587	100%	100%
Cochlear implants	4 554	2 226	2 783	125%	61%
Total	**50 267**	**59 170**	**60 713**	**103%**	**121%**

Demand for bone marrow transplants and cochlear implants in 2005 proved to exceed the proposed budget, and these costs were offset by unused resources for haematological treatment sessions and risk balance.

For the first time, the budget for scheduled treatment in a foreign country was exceeded in 2005. The number of applicants for a scheduled treatment in a foreign country has increased in connection with rise of awareness of the insured and opportunities to move freely in the Member States of the EU. If, in 2004, the EHIF paid for treatment of 9 insured in a foreign country (incl. 5 children), then in the accounting period, the EHIF paid for treatment of 53 insured in a foreign country of whom 28 were children. Also the costs spended on search for non-relative donors necessary for bone marrow transplants which are paid to the Finnish Red Cross Blood Service according to agreement, concluded in 2005, are included in the expenditure.

Underspending on peritoneal dialysis service is due to lower cost per case than intended (61 percent). Underspending on other centrally contracted health services is due to lower demand as predicted. Estimated cases and funds on medical check-ups for young athletes were divided evenly between the regions, taking into account the number of children aged 7-18. Underspending on caseload by 12 percent is due to lower demand in Viru region.

Table 28. Implementation of the caseload of centrally contracted health services in 2005 (CL – caseload, ACPC - average cost per case)

Centrally contracted health services	2004 actual		2005 budget		2005 actual	
	CL	ACPC	CL	ACPC	CL	ACPC
Bone marrow transplants	25	198 320	24	220 830	32	168 250
Exceptional treatment in a foreign state	9	172 666	34	236,088	53	247 053
Peritoneal dialysis	106	219 622	72	338 890	110	206 664
Emergency transportation of the insured (airplane, helicopter)	70	24 885	100	27 000	76	22 802
Medical check-ups for young athletes	7,454	557	8,620	563	7 573	593
Haematological treatment sessions	55	168 018	70	145 700	59	164 542
Antidotes and serums	2	100 000	2	100 000	2	100 000
Artificial urinary sphincters	7	83 815	7	83 815	7	83 815
Cochlear implants	18	253 006	8	278 307	10	278 307

Nursing care

In 2005, the EHIF paid EEK 113,920 million in nursing care, which makes 100 percent of the budget. Compared to 2004, spending on nursing care has increased by 20 percent or in excess of EEK 18,743 million.

Table 29. Implementation of the budget for nursing care in 2005

Outpatient and inpatient nursing care (in EEK thousand)	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %	2005 actual / 2004 actual %
Inpatient nursing care	81 769	97 284	98 485	101%	120%
Outpatient nursing care, incl.	13 408	16 716	15 435	92%	115%
home nursing	10 853	13 137	11 943	91%	110%
home care for cancer patients	2 159	2 673	2 663	100%	123%
geriatric assessment	396	906	829	92%	209%
Total	**95 177**	**114 000**	**113 920**	**100%**	**120%**

Overspending on nursing care services in 2005 is mainly due to the conditions established in the wage settlement entered into between the Government of the Republic, the Estonian Hospitals Association and the Estonian Medical Association which specified rise in the reference prices, including reference prices of a nursing day by 18 percent.
In 2001-2005, the overall spending on nursing care has increased by nearly EEK 66 million, whereas the provision of community-based nursing care has developed particularly fast.

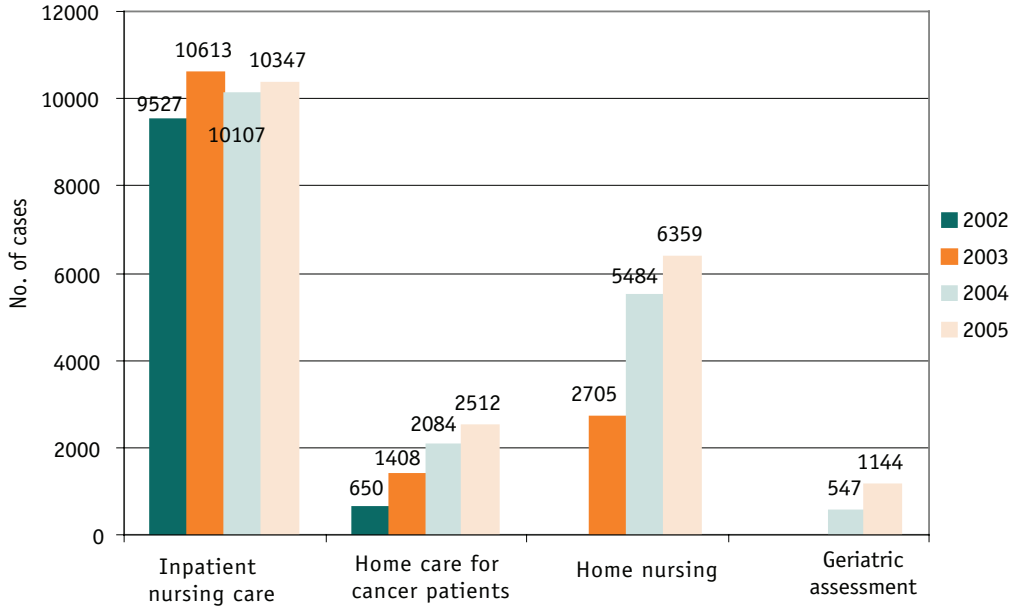
In 2004, geriatric assessment was introduced as a new service. In 2005, geriatric assessment service was provided in all four regional departments of the EHIF for EEK 829,000 in total. The service was provided two times as much as in 2004.

Table 30. Caseload (CL) and average cost per case (ACPC) in nursing care in 2004 and in 2005.

	2004 CL	2005 CL	2005 / 2004 CL	2004 ACPC	2005 ACPC	2005 / 2004 ACPC
Inpatient nursing care	10 107	10 347	102%	8 090	9 518	118%
Outpatient nursing care, incl.	8 115	10 015	123%	1 652	1 541	93%
home nursing	5 484	6 359	116%	1 979	1 876	95%
home care for cancer patients	2 084	2 512	121%	1 036	1 060	102%
geriatric assessment	547	1 144	209%	724	725	100%
Total	**18 222**	**20 362**	**112%**	**5 223**	**5 595**	**107%**

Increase in caseload in outpatient home nursing service is also due to revising the definition of home nursing case, resulting from the random sampling carried out by the EHIF in 2004.

Chart 7. Caseload in nursing care in 2002-2005



As regards the average cost per case in nursing care in 2005, the most striking is the growth in the cost of inpatient nursing care: In 2004, the average cost per case was EEK 8,090 and in 2005, it was EEK 9,518, thus spending on a treated patient has increased by 18 percent or by EEK 1,428.

Dental care

Pursuant to the Health Insurance Act, the EHIF covers the cost of dental services provided to the insured persons under age 19 and to adults in case of emergency dental care.

Table 31. Implementation of the 2005 budget for dental benefits, compared to 2004

Dental care (in EEK thousand)	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %	2005 actual/ 2004 actual %
Dental treatment in children	133 949	150 514	146 071	97%	109%
Orthodontia	21 387	23 429	22 885	98%	107%
Dental diseases prevention	12 574	8 262	8 133	98%	65%
Emergency dental care to adults	5 924	4 995	6 431	129%	109%
Total	**173 834**	**187 200**	**183 520**	**98%**	**106%**

In dental treatment in children, the EHIF guaranteed access within the maximum limits of waiting lists. Finding the contracting parties to dental treatment in children is becoming a problem for the EHIF. For example in 2006, Harju Department of the EHIF will enter into contract with all service providers who have applied for dental treatment in children.

Table 32. Caseload in dental services

Number of cases in dental care	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %	2005 actual/ 2004 actual %
Dental treatment in children	293 357	266 142	290 523	109%	99%
Orthodontia	40 503	36 782	33 893	92%	84%
Dental diseases prevention	97 624	51 223	55 816	109%	57%
Emergency dental care to adults	24 468	19 709	23 116	117%	94%
Total	**455 952**	**373 856**	**403 348**	**108%**	**88%**

The EHIF paid EEK 6,431 million in 2005 for emergency medical care for adults. The amount exceeds the 2005 budget by 29 percent and the 2004 expenditure by 9 percent.

2. Health promotion expenses

The EHIF is engaged in health promotion activites on the basis of the project which specifies the priorities approved by the Supervisory Board of the EHIF, acting in concert with the Ministry of Social Affairs.
Of the total EEK 10 million allocated to health promotion, EEK 8,564 million (86 percent) were utilized.
In 2005, the EHIF financed 34 projects, 14 of which are still in effect in 1st half of 2006.

Table 33. Implementation of the 2005 budget for expenditure, compared to 2004

Health promotion activity	2004 actual In EEK thousand	2005 budget In EEK thousand	2005 number of projects	2005 actual In EEK thousand
1. Health promotion activities in total targeted at children	5 226	3 300	11	3 515
Prevention of damages to the health caused by alcohol			Activities in 2 projects	656
2. Health promotion activities in total targeted at adults	8 254	6 700	23	5 049
Prevention of cardio-vascular diseases	2 449	1 900	Activities in 3 projects	723
Early detection of malignant tumours	414	1 200	Activities in 1 project	380
Prevention of home and leisure injuries and intoxication	2 950	1 200	Activities in 12 projects	1 225
Prevention of damages to the health caused by alcohol	200	940	Activities in 11 projects	873
Projects targeted at various priority areas	2 241	1 460	Activities in 9 projects	1 848
Total	**13 480**	**10 000**	**34**	**8 564**

* Projects financed in 2004 are classified in conformity with new priorities

Underspending is due to the fact that the 1st quarter was the stage of finding partners and launching activities for most of the projects, and accordingly, the initially planned activities of the long-term projects were shifted to 1st half of 2006.

Table 34. Indicators for the 2005 project activities

Health promotion activity	2003	2004	2005
People participating in sports, training courses and activities meant for the general public	67 700	76 720	5 250
People in personal counselling	11 100	13 740	6 680
Participants in training for medical professionals	1 200	1 540	1 000
Participants in training for teaching staff	2 100	3 830	1 950
Participants in training for other associated groups (social workers, managers, project groups)	3 200	4 130	1 780
Different publications	62	82	23
Full circulation of publications	273 000	293 800	277 000
TV and radio programmes/clips	126	137	81

Health promotion activities which were intended to meet the objectives, were mainly aimed at to target groups: schoolchildren and adults. Additional target group defined pregnant, parents of infants and patients with chronic diseases. One reaches the target groups directly via the media or associated groups.

Two media campaigns have taken place – passive smoking campaign for adults and anti-alcohol consumption campaign for youth. Noticeability of smoking campaign was 81 percent. The fact that the media has intensively reflected smoking topic, has an effect on (passive) smoking of respondent or his or her relatives by 30 percent. Noticeability of alcohol prevention for youth was 84 percent, expost survey shall take place in 2006.

The financial audit of the 2005 health promotion projects (20 percent of funded projects) and the content evaluation of the projects (30 percent of funded projects), as well as the analysis of project effectiveness will be carried out in the 1st quarter of 2006.

