Eesti Haigekassa
Estonian Health Insurance Fund

Estonian Health Insurance Fund Annual Report 2004

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Principal activity	Public health insurance
Management Board	Hannes Danilov (Chairman) Arvi Vask Maigi Pärnik-Pernik
Auditor	KPMG Estonia
Annexed documents:	Auditor's Report

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Relevant statistics 2002-2004

Table 1. Summary of major indicators from 2002 to 2004

	2002	2003	2004	2004/2003 (%)
Number of the insured	1,284,076	1,272,051	1,271,558	-0.04 %
Revenue (in EEK thousand)	5,099,324	5,690,137	6,350,129	11.60 %
Expenditure on health insurance benefits (in EEK thousand)	4,647,939	5,292,194	6,136,989	15.96 %
Operating expenses (in EEK thousand)	82,953	86,625	80,112	-7.52 %
Insured who received specialised medical care (persons)	919,470	914,611	917,275	0.29 %
Average duration of treatment (days)	7.2	6.8	6.6	-2.94 %
Emergency care as a percentage of expenditure on specialised medical care:				
- outpatient	14.4	13.9	15.0	7.91 %
- inpatient	56.4	56.6	60.0	6.01 %
Average cost per case in specialized medical care (EEK)				
- outpatient	275	346	409	18.21 %
- inpatient	6,264	7.566	8,701	15.00 %
Number of prescriptions	4,050,231	4,012,989	4,775,221	18.99 %
Average prescription cost for the EHIF	180.6	171.2	180.0	5.14 %
Days of incapacity covered by insurance	6 411 107	6 717 278	7 321 490	8.99 %
Cost of incapacity benefit per day	128	138	151	9.42 %

Corporate overview

The Health Insurance Act took effect in Estonia in 1992 and 22 sickness funds were set up in the counties and in the cities subordinated to central government. As a result of the administrative reform undertaken in Estonia, a two-tier administrative system was set up – the state and the local government. This conditioned the centralization of the health insurance system in 1994 and the foundation of the Central Health Insurance Fund, whose function was to provide compulsory health insurance coverage through its regional departments.

The Estonian Health Insurance Fund (EHIF) is a legal person governed by public law. Established in 2001, the EHIF provides public health insurance and medical benefits for the insured. Another function of the EHIF is to promote the development of the national standard of treatment and the clinical practice guidelines, and to encourage health care institutions to enhance the quality of medical services. Further, the EHIF is to arrange for the execution of international agreements concerning health insurance and the health insurance fund, participate in planning for health care, give opinion on draft legislation and proposed international agreements relating to the EHIF and health insurance and to advise on health insurance issues.

The goals, functions, competence and principles of activity, as well as the structure of the EHIF are established by law.

Corporate Structure

The highest body of the EHIF is the Supervisory Board comprised of 15 members, of whom 5 represent employers, 5 represent insured persons and 5 represent the Government. The EHIF is governed by a 3-member Management Board. The structure of the EHIF has been altered several times since 1992. In 2001, seven of the 17 regional departments were retained and the latest structural change of 2003 reduced the number of departments to 4.

The Harju Department services the insured in Tallinn and the Harju County.
The Pärnu Department, along with the local offices in Kuressaare, Kärdla, Haapsalu and Rapla, services the insured of the Counties of Pärnu, Saare, Hiiu, Lääne, Rapla respectively.
The Tartu Department, along with the local offices in Jõgeva, Viljandi, Valga, Põlva and Võru, services the insured in the Counties of Tartu, Jõgeva, Viljandi, Valga, Põlva and Võru respectively.
The Viru Department, along with its offices in Paide, Rakvere and Narva, services the insured in the Counties of Järva, Lääne-Viru and Ida-Viru.

As of 1 January 2004, the EHIF employed 251 employees in its 256.5 job positions, 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, 2004.

Education		Length of service		Age	
Secondary vocational	22.3%	Up to 1 year	17.2%	Aged 22-30	16.3%
Secondary	21.5%	Up to 3 years	33.9%	Aged 31-40	25.9%
Higher	56.2%	Up to 5 years	8.8%	Aged 41-50	25.1%
		Over 5 years	40.1%	Aged 51-65	32.7%

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.
In September 2004, the EHIF as a public sector entity representing Estonia made a presentation at the 4th Quality Conference for Public Administrations in the EU in Rotterdam. For the second 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.

Our mission

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

Our 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.

Our 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

2004 was a year of development for the Estonian Health Insurance Fund. Accession to the European Union made a great difference. We introduced the common European Health Insurance Card that entitles the Estonian insured to needed medical care while travelling or working in a member state of the European Union.