3. Expenditure on drug benefits

Spending on covered prescription drugs is an open commitment for the EHIF. Possible measures for cost-containment, including the lists of illnesses and covered drugs, references prices, price agreements, procedure for the prescription and dispense of medicines, mark-up on wholesale and retail, are prescribed by the Ministry of Social Affairs and the Government of the Republic.
The overall spending on prescription drugs reimbursed for the insured amounted to EEK 871,762 million in 2005. If overspending on drug benefits in 2004 increased by 6 percent, then the actual expenditure on drug benefits in 2005 accounted for 98 percent of the budgeted amount. Compared to 2004, spending on drug benefits grew by EEK 7,915 million.

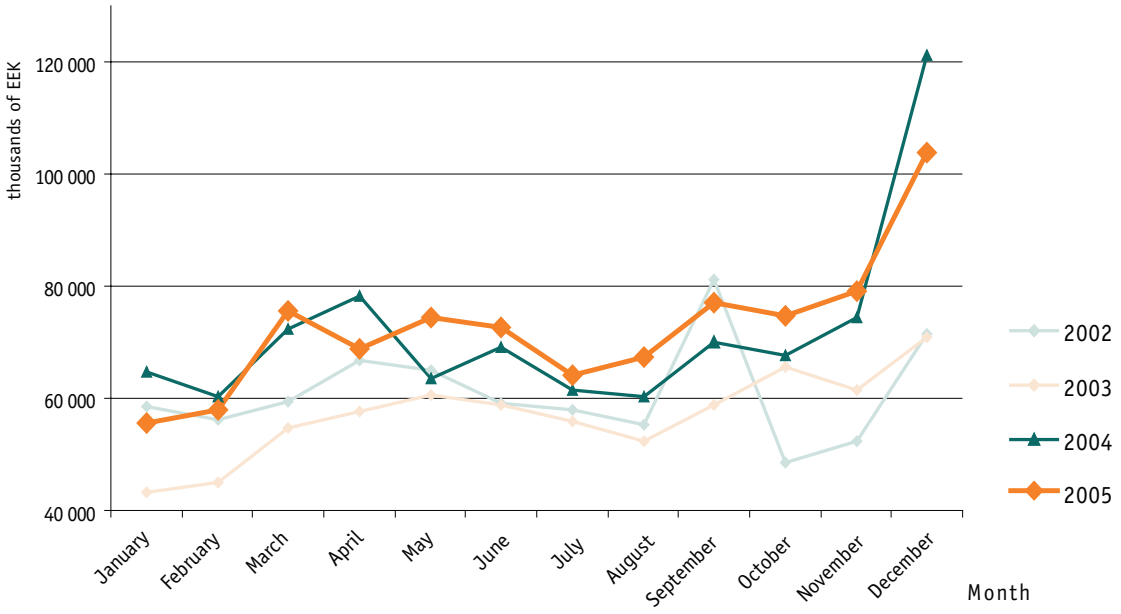
Table 35. Implementation of the 2005 budget for drug benefits by covered prescription drugs, compared to 2004.

Drugs reimbursed for the insured (in EEK thousand)	2004	2005	2005 vs 2004 (%)	percentage of expediture on covered prescription drugs in drug benefits 2004	2005
Drugs reimbursed at 100 %	301 219	329 540	109%	35%	38%
Drugs reimbursed at 90 %	320 779	299 282	93%	37%	34%
Drugs reimbursed at 75 %	81 678	69 302	85%	9%	8%
Drugs reimbursed at 50 %	156 323	165 954	106%	18%	19%
Drugs reimbursed under special conditions	3 848	7 684	200%	0.45%	0.88%
TOTAL	**863 847**	**871 762**	**101%**		

Expenditure on drug benefits in 2005 reflect expressively the effect on drug consumption of individuals in the conditions of change in legislation.
Media reports on the new method for calculating the reference prices, enforceable in January 2005, incited the buying fever of population and brought about a 70-percent increase in expenditure on drug benefits in December 2004. As expected, underspending of expenses took place in January 2005: If in January 2004 the drug benefits were paid in the amount of EEK 64,800 million, then in January 2005 the corresponding amount was EEK 55,700 million.
It is striking, that although, the expenditure on drug benefits in February stayed on the level of 2002 and 2004, the amount of drug benefits increased considerably in March. In March, the EHIF reimbursed drugs for ca EEK 76 million which exceeds the expenditure in March in the last three years, this was followed by a decrease in April. It cannot be incidental that drug consumption increased considerably in the situation where the list of covered drugs was again renewed as from 1 April and the reference prices were changed. The subject found an active reflection in the press. The articles about increase in price of drugs and deletion of some drugs in the list of covered drugs were published. Tendency where monthly expenditure after the change in legislation is lower than before the change has continued throughout the whole year of 2005. Substantial fluctuation in expenditure shows that the patients are sensitive about changes and prefer providing themselves with drugs supplies to changing the proprietary medicinal product after the change in the reference prices.

Usual seasonal character which includes decrease in use of prescription drugs in summer months became this year apparent only in July and August. It will be observed that expenditure on drug benefits has steadily exceeded the expenditure of same period the last year. Overspending has increased by nearly 10 percent since autumn. Spending on drug benefits accounted for EEK 103,933 million in December which is smaller than the record December in 2004, but still exceeds the expenditure of the same month in 2003 by 47 percent or EEK 33 million.

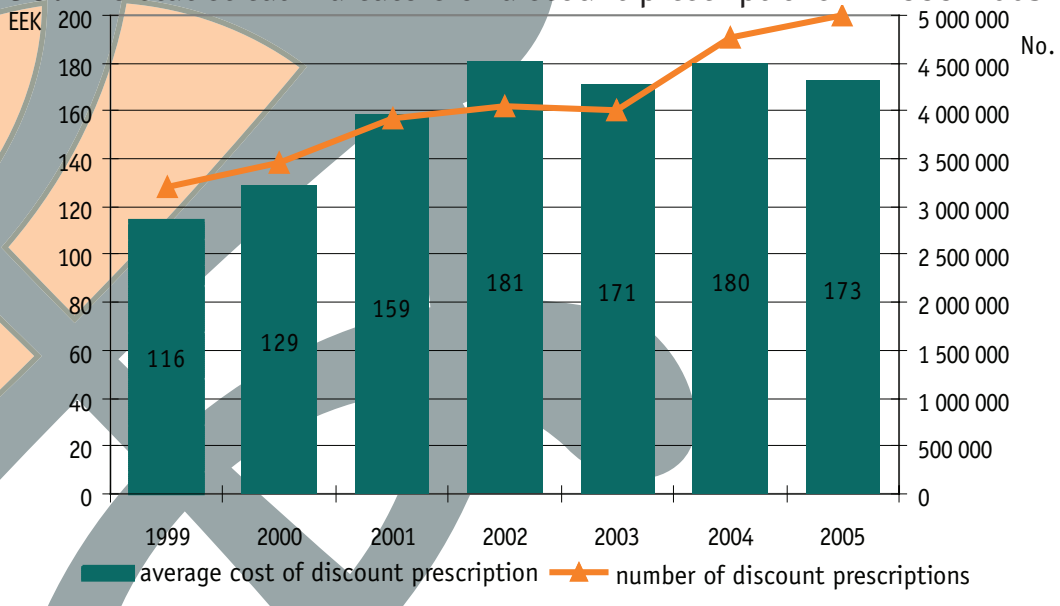
Chart 8. Seasonal aspects of expenditure of the EHIF on drug benefits in 2002-2005



For the first time, the number of prescriptions reimbursed exceeded the line of 5 million in 2005. Compared to 2004, the total number of covered prescriptions increased by 5 percent in 2005. The proportion of prescriptions reimbursed at 100 percent as a percentage of total drug benefits expenditure has showed a reamarkable growth (21 percent).

Increase in number of discount prescriptions in 2005 refers to better access to prescription drugs among the population.

Chart 9. The statistical indicators of discount prescriptions in 1999-2005



The effect of the change in methodology for calculating reference prices, effective since 1 January 2005, we obviously shall see in the summary of 2005 when assessing the change in average price of a prescription. If formerly a reference price was calculated on the basis of the average of the prices of the second and third cheapest medicinal product, then now, in the event of two medicinal products, only the cheapest shall be taken into account and, in the event of three or more medicinal products, the second cheapest price shall be taken into account. The EHIF shall not pay for the part of the price of the medicinal product exceeding the reference price. In 2005, the average cost of prescriptions reimbursed at 90 percent as a percentage of total drug benefits expenditure has decreased most of all. As expected, the change in methodology for calculating reference price has not resulted in decrease in price of covered prescriptions reimbursed at 50 percent.

Table 36. Number and average cost of covered prescriptions (CP) reimbursed by the EHIF in 2004 and 2005

	2004 prescriptions	2004 average cost in EEK	2005 prescriptions	2005 average cost in EEK	change in number of CP %	2005 vs. 2004 average cost of CP %
Reimbursed at 100 %	427 868	704	518 992	635	121%	90,2%
Reimbursed at 90 %	1 645 021	195	1 707 462	175	104%	89,9%
Reimbursed at 75 %	436 781	187	398 638	174	91%	93,0%
Reimbursed at 50 %	2 265 551	69	2 375 510	70	105%	101,2%
TOTAL	**4 775 221**	**180**	**5 000 602**	**173**	**105%**	**96,1%**

Observation of change in cost-sharing by a patient confirmed that some patients did not wish to change usual medicinal products and were rather ready to pay more for them.

Table 37. Cost-sharing of the insured upon payment for covered prescription drugs

	2004	2005
Reimbursed at 100 %	3.7	5.6
Reimbursed at 90 %	26.7	29.8
Reimbursed at 75 %	37.0	39.6
Reimbursed at 50 %	66.2	67.1
TOTAL	**36.0**	**38.0**

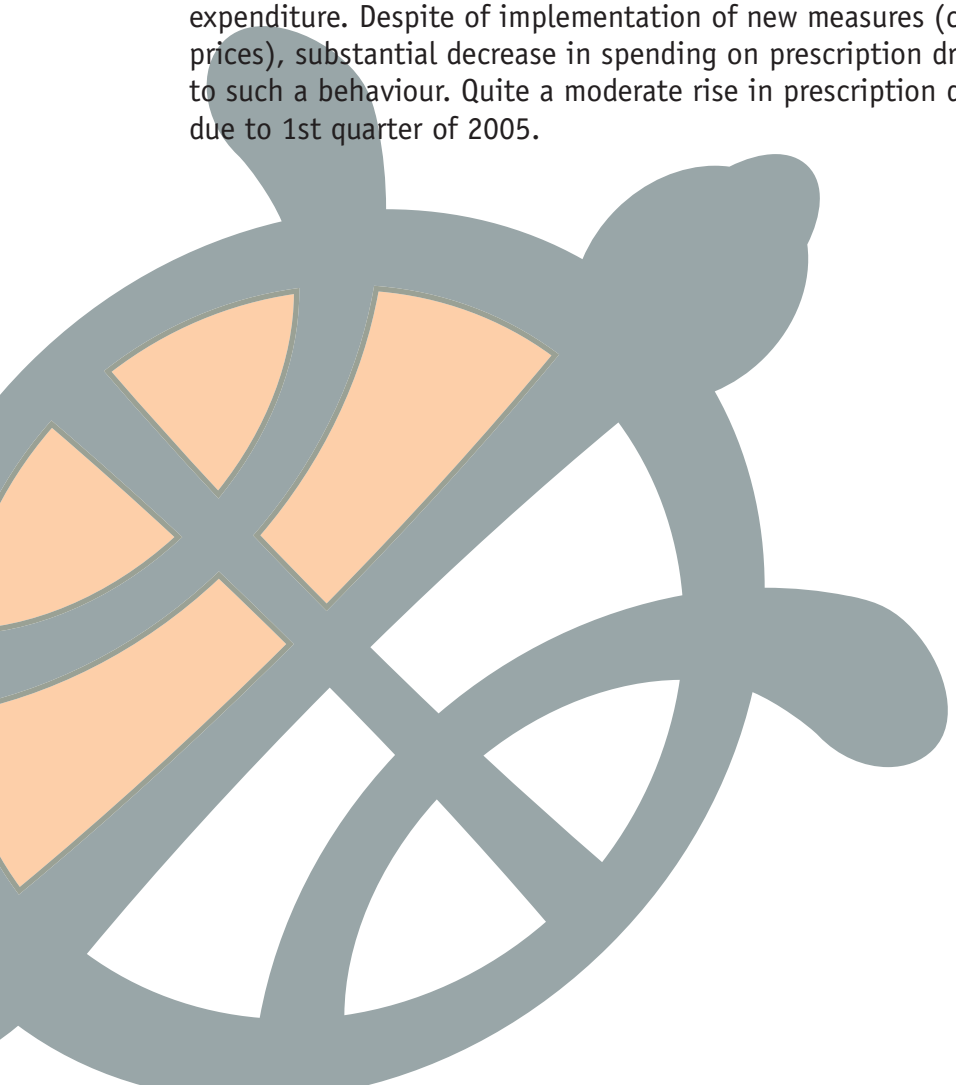
The biggest expenditure upon reimbursement of prescription drugs is still related to the diagnosis of hypertension. The fact that number of users and prescriptions of drugs for curing hypertension is continously growing can be seen as a positive trend, whereas the expenditure, compared to 2004, has fallen. This must result from continous increase in generics of medicinal products, wide selection and competition between drugs for curing hypertension.
The most intense increase of prescriptions takes place in treatment of primary hypercholesterolemia with statines, the number of users in the group with the diagnosis of diabetes.
The biggest increase in expenditure per prescription is related to the diagnosis of bronchial asthma which prescription has increased on average by 21 percent over the year.

Table 38. Percentage of the most expensive diagnoses of total drug benefits expenditure in 2004 and 2005

	2004			2005				2005 vs. 2004 (%)	
Diagnosis	users	pres-criptions	reimbursed in EEK thousand	users	pres-criptions	reimbursed in EEK thousand	% of total drug benefits expenditure	users	prescriptions
Hypertension	199 092	1 160 750	216 727	207 908	1 193 937	190 531	22%	104%	103%
Diabetes	27 458	141 104	109 094	33 037	151 000	102 472	12%	120%	107%
Cancer	7 798	29 912	50 477	7 880	33 508	59 021	7%	101%	112%
Bronchial asthma	24 206	120 027	43 504	24 229	113 418	49 803	6%	100%	94%
Glaucoma	17 324	78 982	33 122	18 582	85 235	37 578	4%	107%	108%
Primary hyper-cholesterolemia	15 977	58 523	33 343	17 432	67 970	30 996	4%	109%	116%

Analysing the spending on drugs benefits by different reimbursement rates and number of prescriptions, certain changes in percentage become apparent (see tables 35 and 36).

In summary, when analysing the expenditure on drug benefits in 2005, it can be considered that the change in methodology for calculating reference prices has brought about the decrease in average price of covered prescriptions to a certain degree for the EHIF. Compared to the previous years, the proportion of covered prescriptions reimbursed at 100 percent has substantially increased, rising in expenditure by 9 percent, resulting from amendments to Acts, entered into force 1 August 2004. Despite of the limit of EEK 200 per a prescription and the shift of expenditure connected with children under age 4 to another statistical group, spending on the benefits of covered prescription drugs reimbursed at 50 percent has increased by 6 percent per year. Frequent changes and their reflection in the press has increased drug consumption among population before the changes enter into force and has brought about swing change in the expenditure. Despite of implementation of new measures (change in methodology for reference prices), substantial decrease in spending on prescription drugs has not actually taken place, due to such a behaviour. Quite a moderate rise in prescription drug benefits in 2005 has been achieved due to 1st quarter of 2005.



4. Expenditure on benefits for temporary incapacity for work

In the 2005 budget 1,248,273,000 kroons were appropriated for the benefits for temporary incapacity for work. The actual spending in 2005 exceeds the budget by 1 % or by 16,790,000 kroons.
Spending on benefits for temporary incapacity for work increased by 15% in 2005, as compared to 2004.

Table 39. Spending on benefits for temporary incapacity for work in 2004 and 2005

Expenditure on benefits for temporary incapacity for work in EEK thousand	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %
Sickness benefits	723 458	785 100	817 636	104%
Nursing benefits	104 890	111 596	127 114	114%
Maternity benefits	253 219	330 260	297 413	90%
Work injury benefits	20 413	21 317	22 900	107%
Total	**1 101 980**	**1 248 273**	**1 265 063**	**101%**

Spending on the benefits for temporary incapacity for work has grown by 16 % on the average since 2002 and has been increasing gradually over the past four years. From 2002 to 2005 spending on sickness benefits and nursing benefits increased on average by 16%, the expenditure on maternity benefits increased by 18% and expenditure on work injury benefits decreased by 3%.

Of all expenditure on benefits for temporary incapacity for work, sickness benefits account for ca 65%, maternity benefits ca 23%, nursing benefits for 10% and work injury benefits for 2%. Such breakdown of expenditure on benefits for temporary incapacity for work has been comparatively stable over the years.

Table 40. Spending on benefits for temporary incapacity for work in 2002-2005

Expenditure on benefits for temporary incapacity for work	in EEK thousand	2002	2003	2004	2005	2003/ 2002	2004/ 2003	2005/ 2004
Sickness benefit	Number of certificates	345 554	382 685	412 363	433 944	11%	8%	5%
	Number of days	4 503 983	4 732 748	5 222 195	5 454 390	5%	10%	4%
	Benefit amount	529 829	604 217	723 458	817 636	14%	20%	13%
	Average earnings per day	118	128	139	150	9%	9%	8%
	Average length of sick leave	13.0	12.4	12.7	12.6	-5%	2%	-1%
Maternity benefit	Number of certificates	12 330	11 241	11 537	11 441	-9%	3%	-1%
	Number of days	1 177 729	1 252 850	1 356 258	1 414 096	6%	8%	4%
	Benefit amount	182 022	204 727	253 219	297 413	12%	24%	17%
	Average earnings per day	155	163	187	210	6%	14%	12%
	Average length of sick leave	95.5	111.5	117.6	123.6	17%	5%	5%
Nursing benefit	Number of certificates	64 445	69 184	73 325	81 850	7%	6%	12%
	Number of days	557 545	585 269	624 096	691 348	5%	7%	11%
	Benefit amount	82 229	91 877	104 890	127 114	12%	14%	21%
	Average earnings per day	147	157	168	184	6%	7%	10%
	Average length of sick leave	8.7	8.5	8.5	8.4	-2%	1%	-1%
Work injury benefit	Number of certificates	7 572	6 871	5 863	5 996	-9%	-15%	2%
	Number of days	171 850	146 411	118 941	125 314	-15%	-19%	5%
	Benefit amount	25 177	23 108	20 413	22 900	-8%	-12%	12%
	Average earnings per day	147	158	172	183	8%	9%	6%
	Average length of sick leave	22.7	21.3	20.3	20.9	-6%	-5%	3%
Total benefits	**Number of certificates**	**429 901**	**469 981**	**503 088**	**533 231**	**9%**	**7%**	**6%**
	Number of days	6 411 107	6 717 278	7 321 490	7 685 148	5%	9%	5%
	Benefit amount	819 257	923 929	1 101 980	1 265 063	13%	19%	15%
	Average earnings per day	128	138	151	165	8%	9%	10%
	Average length of sick leave	14.9	14,3	14.6	14,4	-4%	2%	-1%

The continued growth in spending on benefits for temporary incapacity for work from 2002 to 2005 was caused by:

- Growth in the average earnings per day;
- Growth in the number of certificates and days of incapacity for work.

Growth in the average earnings per day

A rise in gross wages over the years, on average by 9% per annum, has increased the average cost of a day of incapacity for work. Further, the growth in the average earnings per calendar day is affected since 2003 by changes in the principles for calculating the average earnings per calendar day[1].

Increase in days of incapacity for work

From 2002 to 2005 the number of days of incapacity for work grew on average by 6%.
The increase in days of incapacity for work has been caused by decrease in unemployment rate[2], increased number of working insured[3] and changes on labour market. The changes were caused by a bigger number of employees, increased value of workforce, decreased unemployment rate, more stable life and people's bigger motivation to invoke benefits of incapacity for work. The growth in the days of incapacity for work was lower in 2005 than in the previous year, but similar to the growth in days in 2002-2003.

Since 2002 the number of working insured has been growing. The number of working insured increased by 4% in 2005, as compared to 2004 and forms 49% of people covered by health insurance.

Table 41. Number of people covered by health insurance and relationship with the number of working insured from 2002 to 2005

Number of persons	2002	2003	2004	2005	2003/ 2002	2004/ 2003	2005/ 2004
Number of the insured	1 284 076	1 272 051	1 271 558	1 271 354	-1%	0%	0%
Insured in employment	578 673	584 885	595 734	617 ,625	1%	2%	4%
Insured in employment as a percentage of all insured	45%	46%	47%	49%			

1 Since 1 April 2003 earnings received as a member of an executive or supervisory body of a legal person or received for services provided under a contract under the law of obligations are included in the earnings on which the calculation of incapacity benefits is based.
2 According to the Statistical Office employment has increased and unemployment decreased since 2001.
3 See Table 41. Number of people covered by health insurance and relationship with the number of working insured from 2002 to 2005.

The number of people consulting medical institutions[4] has increased and the certificates for temporary incapacity for work are being used more often than before. The number of certificates has increased on average by 7% from 2002 to 2005. Employers' complaints about the substance of certificates issued to employees are also more frequent. The majority, on average 75% of the certificates have been issued by family physicians.
In the course of auditing the substance of leave of long-term (20-30 days) certificates issued by family physicians it was identified that in 5% of the total of 1,461 audited cases the leave was not justified enough and in 54% of the cases the length of the leave was not justified.