The opening of the European labour market brought about the demand for a wage increase in the health professions, leading to the setting of minimum hourly wage rate for physicians at EEK 75 by 2007. In order to more precisely determine the proportion of wages in health care costs, the EHIF together with health care institutions prepared a list of services using activity-based costing. It was an extremely extensive work. Although the Supervisory Board did not approve the list in 2004, we continue our activity during 2005. I am certain that we can introduce activity-based prices already in the near future.

Last year we started the long-prepared process of reforming the basis for funding public hospitals. Diagnosis-specific funding for hospital-based care was introduced within 10 percent, with a view to replacing fee-for-service or service-based funding.
Diagnosis-specific funding will help control the costs and make the health care institutions focus more on the results. In the light of increased demand for health services, most European countries face growing waiting lists. It is the diagnosis-specific funding that is regarded as a useful tool for controlling resource utilization across groups of patients with the same principal diagnosis (diagnosis-related groups, DRG), at the same time motivating public hospitals to increase the hospital's case-mix.

In 2004 we started the systematic monitoring of waiting lists in health care institutions and since September we have been publishing the data about waiting lists on our web page. It appeared that the main reason for waiting lists in the big hospitals of Tallinn and Tartu is the shortage of physicians or necessary operating rooms, not the shortage of funds allocated by the EHIF. In the county hospitals, however, there is no considerable waiting time for patients.

The EHIF has been steadfastly dedicated to improving the system of making and monitoring contracts with health care institutions. The contract discipline is excellent. The contracts for specialised medical services were funded for a total cost of EEK 3.24 billion or for nearly 100 percent.

In 2003 we started preparations for the 3-year revenue and cost projections and in 2004 we substantially improved the quality of data making the grounds for the forecast. To date, the 3-year forecast is the basis for preparing annual budgets.

2004 was a year of development and adjustment to the new regional structure for the whole of our organisation because from 1 January 2004 the number of regional departments was reduced from seven to four.

I want to thank everyone whose support and contribution have helped us manage those great changes.

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

Annual Report 2004

This report is composed of three parts:

- The management report on the implementation of the 2004-2006 development plan and the 2004 scorecard in terms of the set objectives;
- The analysis of the utilization of medical benefits and notes to budget implementation;
- The annual financial statements for the year ended 31 December 2004.

Executive summary

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 2004-2006 development plan and the 2004 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 delegate the objectives to structural units and management levels in a clear and measurable manner.
Below is a summary evaluation of the implementation of the development plan and the balanced scorecard in 2004. The EHIF scorecard covered all the measurable objectives specified in the development plan. Overall, the EHIF achieved 91 percent of the objectives listed on its 2004 scorecard.
The main outcomes of strategic objectives in 2004 are presented below, whereas a more detailed overview of the accomplishment of key tasks is provided after this summary and Table 3.

1. Satisfaction and awareness of insured persons of their rights and responsibilities – achievement rate was 91 percent.
2. Access to and quality of health services – achievement rate was 94 percent.
3. Balance between the resources and health insurance benefits and the purposeful use of benefits – achievement rate was 78 percent.
4. Quality of customer service in the EHIF – achievement rate was 100 percent.
5. Corporate governance and efficient and effective business processes – achievement rate was 90 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, 2003-2004