Sickness benefits

The number of sickness benefit days of incapacity for work increased by 4% in 2005, as compared to 2004 and the average cost of a sickness day increased by 8%. Compared to the increase of days of incapacity for work in 2002-2004, the growth of said days has slowed down somewhat in 2005.

The increase in the number of sickness benefit days of incapacity for work has been caused by the increase in the number of working insured by 4% and increase in the number of treatment cases[5]. Average cost of a day of incapacity for work increases based on the increase in the income taxed with social tax.

One of the more frequent reasons for incapacity for work have been respiratory diseases[6].

In the age structure of the use of certificates for sick leave, the majority (24%) of certificates have been issued to people belonging to the 40-49 age group. The age structure of the use of certificates for sick leave has been comparatively stable from 2002 to 2005, the number of certificates issued to people belonging to the 50-59 age group has increased by 1% since 2004 and the number of certificates issued to people belonging to the 30-39 age group has decreased by the same amount.
Observing the length of sick leave by age groups it can be said that the leave is the longest, 15 days, in the 60-69 age group. In the 40-49 age group the average length of sick leave is 13 days.

Since 1 May 2004 the benefit for temporary incapacity for work is also paid in the case of ilness in foreign states based on the certificate issued by foreign state's doctor. In 2005, ca 753,000 kroons were paid for benefits for incapacity for work based on certificates issued by foreign state's doctors.

Maternity benefits

Maternity benefit days of incapacity for work has increased by 4% and the average cost of day by 12%, as compared to 2004.

The number of certificates for maternity leave has decreased by 1% in 2005, but the average lenth of maternity leave increases gradually. The average length of maternity leave has increased by 5% in 2005, as compared to 2004.

The continued increase in the number of days of maternity leave per person is caused by the longer disbursement period of maternity benefits, based on the amendment to Health Insurance

4 Total number of outpatient treatment cases has increased by 8% in 2005, as compared to 2004. (See Table 24)
5 See Table 24
6 http://www.sm.ee/est/pages/index.html

Act[7] and increase in the number of cases of taking the maternity leave in time[8]. The latter is caused by the opportunity of the persons giving birth to choose the option economically more suitable for them from both parental and maternity benefit's point of view.[9]

Nursing benefits

The number of nursing days has increased by 11% in 2005, as compared to 2004. At the same time, the average cost of a nursing day has increased by 10%.

The average cost of a nursing benefit day has been on average 30 kroons higher than the cost of sickness benefit day in the past three years. This is due to the increase in the number of maternity benefits applicants with a higher than average income over the last years. From 2002 to 2005, the average cost of the benefit day of the applicants for maternity benefit has been on average 45 kroons higher than the average cost of sickness benefit day. At the same time this indicator increased by an average of 11%. Returning from parental leave, the women who have given birth are the potential users of certificates for care leave, which is why the daily earnings of nursing benefits are expected to increase. On the other hand, there is the parents' opportunity to choose that the parent with higher income will be on parental leave. The analysis of the payment of nursing benefits shows that in the case of almost 19% of certificates for care leave the caregiver is a male parent whose average earnings of a nursing day are 291 kroons, or 1.8 times higher than the average earnings of the nursing day of a female caregiver. Compared to 2004 the number of male caregivers has increased by ca 1%.

The number of nursing days is not only increasing in the age group of children born in the past few years, but in all age groups. Thus the main reason for the increase in nursing days is not only the increased number of births but also the more frequent use of certificates for care compared to previous years.

Work injury benefits

The number of benefit days related to work injury decreased in 2003 and 2004 due to the amendment effective 1 July 2003, according to which accidents that happen on way to work are not regarded as work accidents. The number of work injury benefit days increased by 5% in 2005, as compared to 2004.

According to Labour Inspectorate the number of accidents at work did not increase comparatively in 2005. The number of registered accidents at work remains similar to 2004. Thus, the main reason for the increase in days of incapacity for work related to work injury in 2005 is the lengthening of the period of incapacity for work of certificates issued after serious accidents at work. According to Labour Inspectorate, serious accidents at work form on average of 29% of all work injuries of 2004-2005[10].

---

7 An amendment to Health Insurance Act entered into force on 1 October 2002, pursuant to which the period of maternity leave increased from 126 days to 140 days and to 154 days in exceptional cases.

8 Pursuant to Holidays Act women have the right for a pregnancy and maternity leave at least 70 calendar days before the assumed due date set by the doctor.

9 Pursuant to Health Insurance Act the number of maternity leave days will be reduced if the maternity leave starts less than 30 days before the assumed due date set by the doctor

10 http://www.ti.ee

5. Other cash benefits

Dental benefits for adults

Overall, Estonian Health Insurance Fund paid 77,020,000 kroons for dental benefits in cash in 2005. Compared to 2004, the budget increased by 11%, the 2005 budget was implemented at 97%.

The EHIF reimburses the cost of dental services for the insured according to the following rates:

- 150 kroons for a person aged 19 and over;
- 450 kroons for a pregnant woman;
- 300 kroons for persons with an increased need for dental treatment;
- 300 kroons for a mother with a child under 1 year of age;
- 2,000 kroons spread over a period of 3 years as reimbursement for dentures to an insured person aged at least 63 years and to an old-age pensioner who may be younger than 63.

Table 42. Implementation of the 2005 budget for dental benefits

Dental benefits in EEK thousand	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget	2005 actual/ 2004 actual%
Denture benefit	41 357	44 635	39 396	88%	95%
Dental treatment benefit	28 260	35 040	37 624	107%	133%
Total	**69 617**	**79 675**	**77 020**	**97%**	**111%**

Compared to 2004, the number of applicants for denture benefit has remained the same, forming 11% of the target group. The respective indicator for 2004 was 10%.
The number of applicants for dental treatment benefit forms 24% of entitled persons.
In 2003 and 2004 the respective indicators were 10% and 18%.
The number of applicants for dental treatment benefit has increased by 32%, as compared to 2004.

Table 43. Number of dental benefit cases

Number of dental benefit cases	2005 target group	2004 cases	estimated cases 2005	actual cases 2005	2005 actual	2005 actual/ 2004 actual%
Denture benefit	248 000	27 851	27 897	27 439	98%	99%
Dental treatment benefit	968 000	177 914	221 072	235 336	106%	132%
Total	**1 216 000**	**205 765**	**248 969**	**262 775**	**106%**	**128%**

Supplementary benefit for medicinal products

In 2005, the EHIF paid the total of 2,741,000 kroons for supplementary benefits for medicinal products to 1,101 persons.

Table 44. Implementation of the budget for supplementary benefit for medicinal products in 2005

Supplementary benefit for medicinal prodcuts	2004 actual	2005 budget	2005 actual	2005 vs 2004
sum paid in EEK thousand	2 820	3 750	2 741	97%
people receiving benefit	704	1 500	1 101	156%
average sum paid to person in EEK	4 006	2 500	2 489	62%

The insured became entitled to supplementary benefit for medicinal products on 1 January 2003, when § 47 of the Health Insurance Act entered into force. Supplementary benefit for medicinal products is a cash benefit calculated on the basis of expenses incurred by a person on covered prescription drugs during a calendar year. The aim of the procedure was to enable the people who spend more than 6,000 kroons per calendar year on buying drugs included in the EHIF drug list, to receive additional monetary benefit. The maximum supplementary benefit per person per calendar year is 9,500 kroons.

Supplementary benefit for medicinal products helps reimburse the cost of drugs first and foremost for those who:

- use very expensive drugs in their treatment schemes;
- suffer from chronic diseases and must use medication for a prolonged period;
- use several drugs in a combination.

Payment of supplementary benefit for medicinal products decreased by 3% in 2005, as compared to 2004. At the same time the number of persons receiving the benefit has increased by 56%. Thus, more people receive additional monetary benefit for medicinal products.

6. Other expenditure on health insurance benefits

Health insurance benefits of those insured by the EHIF in other European Union member states and states of European Economic Area (except Switzerland) and the expenditure on health services in Estonia of those insured in other European Union Member States and states of European Economic Area (except Switzerland)

After Estonia became a full member of the European Union on 1 May 2004, the provision of and payment for health services are regulated by the Council Regulation (EEC) No. 1408/71 on the application of social security schemes in the EU member states and the the implementing regulation No. 574/72.

Said Regulations of the European Council are binding in their entirety and directly applicable. Health insurance benefits under these regulations are an open commitment for the EHIF.

The persons insured by the EHIF are entitled to:

- emergency care during their temporary stay in another member state;
- any medical care if residing in another member state.

The expenses for said health services are covered by the Estonian Health insurance Fund.

The persons insured in other EU member states are entitled to:

- emergency care during their temporary stay in Estonia;
- any health care if residing in Estonia.

The expenses for health services of people insured in EU member states are first covered by the EHIF, but the final payer for health services is the state where the person was insured.

Thus, both in 2004 and 2005 the plan was based on the statistics of international agreements, on the basis of which the respective 2005 expenditure of the EHIF was estimated to 11,283,000 kroons. Actual expenditure in 2005 was 15,317,000 kroons.

Benefits for medical devices

Table 45. Implementation of the budget for benefits for medical devices in 2005

Benefits for medical devices in EEK thousand	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual /2004 actual %
Primary protheses and orthoses	7 560	8 000	9 117	114%	121%
Diabetes test strips	7 870	7 200	9 203	128%	117%
Stoma appliances	7 230	8 200	7 644	93%	106%
Spacer devices	94	150	35	23%	37%
Other devices	381	5 018	472	9%	124%
Total	**23 135**	**28 568**	**26 471**	**93%**	**114%**

In 2005, the EHIF reimbursed medical devices for 26,471,000 kroons (90% of the budget). Underexpenditure of the budget of medical devices is due to lower spending of sums reserved for stoma appliances, spacers and other devices. The expenditure exceeded the estimate in primary orthoses and test strips. Compared to 2004, the number of recipients of orthoses has increased by almost three times owing to the increased awareness of the insured and supplementation of medical devices' sales network of contract partners. The demand for protheses has remained stable over the years. The number of the recipients of test strips has increased by 15% in 2005. Underspending on other devices is due to lower demand than estimated.

II Operational expenditure of the EHIF

The EHIF's operational expenditure on the administration of health insurance benefits in 2005 was 89,385,000 kroons. The budget for operational expenditure was implemented at 96%.

7. Personnel and administrative expenditure

Table 46. Implementation of the budget for personnel expenditure

Personnel expenditure in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Total salaries	32 940	33 545	39 346	36 827	94%	110%
Basic salary	27 159	27 686	31 967	30 505	95%	110%
Performance pay	4 059	4 157	5 541	4 556	82%	110%
Management Board remuneration (basic and performance-related)	1 719	1,699	1 833	1 764	96%	104%
Supervisory Board remuneration	3	3	5	2	40%	67%
Unemployment insurance premium	149	158	197	160	81%	101%
Social tax	10 871	11 070	12 984	12 153	94%	110%
Total	**43 960**	**44 773**	**52 527**	**49 140**	**94%**	**110%**

Personnel expenditure includes regular salaries and performance pay for employees, remuneration for the Management Board and the Supervisory Board and the social tax and unemployment tax payments thereon.

The 2005 budget for personnel expenditure was implemented at 94%. Underspending was due to lower disbursements of performance pay and taxes calculated thereon. Performance pay was planned in the budget at maximum amount, but the procedure for performance management establishes the criteria for the payment of performance pay, according to which actual performance pay is directly related to the results achieved. Another reason for underspending is the movement of employees and structural changes in departments.

The EHIF plans its activities and operational expenditure based on the development plan approved by the Supervisory Board and scorecard's objectives for the current year. The EHIF uses activity-based costing in the course of which the activities/functions necessary for the attainment of the organisational goals are reviewed and the resources (man years) required for the performance of these functions are proposed. Below are a few examples of the volume of services delivered by the EHIF.

Table 47. Examples of service volumes in the EHIF in 2002–2005

	2002	2003	2004	2005	2005/2004
Medical bills processed	6 512 890	5 889 696	3 879 592	3 986 961	103%
Covered prescriptions processed	4 118 000	4 012 989	4 775 221	5 000 602	105%
Certificates of incapacity for work processed	444 364	639 882	506 355	533 231	105%
Treatment records inspected	5 966	14 186	13 400	10 384	77%
Contract annexes administered	1 321	1 112	1 120	1 090	97%

** A sudden decline in the number of processed medical bills in 2004 is due to the fact that in earlier years the 0-bills filed by family physicians were included in processed medical bills. After introduction of electronic channels for filing medical bills no human resources are spent on the processing of 0-bills. Hence, the said bills have been eliminated from the total pool of medical bills used for the calculation of resource needs. The number of medical records subject to inspection is shown in the EHIF scorecard.*

The resource needs of the EHIF from 2003 to 2005 are exhibited below. It appears from the table that by the end of 2005 the resources required for EHIF business processes has dropped by 4 man years. By the end of 2004, the resource need had decreased by 42 man years, as compared with 2003.

Table 48. Resource needs (number of people) of the EHIF in 2003-2005

Business process and required resource	2003	2004	2005	Change 2005-2004 (man years)
Health coverage administration	37	42	40	-2
Communication with partners and the insured	43	39	25	-14
Management of internal and external communication	4	4	5	1
Analysis of health insurance benefits	8	9	11	2
Planning of health insurance benefits	3	4	4	0
Administration of health services contracts	12	7	9	2
Processing of of health insurance benefits	62	43	56	13
Processing of covered drugs	10	3	8	5
Processing of health services	15	6	10	4
Processing of benefits for incapacity for work	24	23	25	2
Processing of cash benefits	10	10	12	2
Processing of other health services	3	1	1	0
Health insurance benefit inspection	49	41	35	-6
Health insurance benefit development	6	11	13	2
Personnel management and development	2	2	2	0
Management of IT development activities	3	4	4	0
Assurance of availability	12	8	7	-1
Business procedures	15	7	5	-2
Management of economic activities	22	16	14	-2
General management	16	15	18	3
Performance of internal audit	4	4	4	0
Total required resources	**298**	**256**	**252**	**-4**

The internal relocation of resources is due to the change in the organisation's priorities. Due to the reorganisation related to business procedures the number of highly qualified EHIF employees continued to grow in comparison with the ones performing routine tasks.

In 2005 the EHIF started to introduce software supporting the register of the insured with the objective to continue making the business procedures more effective.

Introduction of quarterly planning has necessitated additional resources for the analysis of health insurance benefits but also for the administration of health services contracts in order to raise the quality of longer-term planning (3 to 5 years) in the EHIF and improve the preventive monitoring of agreements.
Benefit development entails the development of the services price list, clinical guidelines, the harmonisation of principles with the EU, complex prices (DRG), etc. Health insurance benefit development contributes to the attainment of a strategic objective of the EHIF - enhance the quality of health services.

Need for the resources for the inspection of health insurance benefits decreased as a result of introduction of electronic controls. Application of electronic controls enabled to reduce the volume of medical files subject to examination and at the same time improved the quality of control..

8. Overhead expenditure

Overhead falls into office expenditure, supplies and equipment, facilities maintenance, business travel, vehicle maintenance and other miscellaneous expenses.

Table 49. Implementation of the overhead budget

Overhead in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget%	2005 actual/ 2004 actual %
Office expenditure	3 626	3 292	3 680	3 208	87%	97%
Facilities' maintenance	7 614	7 650	7 841	7 703	98%	101%
Supplies and equipment	1 458	1 446	1 547	1 772	115%	123%
Vehicle maintenance	1 846	1 703	2 184	1 749	80%	103%
Business travel	461	793	846	821	97%	104%
Other overhead expenditure	700	1 352	2 148	1 539	72%	114%
Total	**15 705**	**16 236**	**18 246**	**16 792**	**92%**	**103%**

The overhead of 16,792,000 kroons represents 92 percent of the budgeted amount. The implementation of the budget by cost category is different. Overspending on supplies and equipment was due to the bigger expenditure on maintenance and repairs than planned. At the end of 2004, a data repository was acquired, the depreciation of which was not planned in the 2005 budget. Vehicle maintenance and other overhead expenditure were underspent. Other overhead expenditure includes expenses incurred in relation with recruitment, health services and other outsourced services (incl. translation service), representation and fringe benefit costs. More translation services were planned for 2005 than in previous periods, but a large portion of the translations were carried out by the employees of the EHIF.

9. Information technology expenditure

Table 50. Implementation of the IT budget

Information technology in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual/ 2005 budget %	2005 actual/ 2004 actual %
Personal hardware and software	1 776	2 187	1 844	2 059	112%	94%
Information systems development	3 596	1 214	6 347	5 223	82%	430%
Information systems maintenance	6 688	5 196	3 582	4 751	133%	91%
Other IT expenses	368	499	543	578	106%	116%
Total	**12 428**	**9 096**	**12 316**	**12 611**	**102%**	**139%**

The budget for IT was implemented at 102%.

Overspending on information technology is mainly due to the strategic decision to buy the server maintenance service from outside. This was caused by the lack of necessary qualifications inside the organisation. In 2005 there was also extraordinary expenditure related to the necessary work in the EHIF's software.

In 2004 procurements were prepared for the development of the projects of e-certificates of incapacity for work and register. The actual implementation of these projects was planned to 2005. Because of this the expenditure on development work has increased significantly, as compared to 2004.

Major IT development programmes in 2005 included:

- electronic processing of medical bills and covered prescriptions.
- partial transition to the system of diagnosis-specific funding (DRG-based system).

10. Development expenditure

Table 51. Implementation of the development budget

Development expenditure in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %	2005 actual / 2004 actual %
Training	1 748	1 756	1 697	1 627	96%	93%
Consultations	1 355	2 413	2 157	2 151	100%	89%
Business consultations	1 022	2 048	1 377	1 637	119%	80%
Legal consultations	333	365	780	514	66%	141%
Total	**3 103**	**4 169**	**3 854**	**3 778**	**98%**	**91%**

Development costs account for 98% of the budgeted amount.

Training costs account for 96% of the budgeted amount. Underspending is due to the increase in work load related to different projects and the introduction of IT-related development projects that did not allow for the full implementation of the training budget.
In 2005, training was mainly conducted in the fields supporting the achievement of strategic objectives – the development of the system for the analysis and planning for health insurance benefits, raising the awareness of the insured of their rights and responsibilities, automation of work processes and support to electronic data between partners.

Outsourcing for consultation services (mainly committees, expert evaluations, advisory bodies, consultation and working groups) are reported under expenditure on business consultations. The budget has been implemented at 119%.

Table 52. Implementation of the budget for business consultations

Business consultations in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget
Price list	492	941	135	94	70%
Complex prices for health services	195	435	420	475	113%
Treatment instructions	137	279	400	655	164%
List of covered prescription drugs	68	35	42		0%
Health services	48	115	200	258	129%
Other	82	243	180	155	86%
Total	**1 022**	**2 048**	**1 377**	**1 637**	**119%**

Legal consultation. The budget has been implemented at 66%. Underspending on the budget of legal consultations expenditure is due to the lower volume of court cases of insured persons.
A bigger expenditure was planned for 2005 based on possible disputes in court that may arise from the implementation of European Union law as well as from disputes with the contractual partners of the EHIF. Due to the lack of legal regulation of the implementation of principles arising from the state's health policy, possible disputes were planned while choosing contractual partners, to solve these disputes it would have been necessary to analyse the concurrence of different acts, decisions of the Supreme Court and legal theoretical positions.

11. Financial expenditure

Table 53. Implementation of the budget for financial expenditure

Financial expenditure in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %	2005 actual / 2004 actual %
Banking charges	495	804	1 000	867	87%	108%
Reserves administration costs	77	66	66	66	100%	100%
Other financial expenditure	29	28	32	766	2 394%	2 736%
Total	**601**	**898**	**1 098**	**1 699**	**155%**	**189%**

The budget for financial expenditure (banking charges and charges for the administration of the legal reserve and other financial expenses) has been implemented at 155%.
Budget surplus is due to extraordinary interest on arrears paid by the EHIF, recorded under other financial expenditure and arising from the elongated dispute in court in 2002.

12. Other operational expenditure

Table 54. Implementation of the budget for other operational expenditure

Other operational expenditure in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %	2005 actual / 2004 actual %
Forms and publications	1 057	1 082	1 404	1 148	82%	106%
Supervision	1 066	945	1 425	879	62%	93%
Public relations/ public information	752	914	874	819	94%	90%
Other expenditure	7 953	1 999	1 662	2 519	152%	126%
Total	**10 828**	**4 940**	**5 365**	**5 365**	**100%**	**109%**

Expenditure on other operational expenses was implemented at 100%.
The cost of the printing of covered prescriptions was included in expenditure on forms and publications. The budget was implemented at 82%.
Expenditure on supervision in 2005 included the financial audit, the internal audit and the clinical audits.
Budget for internal audit and health insurance supervision was implemented only partially.

Table 55. Implementation of the supervision budget

Supervision in EEK thousand	2003 actual	2004 actual	2005 budget	2005 actual	2005 actual / 2005 budget %
Internal audit	89	0	150	68	45%
Health insurance	586	672	935	491	53%
Financial audit	391	273	340	320	94%
Total	**1 066**	**945**	**1 425**	**879**	**62%**

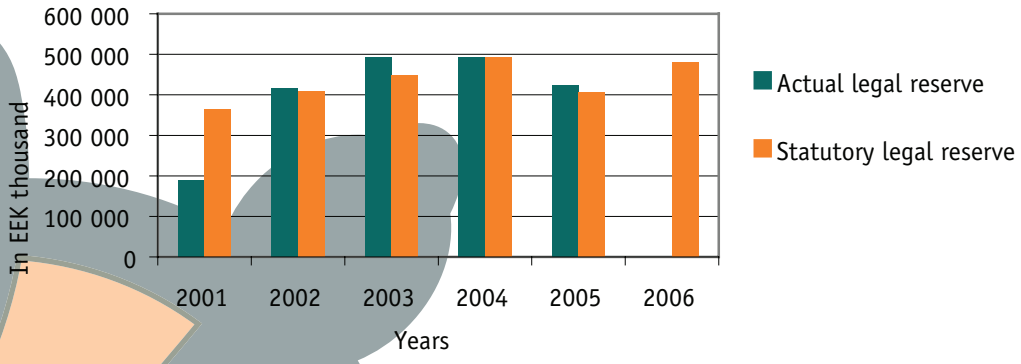
Expenditure on public relations and public information consists of health services flyers, The Estonian Health Insurance Fund Gazette and other information materials, materials of the phone consulation service of family physicians, publicity on the Health Insurance Act and its implementing acts and regular information sessions.