Objective	Performance measure	Weighting **	Unit of measure	2003 outturn	2004 target	2004 outturn	Perform-ance level %
1. Satisfaction and awareness of the insured of their rights and responsibilities		15%					91%
1.1.	Satisfaction of the insured with health insurance coverage *		%	66	75	65	87
1.2.	Awareness of the insured of their rights		%	61	70	66	94
2. Access to and quality of health care services		30%					94%
2.1.	Approved treatment instructions		piece	6	6	6	100
2.2.	Inspected cases		piece	14,186	10,000	10,243	100
2.3.	Quality of contract execution		rating		Good	Good	100
2.4.	Clinical audits		piece	4	5	5	100
2.5.	Coinsurance of the insured on covered prescription drugs		%		32	36	88
2.6.	Insured having access to primary medical care within established time limits		%	100	97	98	100
2.7.	Insured having access to specialised medical care within established time limits		%	98	97	99.9	100
2.8.	Length of waiting time (should not exceed 3 weeks in outpatient specialized medical care for financial reasons)		%		100	64	64
3. Balance between the resources and benefits and the purposeful use of benefits		25%					79%
3.1.	Budget/expenditure on health insurance benefits by type of benefit and in total		rating	Good	Good	Good	100
3.2.	Opinion of the Auditor General / Auditor on the purposeful activity and resource utilization			Un-qualified	Un-qualified	Un-qualified	100
3.3.	Percentage of inpatient medical services reimbursed through diagnosis-specific funding		%	Listing of prices	10	10	100
3.4.	Health insurance benefits in specialized, nursing and dental care purchased through a competitive process		%	20	20	19	95
3.5.	Quality of needs assessment		rating	0	Good	-	0
4. Quality of customer service in the EHIF		15%					100%
4.1.	Satisfaction of the insured with the level of service		%	82	80	84	100
4.2.	Satisfaction of employers with the level of service		%	95	85	96	100
4.3.	Satisfaction of related parties with the level of service		%	78.2	80	79.6	99.5
5. Corporate governance and efficient and effective business processes		15%					90%
5.1.	Staff competence		%	98	100	93	93
5.2.	Staff satisfaction		rating	2.5	4	3.24	81
5.3.	Change in the cost of core processes		%	50	50	50	100
5.4.	Transactions via electronic channels		%	6	90	78	87
	TOTAL	**100%**					**91%**

* Attainment rate for 2003 has been adjusted for comparability.

** The weights of measures are even.

Objective 1: Satisfaction and awareness of the insured of their rights and responsibilities

In September-October 2004, the public opinion research company Factum conducted a survey among Estonian inhabitants to find out people's evaluation of health services and their satisfaction with the medical care received. The sample comprised 1000 inhabitants aged 15-74 years. The purpose of the survey was to find out about:

- Evaluation of the population of their health and attitude to healthy lifestyles;
- Experience with medical care, evaluation of its accessibility and satisfaction with:
  - primary care
  - outpatient specialized medical care
  - inpatient specialized medical care;
- Awareness of entitlement to different public health services;
- Health care system evaluation, incl. satisfaction with the EHIF.

1.1. Satisfaction of the insured with the health insurance coverage

The target for 2004 was to achieve a satisfaction rate of at least 75 percent. The actual achievement was 65 percent. Thus the performance level was 87 percent.

Table 4. Satisfaction of the insured with different components of the health system (very satisfied and satisfied evaluations were added together as a single result)

Component	2001	2002	2003	2004
General medical care	79 %	87 %	88 %	87 %
Specialized medical care	87 %	86 %	91 %	87 %
Access to services	56 %	50 %	52 %	52 %
Quality of services	70 %	62 %	56 %	59 %
Range of services		43 %	44 %	41 %
Average	**73 %**	**65.6 %**	**66.2%**	**65.2%**

1.2. Awareness of the insured of their rights

The target for 2004 was a situation where 70 percent of the insured know their rights and responsibilities. A survey conducted by Factum showed that 66 percent of respondents knew their rights well. Thus the target was met within 94 percent.

Table 5. Topics covered by the survey

	2003	2004
General medical care	73.6 %	75 %
Specialized medical care	35.6 %	58.7 %
Cash benefits	52.7 %	56.6 %
Prescription drug coverage	69.5 %	59 %
Scope of insurance cover	71 %	81 %
Total level of awareness	**60.5 %**	**66 %**

In order to raise the awareness of the insured, the EHIF prepared the following information materials:

- The Estonian Health Insurance Fund Gazette, 2nd edition, circulated as a supplement to the daily Eesti Päevaleht
- Medical devices and benefits
- Flyer to expectant mothers and young parents
- Procedure for the calculation and payment of benefits for incapacity for work
- In-vitro fertilization
- Dental benefits
- Rights and responsibilities of the self-employed (3rd print)
- Entitlement to health services in the European Union.

The EHIF notified regularly and in advance of all amendments to the Health Insurance Act and other legal acts through different media channels: national newspapers, local newspapers, special publications, also via electronic media channels. Changes in pharmaceutical prices over the last three years and their potential implications, as well as the principles for the choice of contractual partners were thoroughly explained to the public.
A more serious interest was taken in the issue of waiting lists in September 2004, when we first reported on the EHIF homepage the waiting lists for specialized medical services in hospitals included in the hospitals network development plan. Increased attention to the prevention programmes funded by the EHIF as well as all other health promotion activities became evident.

Objective 2: Access to and quality of health care services

2.1. Approved treatment instructions

The target for 2004 was to get approval of 6 treatment instructions. During 2004, the EHIF indeed approved 6 treatment instructions.
The EHIF arranges for the development of clinical guidelines by professional medical associations in order to promote best clinical practices with optimal use of resources.