Other expenses. Overspending was due to writing-off claims amounting to 1,281,000 kroons under other operating expenses. By respecting the constraint of conservatism, the EHIF establishes as doubtful all claims outstanding over one year. Uncollectible accounts have been written off the balance sheet.
Other expenses cover also the liability insurance of the Management Board and Supervisory Board in the amount of 198,000 kroons and 802,000 kroons of expenditure on fringe benefits has been entered into expenditure and taxes paid on them.

13. Legal reserve

Amendments to the Estonian Health Insurance Fund Act were adopted on 16 December 2004, establishing among other things that the legal reserve be 6% of the budget volume (before the required volume of legal reserve had been 8%). The amendment took effect on 1 January 2005. As of the end of 2004, the legal reserve of the EHIF was 493,363,000 kroons. Pursuant to the decision of the EHIF Supervisory Board, 70 million kroons were utilised from the legal reserve in 2005. As of 31 December 2005, the legal reserve of the EHIF was 423,363,000 kroons.
Pursuant to the volume laid down by law, the amount of the legal reserve will be 481 million kroons in 2006. Arising from this an appropriation of 58 million kroons has been planned to the legal reserve from the retained earnings of 2005.

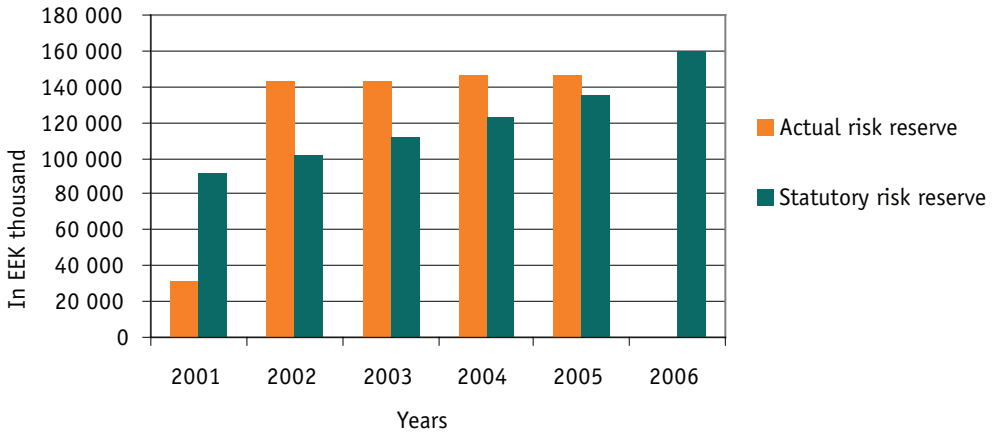
Chart 10. Legal reserve of the EHIF in 2001-2006 in EEK thousand



14. Risk reserve

The risk reserve equals 2% of the health insurance budget of the EHIF, pursuant to Estonian Health Insurance Fund Act.
As of 31 December 2005, the EHIF risk reserve was 146,148,000 kroons. Pursuant to the volume laid down by law, the amount of the risk reserve will be 160 million kroons in 2006. Arising from this an appropriation of 14 million kroons has been planned to the legal reserve from the retained earnings of 2005.

Chart 11. Risk reserve of the EHIF in 2001-2006 in EEK thousand



15. Retained earnings

As of 31 December 2005, the retained earnings of the EHIF constituted 1 218 740 000 kroons. The retained earnings have been formed from:
1) retained earnings of 233 362 000 kroons from the 2003 fiscal year and the retained earnings of 133 028 000 kroons from the 2004 fiscal year and pursuant to the decision of the Supervisory Board from the 70 million kroons utilised from legal reserve;
2) inflows in social tax, which exceeded the estimated amounts by 602 545 000 kroons (9%) in 2005. The EHIF used part of this surplus for covering the overspending on drugs and incapacity benefits. As a result, the retained earnings for the 2005 fiscal year are 273 755 000 kroons.
3) adjustments to the retained earnings from 2003 have been made in the 2004 financial statements, because the Tax and Customs Board changed its accounting policies. According to § 14 (1) of the general accounting rules of the government, taxes are reported in the statement of revenue and expenditure and on the balance sheet of the government accounting entity, who is the beneficiary of that tax as established by the law. Hence, the EHIF had to adjust the 2003 annual accounts in respect of the retained earnings from previous periods and in respect of claims - the retained earnings for the earlier periods increased by 502 617 000 kroons transferred by the Tax and Customs Board and by 5 979 000 kroons transferred by the Social Insurance Board. Increase in the retained earnings for the previous periods does not increase real cash flows.

Annual accounts 2005

Statement by the Management Board

The Management Board declares its responsibility for the accuracy of the Estonian Health Insurance Fund's annual accounts for 2005 as set out on pages 73 to 88 and confirms, to the best of its knowledge, that:

- the accounting principles used in preparing the annual accounts are in compliance with the generally accepted accounting principles;
- the annual accounts present a true and fair view of the financial situation, the revenue and expenditure and the cash flow of the Estonian Health Insurance Fund;
- all relevant circumstances, which have occurred before the completion of the report on 31 March 2006, have been duly recognised and reflected in the annual accounts;
- the Estonian Health Insurance Fund is a going concern.

		Date	Signature
Chairman of the Management Board	Hannes Danilov	.....	.....
Member of the Management Board	Arvi Vask	.....	.....
Member of the Management Board	Maigi Pärnik-Pernik	.....	.....
Member of the Management Board	Eliko Pedastsaar	.....	.....

Balance sheet

	Balance sheet 31.12.2004	Balance sheet 31.12.2005	Note
ASSETS			
Current assets			
Cash and bank accounts	394 103 852	419 875 590	2
Shares and other securities	601 400 250	915 539 019	3
Claims and advance payments			
Customer receivables	3 147 491	3 186 253	
Other short-term receivables	19 890 058	15 120 401	4,8
Interest receivable	501 545	394 746	
Other accrued income	618 974 027	752 805 238	5
Prepayments	1 386 019	1 888 458	
Total	**643 899 140**	**773 395 096**	
Inventories			
Goods for resale	102 059	323 023	6
Total current assets	**1 639 505 301**	**2 109 132 728**	
Fixed assets			
Long-term financial investments			
Shares	90 000	90 000	3
Long-term securities and bonds	297 876 520	188 957 385	3
Other long-term receivables	19 703 862	14 261 410	7,8
Total	**317 670 382**	**203 308 795**	
Tangible fixed assets			
Land and buildings (residual value)	990 655	1 423 564	
Machinery and equipment (residual value)	3 458 491	2 911 837	
Other inventories (residual value)	3 856 925	4 204 809	
Total	**8 306 071**	**8 540 210**	**9**
Intangible fixed assets			
Purchased licences	1 230 171	731 416	9
Total fixed assets	**327 206 624**	**212 580 421**	
TOTAL ASSETS	**1 966 711 925**	**2 321 713 149**	

LIABILITIES AND EQUITY CAPITAL	31.12.2004	31.12.2005	Note
Liabilities			
Current liabilities			
Loan commitments			
Repayments of long-term loan commitments in the next period	1 879 244	193 158	10
Debts and advance payments			
Supplier payables			
Accounts payable for medical care services	279 644 391	373 203 526	
Accounts payable for medicinal products subject to discount	106 175 460	87 219 000	
Supplier payables for health insurance benefits	22 826 243	34 286 876	
Other supplier payables	3 831 736	1 898 916	
Total supplier payables	412 477 830	496 608 318	
Taxes payable	31 231 806	29 636 805	11
Employee-related liabilities	6 241 161	6 620 383	
Other debts	194 889	402 545	
Total	**450 145 687**	**533 268 051**	
Total current liabilities	452 024 931	533 461 209	
Long-term liabilities	190 051	0	
Total liabilities	452 214 982	533 461 209	
Equity capital			
Reserve			
Reserves	639 511 528	569 511 528	
Net surplus/deficit			
Net surplus/deficit for previous periods	741 957 843	944 985 415	
Net surplus/deficit for financial year	133 027 572	273 754 997	
Total equity capital	1 514 496 943	1 788 251 940	
TOTAL LIABILITIES AND EQUITY CAPITAL	**1 966 711 925**	**2 321 713 149**	

Statement of revenue and expenditure

	2004	2005	Note
Revenue from the health insurance part of social tax and claims collected from other persons	6 287 583 244	7 287 617 928	12
Expenditure on health insurance	-6 136 989 416	-6 983 752 043	13
Gross surplus/deficit	150 593 828	303 865 885	
General administrative expenditure	-74 273 641	-82 320 618	14
Other operatational expenditure	31 467 195	33 799 000	
Other operatational expenditure	-4 940 145	-5 365 215	
Operating surplus/deficit	102 847 236	249 979 052	
Financial revenue and expenditure			
other interest and financial expenditure	31 078 423	25 474 969	
other financial expenditure	-898 087	-1 699 024	
Total financial revenue and expenditure	30 180 336	23 775 945	
Net deficit/surplus for financial year	**133 027 572**	**273 754 997**	

Cash flow statement

	2004	2005
Cash flow from operating activities		
Social tax received	6 250 504 965	7 143 848 200
Payments to suppliers	- 6 164 534 965	- 6 910 550 316
Personnel expenses paid	- 33 020 981	- 36 663 464
Taxes paid on personnel expenses	- 11 389 140	- 13 417 783
Other revenue received	89 175 888	61 024 769
Other expenses paid	- 563 855	- 502 439
Total cash from operating activities	**130 171 912**	**243 738 967**
Cash flow from investing activities		
Purchase of fixed assets	- 7 311 403	- 6 113 998
Proceeds from disposals of fixed assets	2 484 987	0
Proceeds from disposals of financial assets	2 322 410 387	1 504 655 194
Purchase of financial assets	- 2 265 952 631	- 1 716 508 425
Total cash flow from investing activities	**51 631 340**	**- 217 967 229**
Total cash flow	181 803 252	25 771 738
Cash and cash equivalents at the beginning of period	212 300 600	39 4103 852
Change in cash and cash equivalents	181 803 252	25 771 738
Cash and cash equivalents at the end of period	394 103 852	419 875 590
incl. short-term deposits	372 000 000	381 586 560

Statement of changes in equity

	2004	2005
Reserves		
Reserves at the beginning of the year	561 555 528	639 511 528
Increase/decrease of reserves*	77 956 000	- 70 000 000
Reserves at the end of the year	639 511 528	569 511 528
Net surplus/deficit for previous periods		
At the beginning of the year	819 913 843	874 985 415
Increase/decrease of legal capital*	- 77 956 000	70 000 000
Net surplus/deficit for financial year	133 027 572	273 754 997
At the end of the year	**874 985 415**	**1 218 740 412**
Equity at the beginning of the year	1 381 469 371	1 514 496 943
Equity at the end of the year	**1 514 496 943**	**1 788 251 940**

* Pursuant to the decision of the EHIF Supervisory Board, 70 million kroons from the legal reserve will be utilised in 2005.