The EHIF signed memoranda of approval for the following treatment instructions:

- "Instruction for the treatment of rheumatoid arthritis" with the Estonian Society for Rheumatology,
- "Instruction for the treatment of acute pancreatitis" with the Estonian Association of Surgeons,
- "Instructions for dental treatment in children" with the Estonian Society of Stomatology,
- "Guidelines on health care in schools" with the Estonian Nurses Association,
- "Instruction for the treatment of insult" with the Puusepp Society of Neurology and Neurosurgery,
- "Guidelines on home care" with the Estonian Nurses Association.

2.2. Cases inspected in health care institutions

The target for 2004 was to inspect 10,000 treated cases. The purpose of inspection of treatment records is to ensure that the utilization of medical benefits is accurate and justified.
In 2004, all in all 10,243 cases were inspected and on the basis of medical records, the following was examined:

- the diagnosis and treatment patterns for the gallstone disease in inpatient specialised medical care and the diagnosis and treatment patterns for peptic ulcer in family practice;
- compliance of the prescription of orthoses with the law;
- the diagnosis and treatment patterns for hypertension at different levels of medical care;
- certain cases for the prescription of specific drugs (statins, granisetron);
- follow-up on the clinical audit in general surgery.

As a result of the inspection of treatment records, a claim for EEK 449,579 has been made on medical care providers.

2.3. Quality of contract execution

The target for 2004 was the execution of contracts with health care institutions for the rating of "good". In pursuing this objective, we set ourselves the task to inspect how waiting lists are maintained in hospitals covered by the hospitals network development plan.

In the first half of 2004, the EHIF inspected all hospitals included in the hospitals network development plan in respect of waiting lists. In case of shortcomings, written proposals were submitted to the hospital operator and terms were set for the elimination of the said shortcomings. In the second half of the year, we inspected how proposals were implemented. All hospitals covered by the hospitals network development plan maintain waiting lists in compliance with legislation.

2.4. Completed clinical audits

The target for 2004 was to perform 5 clinical audits. The EHIF conducts clinical audits in order to inspect the quality and purpose of services funded partially or fully by the EHIF. The motivation of service providers, through feedback from audits, to offer a better-quality service is an essential goal for the EHIF. The subjects of clinical audits under consideration were proposed by the regional departments of the EHIF and by professional medical associations.

The following clinical audits were performed:

- "Practicability of antimicrobial therapy for urinary tract infections and the quality of diagnostic tactics", by M.D. P. Naaber;
- "Practicability of treatment tactics in the intensive care units of regional hospitals and the accuracy and quality of TISS-scoring (Therapeutic Intervention Scoring System) according to the health services delivered", by Asst. Prof. J. Samarüütel;
- "Communication audit: provision of medical services in Estonian central hospitals in line with expected care", by T. Truusa and K. Kirspuu;
- "Practicability of using broad-spectrum antibiotics in family practice", by M.D. P. Naaber;
- "Comparative analysis of the dental decay (caries) in the primary and permanent dentition, endodontic and paradontological treatment and cost of such treatment for the insured under 19 years of age, 2nd part", by Dr. S. Russak.

2.5. Coinsurance of the insured on covered prescription drugs

The target for 2004 was to set the patient coinsurance rate for covered prescription drugs at 32 percent. According to the Health Insurance Act, the minimum co-payment is EEK 20 (for covered drugs reimbursed at 100 %, 90 % and 75 %) or EEK 50 (for covered drugs reimbursed at 50 %) per prescription. The EHIF does not assume an obligation to pay for the amount in the cost of drugs exceeding the reference price or the price provided for in the price agreement.

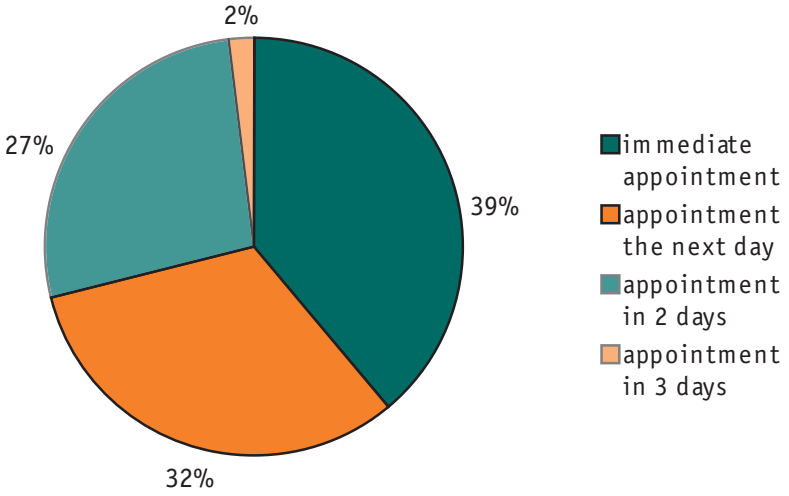
Mention should be made of significant variation in the coinsurance amounts with respect to drug reimbursement rates. In 2004, in case of drugs reimbursed at 100 percent, an insured person paid on average 4 percent of the drug cost, but in case of drugs reimbursed at 50 percent, the patient coinsurance rate was 66 percent. The rather big contribution of a patient in the latter case can be explained by a limitation in the regulation, which stipulates that the amount exceeding the minimum co-payment is subject to reimbursement by the EHIF within 50 percent to a maximum of EEK 200 per prescription. In case of drugs reimbursed at 75 percent, the average coinsurance rate was 37 percent and in case of the reimbursement rate of 90 percent, the average co-insurance rate was 27 percent of the prescription drug cost.

In case of drugs reimbursed at 50 %, 75 %, 90 % and 100 %, the coinsurance amount of the insured represented 36 percent of the cost of the covered drugs in 2004.

2.6. Insured having access to primary medical care within established time limits

The target for 2004 was a timely appointment with the primary care physician of 97 percent of the insured. According to the services contract concluded between the EHIF and the family physicians, the primary care physician must be accessible on the same day for a patient with an acute condition and within three workdays for a patient with a chronic disease. In 2004, 98 percent of the insured with a chronic disease could see their family physician within the prescribed three workdays.

Chart 1. Insured having access to primary care within established time limits, 2004.



2.7. Insured having access to specialized medical care within established time limits

The target for 2004 was to achieve that 97 percent of the insured have a timely appointment with a specialist doctor during his/her regular reception hours. According to the waiting list data supplied by health care institutions, the accessibility of both outpatient and inpatient specialized medical care was 99.9 percent, on the grounds of resources available.

Table 6 shows the outcome for 2004 by quarters. All indicators relate to the waiting lists caused by the shortage of financial resources.

Table 6. Access to specialized medical care. Patients waiting beyond the maximum length of the waiting list[1] because of insufficient financial resources [1] (per 1000 insured)

	Outpatient				Inpatient			
Dept.	1st Qrt	2nd Qrt	3rd Qrt	4th Qrt	1st Qrt	2nd Qrt	3rd Qrt	4th Qrt
Harju	4.9	0.3	1.1	1.5	0.7	0.1	0.1	0.1
Pärnu	0.0	0.6	0.7	0.2	0.0	0.4	0.5	0.1
Tartu	6.6	4.3	0.3	0.2	0.0	3.0	0.1	0.5
Viru	7.5	0.3	2.4	0.1	0.0	0.1	0.0	0.0
Total	**5.2**	**1.4**	**1.1**	**0.7**	**0.3**	**0.9**	**0.2**	**0.2**

The EHIF will negotiate with health care providers about improved accessibility to health services within the available budget resources, if the reason for waiting lists is the volume of funding provided by the EHIF.

[1] The maximum length of the waiting list – the maximum length of waiting time for an appointment with a doctor in specialized medical care, day surgery, dental and nursing care, as established by the Supervisory Board of the Estonian Health Insurance Fund.

2.8. Length of patient waiting time

We set ourselves the target to publish on our Internet homepage the data about our contractual partners along with information about offered specialties, location of service delivery and length of waiting time in each specialty. Such publicity of patient waiting lists should allow for the general public to better understand the length of waiting time and give the insured a better picture of the length of waiting lists across the same specialty in different hospitals. Hence, the insured can choose a service provider whose waiting list is shortest.

The EHIF has been publishing information about the length of waiting lists in hospitals covered by the hospitals framework development plan on its web page since 16 September 2004. The data are presented separately for specialties in outpatient and inpatient medical care by our contractual partners in regional departments. The data are updated on the 16th day of each month.

Objective 3: Balance between the EHIF resources and benefits and the purposeful use of benefits

3.1. The budget/ expenditure on health insurance benefits

The target was to cater for the therapy needs of the insured within the budgetary resources of the EHIF, by ensuring access to health care services within the maximum time limits established by the Supervisory Board of the EHIF, by maintaining the balance of the budget and the purposeful resource use to the rating of "good". We implemented 99.5 percent of the 2004 health services budget in terms of expenditure, and 99.9 percent of the budget for specialized medical care. Treatment caseload has increased by 1 percent compared with 2003. According to the waiting lists data reported by health care institutions, the accessibility of both outpatient and inpatient specialized medical care is 99.9 percent on the grounds of resource availability. Thus the objective has been achieved for the rating of "good".