Notes to the Annual Accounts

Note 1. Accounting methods and assessment criteria used for preparing the annual accounts

General principles

The annual accounts for 2005 of the EHIF have been drawn up in accordance with the accounting principles generally accepted in Estonia based on internationally recognised accounting and reporting policies. Basic requirements of generally accepted accounting principles have been established with Accounting Act and supplemented by instructions issued by the Accounting Committee.

The financial year began on January 1, 2005 and ended on December 31, 2005. The figures in the annual accounts have been given in Estonian kroons.

Layouts used for reporting purposes

In the financial year, the balance sheet layout used in Annual Accounts was changed due to the change in Accounting Committee's instruction No. 2, Requirements for the presentation of information in Annual Accounts. To guarantee comparability, the respective data of the previous period has been adjusted.

For the purpose of the revenue and expenditure account, layout no. 2 of the profit and loss account set out in the Accounting Act is used with the structure of its entries adjusted to accommodate the specific features of the activities of the EHIF.

Financial assets and liabilities

Regarded as financial assets are monies, short-term financial investments, customer receivables and other current and long-term receivables. Regarded as financial liabilities are supplier payables, accruals and other short and long-term loan commitments.

Financial assets and liabilities are initially registered in their acquisition cost, which is the just value of the amount paid or received for the said financial asset or liability. Initial acquisition cost covers all transaction expenses directly related to the financial asset or liability.

Financial liabilities are recorded on the balance sheet in adjusted acquisition cost.

Financial assets are removed from the balance shet when the EHIF loses the right for cash flows from financial assets or it gives to the third party the cash flows arising from the assets and most of the risks and benefits related to financial assets. Financial liability is removed from the balance sheet when it has been met, terminated or expired.

The purchase and sale of financial assets are recorded in a consistent manner on the value date, i.e. on the date when the EHIF becomes the owner of the purchased financial assets or loses the right of ownership for sold financial assets.

Foreign exchange accounts

Transactions in foreign currency are recorded in Estonian kroons on the basis of the exchange rate published by the Bank of Estonia applicable on the transaction day. Assets and liabilities established in foreign currency are re-valued on the basis of the exchange rate valid on the balance sheet date and the currency translation reserve is shown in the revenue and expenditure account.

Financial investment accounts

Short-term financial investments relate to securities, which have been acquired for the purpose of subsequent resale during the financial year following the balance sheet date or which have a redemption time limit of one year or less, calculated from the balance sheet date.

Accounts for securities acquired for short-term holding

Securities and bonds acquired for short-term holding are recorded on the balance sheet proceeding from their just value. The assessment of the just value is based on the market value of the financial investment of the day of drawing up the balance sheet.

Long-term financial investment accounts

Long-term financial investments are recorded on the balance sheet according to the just value method. Profits and losses arising from the changes in value are recorded in the statement of the revenue and expenditure on the financial year.

Receivable and loan accounts

Receivables and granted loans are assessed individually and reflected on the balance sheet on conservative basis in view of the amounts collectible. Receivables and granted loans, which are uncollectible, are expensed for the period and shown on the balance sheet with a minus. Receivables and loans, which do not justify any recovery measures for practical or economical reasons, are deemed irrecoverable and written off.

Stock accounts

Stocks are recognised at acquisition cost and expensed using the FIFO method. The stocks are appraised on the balance sheet on the basis of either their acquisition cost or the net realisable value, whichever is the lower.

Tangible fixed asset accounts

Tangible fixed assets are assets having an expected useful life of more than one year and an acquisition cost of more than 10,000 kroons. Assets, which have a shorter expected useful life and a smaller acquisition cost, are expensed at the time of acquisition.
Tangible fixed assets are recognised at their acquisition cost and depreciated on a straight-line basis in accordance with their expected useful life. Land is not subject to depreciation.
The following depreciation time limits (in years) are applied:

- buildings 10-20
- inventories 2-4
- cars and other vehicles 3-5
- equipment 3-5
- intangible fixed assets 2-4

Intangible fixed assets

Intangible fixed assets are identifiable non-monetary assets, which have no physical substance, have an expected useful life of more than one year, are used for own activities and have an acquisition cost of more than 10,000 kroons.
Intangible fixed assets are recognised at their acquisition cost and depreciated on a straight-line basis in accordance with their expected useful life within 3 to 5 years.
Expenditure on tangible and intangible assets incurred after acquisition are, as a rule, expensed for the period. Additional expenditure are added to the cost of intangible fixed assets, if it is likely that this expenditure allows the asset to generate more economic benefits in the future than expected and if this expenditure can be reliably assessed and related to the asset.

Revenue and expenditure accounts

Revenue and expenditure have been recorded in accordance with the accrual method. Interest income is recorded as accrued and dividends are recorded when the entitlement to dividends is established.

Operating and financial lease accounts

A lease is deemed to be financial lease, if all the main risks and benefits related to the ownership of the assets are transferred to the lessee. In the opposite case the lease is deemed to be an operating lease.
The property leased by way of financial lease is recognised on the balance sheet as assets and liabilities, according to the just value of the leased property. The lease payments are divided into finance costs and downwards adjustment of liabilities. Finance costs are recognised during the lease period.
Operating lease payments are recognised as expenses during the lease period, using the linear method.

Risk reserve

The risk reserve of the EHIF budget is a reserve governed by § 39¹ of the Estonian Health Insurance Fund Act as follows:

- The risk reserve of the Health Insurance Fund is the reserve formed from the budgetary funds of the Health Insurance Fund in order to minimise the risks arising for the health insurance system from the obligations assumed.
- The risk reserve equals 2 percent of the health insurance budget of the EHIF.
- The funds of the risk reserve may be used upon a decision of the supervisory board of the Health Insurance Fund.

The health insurance fund has the obligation to establish a risk reserve as of 1 October 2002 with regard to the entry into force of the new Health Insurance Act. The said Act amended the Estonian Health Insurance Act by adding § 39¹ to it.
The amount transferred to the risk reserve shall be specified with the decision of the supervisory board after the approval of the audited annual report.

Legal reserve

The legal reserve formation is governed by § 38 of the Estonian Health Insurance Fund Act as follows:

- The legal reserve of the health insurance fund means the reserve formed of the budget funds of the health insurance fund for the reduction of the risk which macro-economic changes may cause to the health insurance system.
- The legal reserve shall amount to 6% of the budget. Each year, at least one-fiftieth of the total budget of the health insurance fund and revenue from the social tax revenue prescribed for the payment of health insurance benefits which is higher than prescribed in the state budget shall be transferred to the legal reserve, until the amount of the legal reserve provided by this Act is reached or restored.
- The legal reserve may only be used as an exception by an order of the Government of the Republic on the proposal of the Minister of Social Affairs. Prior to submitting a proposal to the Government of the Republic, the Minister of Social Affairs shall hear the opinion of the Supervisory Board of the Health Insurance Fund.

Pursuant to the decision of the EHIF Supervisory Board, 70 million kroons from the legal reserve will be utilised in 2005.
The amount transferred to the legal reserve shall be specified with the decision of the supervisory board after the approval of the audited annual report.

Events following the balance sheet date

The Annual Accounts include significant circumstances affecting the assessment of assets and liabilities, which were identified between 31 December 2005, the date of the balance sheet, and the date when the report was prepared, but are related to the transactions carried out in the accounting period or previous periods.
Events following the balance sheet date that were not taken into account in the assessment of assets and liabilities but significantly affect the result of the next financial year, are published in the notes to Annual Accounts.

Note 2. Cash and bank accounts

	31.12.2004	31.12.2005
Deposits at call	22 103 852	38 289 030
Fixed term deposits	372 000 000	381 586 560
Total cash and bank accounts	394 103 852	419 875 590
Fixed term deposits:		
due within 1 month	260 000 000	241 586 560
due within 1 to 3 months	112 000 000	140 000 000
Total	**372 000 000**	**381 586 560**

Note 3. Shares and other securities

1.Short-term investments

Bond	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Just value	Rate of return
Bond of Kommunalkredit	15.07.2005	16.01.2006	EUR	61 905 610	62 518 744	2.14%
Bond of BFCM	15.09.2005	17.01.2006	EUR	108 725 892	109 400 905	2.14%
Bond of Barclays	31.10.2005	31.01.2006	EUR	46 674 997	46 840 898	2.22%
Bond of the Government of Belgium	14.11.2005	16.02.2006	EUR	63 781 010	63 978 362	2.22%
Bond of ANZ Bank	23.02.2005	7.03.2006	EUR	48 249 420	49 119 713	2.33%
Bond of SEB Eesti Ühispank	1.04.2005	31.03.2006	EEK	20 472 165	20 863 868	2.55%
Bond of Sampo Pank	14.04.2005	13.04.2006	EEK	36 062 901	36 724 833	2.57%
Bond of Kommunalkredit	23.12.2005	24.04.2006	EUR	31 024 049	31 042 785	2.56%
Bond of Sampo Pank	16.06.2005	16.06.2006	EEK	16 579 743	16 787 155	2.50%
Bond of the Government of Finland	17.10.2005	4.07.2006	EUR	47 104 559	47 615 710	2.20%
Bond of Siemens	17.11.2005	4.07.2006	EUR	47 639 203	48 647 201	2.51%
Bond of Sampo Pank	5.09.2005	5.09.2006	EEK	21 710 705	21 835 614	2.45%
Bond of Hansapank	19.10.2004	19.10.2009	EUR	31 278 179	31 587 980	2.41%
Bond of General Electric KP	10.05.2004	4.05.2011	EUR	15 602 790	15 712 714	2.24%
Bond of Citigroup	3.11.2004	3.06.2011	EUR	24 974 477	25 104 833	2.34%
Bond of General Electric KP	28.01.2005	28.07.2014	EUR	31 208 708	31 554 012	2.37%
Bond of Barclay	23.11.2005	23.11.2015	EUR	7 795 918	7 818 929	2.92%
Bond of SEB Eesti Ühispank	1.04.2005	31.03.2006	EEK	38 019 735	38 747 132	2.55%
Bond of Sampo Pank	14.04.2005	13.04.2006	EEK	32 164 209	32 754 617	2.57%
Bond of the Post Bank of Germany	8.11.2005	20.04.2006	EUR	48 025 166	49 201 601	2.35%
Bond of Sampo Pank	16.06.2005	16.06.2006	EEK	17 116 146	17 330 312	2.50%
Bond of the Government of Belgium	8.11.2005	14.09.2006	EUR	33 715 570	33 798 796	2.44%
Bond of the Government of the Netherlands	7.12.2005	29.09.2006	EUR	30 651 547	30 692 353	2.55%
Bond of the Government of Belgium	7.12.2005	16.11.2006	EUR	45 807 430	45 859 952	2.59%
Total				**906 290 129**	**915 539 019**	

Interest as of 31 December 2005 is also reflected in the just value of the securities. The revenue and expenditure of the revaluation are reflected in the statement of revenue and expenditure. Bonds maturing in 2006 and bonds acquired for the purpose of contributing to the risk reserve, which, in the opinion of the EHIF, shall probably be redeemed in 2006 are recognised as short-term investments.