3.2. Opinion of the Auditor General / Auditor

The target was to receive an unqualified audit opinion of the Auditor General or an auditor on the purposeful activity and resource utilisation by the EHIF. KPMG, the auditing company for the EHIF, audited the financial statements for 2003 and performed an interim audit of the 2004 financial statements in autumn. The final and interim audits by KPMG were without qualification in 2004.

The State Audit Office conducted two audits in 2004: accessibility of ophthalmological services and procedure for the conclusion of contracts on specialized medical care in the EHIF. In the former case, the SAO proposed to exercise better control of the data on waiting lists supplied by health care institutions. In the latter case, it was recommended to elaborate the procedures for making amendments to the contracts on specialized medical care and to refine the criteria for processing applications for medical services.

3.3. Percentage of inpatient medical services reimbursed through diagnosis-specific funding

The target was to apply, from 1 April 2004, the DRG-based payment within 10 percent of funding for inpatient specialized medical care and day surgery, i.e. 10 percent of treatment costs are financed using DRG-based pricing and 90 percent of costs are reimbursed through service-based funding. Introduction of DRG-specific prices is aimed at motivating health care institutions to use resources more efficiently. The logic underlying the DRG-based payment method is that patients who are expected to receive similar treatment and consume equivalent hospital resources are grouped together for billing purposes and the hospital is then paid a flat fee for the DRG or a DRG price. This payment represents the average cost of treatment for a patient within each particular diagnosis-related group. When the current system of service-based funding encourages the provision of services, the DRG-based system motivates health care institutions for a more efficient resource use. DRG-based payment is not effected for charges for primary follow-up care, psychiatric and rehabilitation treatment and in cases where the amount claimed for service-based care exceeds the bill subject to payment under DRG-based pricing.

3.4. Health insurance benefits purchased through a competitive process

The target for 2004 was to achieve that health services purchased through a competitive process would constitute 100 percent of dental services and at least 20 percent of home nursing services and community-based specialized medical services. The Health Insurance Act provides for solicitation of contract proposals to select service providers. The outcome of competitive process by regional departments was as follows:

- Competitive bidding was carried out in all regional departments of the EHIF and funds were awarded within 100 percent for the delivery of dental treatment, preventative care and orthodontia for the insured under age 19.
- Treatment services in community-based specialized medical care and home nursing subject to competition and funding granted by the EHIF accounted for the following percentage of the total caseload planned for 2004:
  - 15 % in the Harju Dept.
  - 22 % in the Tartu Dept.
  - 24 % in the Viru Dept.
  - 15 % in the Pärnu Dept.
  - 19 % in Estonia as a whole.

Variations in the percentage of funded services by regional departments are due to the different number of health services providers who were awarded contracts through a competitive process as well as the treatment capacity of those providers.

3.5. Quality of needs assessment

The target for 2004 was to measure and evaluate the quality of planning. In 2004, relevant quality criteria were developed, but the criteria will be applied only from 2005 onward, and therefore this objective cannot be regarded as completed.

In order to improve the quality of planning for insurance needs, the EHIF:

- continued forecasting the needs of the insured and the demand for health care services;
- since 2004, is planning two years in advance the caseload and the average treatment cost per case;
- held consultations with the representatives of public health priority areas (in terms of high morbidity and/or mortality and costs);
- analyzed the demand for a particular drug from a three-year perspective in the course of processing requests for new prescription drug benefits.

Objective 4: Quality of customer service in the EHIF

4.1. Satisfaction of the insured with the level of service

The target for 2004 was to meet an 80 percent customer satisfaction rate, which was achieved. Satisfaction of the insured with the level of service in the EHIF has increased year by year. The percentage of the insured satisfied with the service level in the EHIF was 79 percent in 2002, 82 percent in 2003 and 84 percent in 2004. Increased satisfaction of the insured has been achieved by the introduction of telephone consultation service in April 2004, which led to the falling number of clients turning to our service bureaus, on the one hand, and by the continued expansion of electronic networks for public service channels, on the other hand. For instance, an insured person can order a European Health Insurance Card to his/her postal address via the Citizens' Portal X-Road.

4.2. Satisfaction of employers with the level of service

The EHIF conducts a survey among employers every year in order to find out employers' satisfaction with the business procedures and service quality in the EHIF.

The target for 2004 was to achieve the satisfaction rate of employers at 85 percent. Like in 2003, 96 percent of surveyed employers are satisfied with the quality of service and business management in the EHIF, giving evaluations of "very satisfied" or "generally satisfied".

73 percent of the 500 surveyed companies from all over Estonia communicated the data on their employees' health insurance coverage to the EHIF via electronic channels. The respective indicator for 2003 was 58 percent.

Satisfaction with the EHIF homepage and the information reported thereon, as well as the web application that enables employers to provide online data on employee health insurance, has tremendously increased. The last-mentioned indicator has risen from 51 percent in 2003 to 99 percent in 2004. Increased satisfaction can be explained first and foremost by the building of a new homepage and the launch of the new version of the application program for employers in 2004.

4.3. Satisfaction of related parties with the level of service

The target was to receive the "good" rating for the service level in the EHIF by 80 percent of related parties. In February 2004, the EHIF conducted another survey among the contractual partners to evaluate their satisfaction with cooperation with the EHIF in 2003.

An average satisfaction rating was 4 points on a 5-point scale. All in all, 500 contractors were interviewed, including 203 family physicians, 66 dental services providers, 80 specialized medical services providers and 151 pharmacy directors. The EHIF feedback on responses/problems was evaluated by 495 contractors, of whom 80 percent rated the feedback as "generally positive" or "very positive".

Objective 5: Corporate governance and efficient and effective business processes

5.1. Staff competence

The target for 2004 was to achieve the level of staff competence at 2.1. As a result of the assessments performed, the average level of competence in the EHIF is 2.3.

The assessment of competence or how an employee applies his/her knowledge, skills, experience and attitudes is a strategic tool and serves as a basis for all personnel processes and as a prerequisite for success. The key competencies to be developed and assessed in respect of all employees of the EHIF include: capacity to plan and analyse, depth of knowledge in the field, efficiency, customer relationship management; to be complemented by the assumption of responsibility, decision-making and team-working in respect of managers.

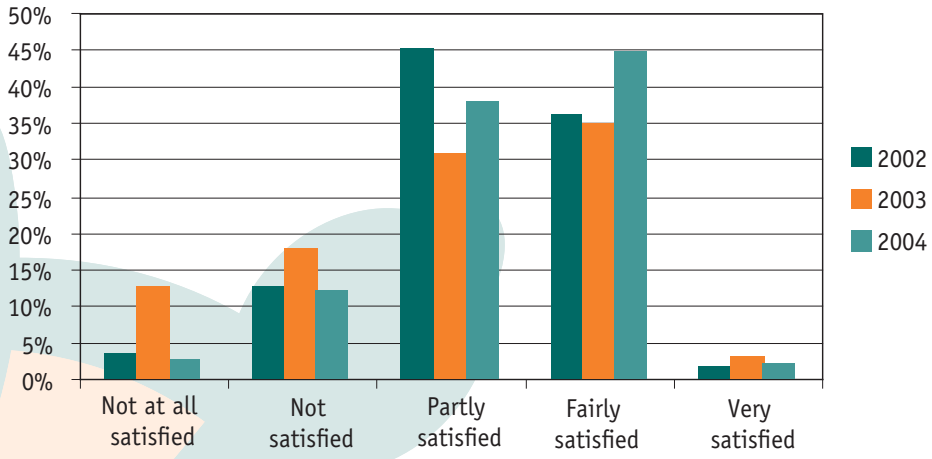
5.2. Staff satisfaction

The target for 2004 was to achieve staff satisfaction at level 4. The annual staff satisfaction survey conducted at the end of 2004 showed that 53 percent of the EHIF employees evaluated their satisfaction with their role, performance management, job and work processes, information technology, communication, cooperation, management, etc as being at least "good" or for the rating of 4, which translates into target achievement at level 3.24. This time 64 percent of the EHIF employees were surveyed (47 percent in 2003).

Evaluation of satisfaction helps the management regularly learn about the attitudes and motivation of employees and ask for proposals for improving the corporate culture and working environment.

In the spring of 2004 we conducted a survey on employee awareness of corporate strategy and its relation with satisfaction. The ratings were rather modest, as expected, because until now we have failed to build corporate vision and goals into daily business routines in a consistent and focused manner.

Chart 2. Employee satisfaction in 2002-2004



5.3. Change in the cost of core processes

Operating expenses incurred during the period account for 89 percent of the budgeted cost amount, which met the target of cutting the increase in operating expenses to 50 percent of the annual average rise in the consumer price index.