2. Long-term investments

The Estonian Health Insurance Fund has acquired shares with the following nominal values:

Shares of AS Viimsi Haigla (at cost)

	2004	2005
Balance at the beginning of year	90 000	90 000
Balance at the end of year	90 000	90 000

The Estonian Health Insurance Fund owns less than 20 % of the shares of mentioned companies.

The Estonian Health Insurance Fund has acquired long maturity bonds as follows:

Bond	Date of acquisition	Maturity date	Underlying currency	Acquisition cost	Just value	Return rate
Bond of the Government of Italy	17.01.2005	1.06.2007	EUR	36 345 612	36 181 743	2.58%
Bond of KFW	29.03.2005	20.06.2007	EUR	46 931 351	47 455 235	2.64%
Bond of the Government of Germany	17.11.2004	17.08.2007	EUR	32 860 989	32 650 821	2.58%
Bond of Rabobank	15.07.2005	15.07.2015	EUR	31 074 148	26 331 676	6.65%
Bond of KFW	5.08.2005	17.05.2016	EUR	15 411 901	15 061 208	3.25%
European Investment Bank KP	6.06.2005	24.03.2020	EUR	16 966 860	16 578 652	3.14%
European Investment Bank KP	22.06.2005	22.06.2020	EUR	15 513 604	698 050	6.48%
Total				**195 104 465**	**188 957 385**	

The coupon payments of long-term investments are reflected in the just value of the securities.

Note 4. Other short-term receivables

Other short-term receivables

Essence	31.12.2004	31.12.2005
Claim to the Russian Federation	3 344 237	0
Claim to Tallinn Social Welfare and Health Care Department (Tallinn Diagnostic Centre)	9 541 194	9 541 194
Short-term part of loans granted (See Note 8)	6 763 042	5 252 206
Claims for reimbursement of maintenance costs	103 719	199 628
Contractual claims against insured persons	191 245	152 897
Allowance for doubtful receivables	- 53 379	- 25 524
Total	**19 890 058**	**15 120 401**

Note 5. Other accrued income

Other accrued income in the sum of EEK 752 805 238 (EEK 618 974,027 as of 31.12.2004) includes health insurance income from social tax paid by tax-payers, but not transferred by the Estonian Tax and Customs Board.

Note 6. Inventories

As of 31.12.2005, the Estonian Health Insurance Fund has in stock unused prescription forms costing EEK 323 023 (EEK 102,059 as of 31.12.2004).

Note 7. Miscellaneous long-term receivables

	31.12.2004	31.12.2005
Long-term part of loans granted to health care institutions by the EHIF (see Note 8)	13 582 375	8 330 168
Long-term tax claim against the Tax and Customs Board	254 823	120 745
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and the Rapla Office	5 866 664	5 810 497
Total	**19 703 862**	**14 261 410**

Note 8. Loans granted by the Estonian Health Insurance Fund

As of 31.12.2004

Health care institution	Loan balance as of 31.12.2004	incl. the short-term part of the loan	incl. the long-term part of the loan	Balance of unpaid interest as of 31.12.2004
SA Põhja-Eesti Regionaalhaigla	18 280 168	5 400 000	12 880 168	0
incl. under previous contracts				
Mustamäe Hospital	9 433 500	3 600 000	5 833 500	0
Estonian Oncological Centre	8 846 668	1 800 000	7 046 668	0
AS Ida-Tallinna Keskhaigla	2 065 249	1 363 043	702 206	171 000
Total	**20 345 417**	**6 763 043**	**13 582 374**	**171 000**

As of 31.12.2005

Health care institution	Loan balance as of 31.12.2005	incl. the short-term part of the loan	incl. the long-term part of the loan	Balance of unpaid interest as of 31.12.2005
SA Põhja-Eesti Regionaalhaigla	12 880 168	4 550 000	8 330 168	0
incl. under previous contracts				
Mustamäe Hospital	5 833 500	2 750 000	3 083 500	0
Estonian Oncological Centre	7 046 668	1 800 000	5 246 668	0
AS Ida-Tallinna Keskhaigla	702 206	702 206	-	0
Total	**13 582 374**	**5 252 206**	**8 330 168**	**0**

Note 9. Fixed assets

Tangible fixed assets

Fixed assets group	Land and buildings	Machinery and equipment	Other inventories	Total
Acquisition cost				
31.12.2004	2 995 841	7 653 338	13 150 525	23 799 704
Purchase of fixed assets	585 139	498 949	3 160 266	4 244 354
Written off	0	- 482 964	- 2 604 856	- 3 087 820
31.12.2005	3 580 980	7 669 323	13 705 935	24 956 238
Accumulated depreciation				
31.12.2004	2 005 185	4 194 847	9 293 601	15 493 633
Calculated depreciation	152 231	1 043 368	2 801 773	3 997 372
Written off	0	- 480 729	- 2 594 248	- 3 074 977
31.12.2005	2 157 416	4 757 486	9 501 126	16 416 028
Residual value				
31.12.2004	990 656	3 458 491	3 856 924	8 306 071
31.12.2005	1 423 564	2 911 837	4 204 809	8 540 210

Intangible fixed assets

Fixed assets group	Purchased licences
Acquisition cost	
31.12.2004	7 627 311
31.12.2005	7 627 311
Accumulated depreciation	
31.12.2004	6 397 140
Calculated depreciation	498 755
31.12.2005	6 895 895
Residual value	
31.12.2004	1 230 171
31.12.2005	731 416

Note 10. Leased assets

Financial lease

The following table contains information on the servers leased under current financial lease contracts.

Type of fixed asset	Other inventories	Other inventories
Final date of the contract period	1.01.2006	15.07.2006
Average interest rate	5.35%	5.30%
Acquisition cost of assets	6 849 960	205 320
Accumulated depreciation	6 849 960	159 693
Depreciation calculated for the accounting year	1 569 782	68 440
Lease payments in the accounting year	1 806 857	62 787
Interest calculated for the accounting year	52 788	4 929
Balance of liability as of 31.12.2005. incl.	154 969	46 611
repayments during the next accounting year (without interest)	154 969	38 189

Operating lease

The revenue and expenditure account includes operating lease payments in the total amount of 6,731,914 kroons, whereof 472,091 kroons were paid for the lease of means of transport and 1,119,632 kroons for the operating lease of computer equipment; 5,140,191 kroons were paid for leased rooms.
Total amount of payments for operating lease in 2006was 5,735,511 kroons.

Note 11. Taxes payable

Tax	31.12.2004 Taxes payable	31.12.2005 Taxes payable
Income tax	27 636 215	25 833 109
Social tax	3 363 265	3 596 648
Turnover tax	29 898	0
Income tax from fringe benefits	51 039	61 646
Unemployment insurance premium	96 597	81 549
Mandatory funded pension premiums	54 792	63 853
Total	**31 231 806**	**29 636 805**

The individual income tax arrears include individual income tax in the amount of 24,657,323 kroons deducted from the benefits for incapacity for work paid by the Health Insurance Fund to the insured. The social tax arrears include social tax in the amount of 659,693 kroons calculated from the holiday pay not disbursed to the employees

Note 12. Revenue from principal activity (thousand EEK)

Revenue from principal activity	2004	2005
Health insurance part of social tax	6 276 577 865	7 277 545 334
Amounts due from other persons	11 005 379	10 072 594
Total	**6 287 583 244**	**7 287 617 928**

Note 13. Health insurance benefits expenditure

Health insurance benefits expenditure	2004	2005
Health service benefits, incl.	4 131 054 763	4 716 814 386
Disease prevention	60 479 775	74 436 041
General medical care	491 660 720	592 154 682
Specialised medical care	3 278 046 757	3 752 783 654
Long-term nursing care	57 415 968	113 920 180
Dental care	243 451 543	183 519 829
Health promotion expenses	13 480 490	8 563 460
Expenditure on benefits for medicinal products, incl.	794 243 625	871 762 121
centrally acquired medicinal products	3 847 928	4 171 554
Expenditure on benefits for temporary incapacity for work	1 101 979 611	1 265 063 398
Other monetary benefits	72 437 016	79 760 815
Other expenditure on health insurance benefits	23 793 911	41 787 863
Health service benefits arising from international agreements	659 197	15 316 807
Benefit for medical devices	23 134 714	26 471 056
Total expenditure on health insurance benefits	**6 136 989 416**	**6 983 752 043**

Note 14. General administrative expenditure

General administrative expenditure	2004	2005
Personnel and administrative expenditure	44 772 187	49 140 568
remuneration	33 544 307	36 827 186
incl. remuneration of the members of the Management Board	1 698 504	1 763 537
incl. remuneration of the members of the Supervisory Board	2 896	1 916
unemployment insurance premium	158 225	160 309
social tax	11 069 655	12 153 073
Management costs	16 235 941	16 791 617
Information technology costs	9 096 303	12 610 788
Development costs	4 169 210	3 777 645
Total general administrative expenditure	**74 273 641**	**82 320 618**

Note 15. Transactions with related parties

Related parties include the Members of the Management Board and of the Supervisory Board as well as businesses connected with them. No transactions have been made with the Members of the Management Board and of the Supervisory Board or with businesses connected with them. Remuneration paid to the Members of the Management Board and of the Supervisory Board in 2005 is indicated in Note 14.

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the annual report for the financial year 2005.
The annual report of 2005, which comprises the management report, notes to the implementation of the budget and the annual accounts, and to which the auditor's report and the net surplus distribution proposal are annexed, has been examined and approved by the Supervisory Board of the Estonian Health Insurance Fund.

		Date	Signature
Management Board:			
Chairman of the Management Board	**Hannes Danilov**	.....	.....
Member of the Management Board	**Arvi Vask**	.....	.....
Member of the Management Board	**Maigi Pärnik-Pernik**	.....	.....
Member of the Management Board	**Eliko Pedastsaar**	.....	.....

Supervisory Board:

	Date	Signature
Jaak Aab	.....	.....
Aivar Sõerd	.....	.....
Mai Treial	.....	.....
Tõnis Kõiv	.....	.....
Peeter Laasik	.....	.....
Ene Tomberg	.....	.....
Valdek Mikkal	.....	.....
Senta Michelson	.....	.....
Harri Taliga	.....	.....
Peeter Ross	.....	.....
Toomas Annus	.....	.....
Tarmo Kriis	.....	.....
Oliver Kruuda	.....	.....
Sandor Liive	.....	.....
Mati Jostov	.....	.....