5.4. Transactions via electronic channels

The target was to process 90 percent of the annual volume of medical bills, covered prescriptions and insurance entries using electronic means. In 2004, 100 percent of medical bills and 77 percent of covered prescriptions were electronically processed and electronic register entries represent 47 percent of all entries. On average, the proportion of transactions submitted electronically was 78 percent.

In January 2004 we introduced an e-Environment for the electronic filing of medical bills by our contractual partners. A similar environment was developed and introduced for the filing of covered prescriptions. The e-Environment enables health care institutions and pharmacies to feed the medical bills and covered drug prescription directly into the EHIF information system, thus improving the business process quality and resource use.

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

Introduction

Explanatory notes to budget implementation serve as an explanation of the execution of the 2004 budget of the Estonian Health Insurance Fund and as an analysis of the utilization of health insurance benefits.

Table 7. Main indicators for the years 2002-2005

Indicator	2001	2002	2003	2004	2005*
Social tax as a percentage of total revenue	99.5	99.2	98.9	98.9	98.9
General medical care as a percentage of total expenditure	7.4	7.9	8.0	7.7	8.6
Specialized medical care as a percentage of total expenditure	47.6	45.3	49.9	51.0	52.5
Incapacity benefits as a percentage of total expenditure	16.5	16.1	16.2	17.4	17.7
Prescription drugs as a percentage of total expenditure	14.6	15.2	12.0	13.6	12.6
Operating expenses as a percentage of total expenditure	1.7	1.6	1.5	1.3	1.3
Reserves as a percentage of total expenditure	0.0	3.7	9.9	10.1	8.1
Health insurance benefits as a percentage of GDP	4.5	4.0	4.2	4.4	4.6

* - approved budget

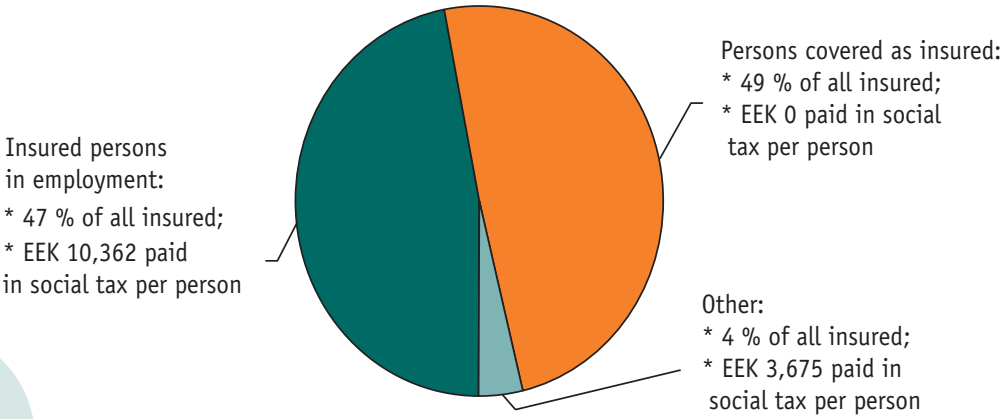
The insured

As of 31 December 2004, the number of people insured by the EHIF was 1,271,558. The number of the insured has decreased by 493 persons as compared with 31 December 2003 and by 12,518 persons as compared with 31 December 2002.

Table 8. Number of the insured

Insured	31.12.2002	31.12.2003	31.12.2004	Variation 2004/2003 %	Proportion of all insured (2004)
Insured persons in employment	578,673	584,885	595,734	1.85%	46.85%
Government insured persons	48,469	49,119	43,869	-10.69%	3.45%
Persons covered as insured	656,926	631,830	626,438	-0.85%	49.27%
Persons covered by international health agreements	8	6,217	5,517	-11.26%	0.43%
Total	**1,284,076**	**1,272,051**	**1,271,558**	**-0.04%**	**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 10,362 per person per year as the health insurance portion of the social tax, whereas the contribution of persons covered as insured is nil. Although there was a 1-2 percent increase in the number of insured persons in employment in 2003-2004, as compared to 2001-2002, arising from a general increase in employed workforce, it is ever more difficult to meet the expectations of the society in respect of health care services in the situation where less than half of insured persons pay for about 96 percent of the health costs of all insured. 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.

Summary of budget implementation (in EEK thousand)

Table 9. Summary of budget implementation, 2002-2004

REVENUE (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Social tax revenue	5,059,996	5,629,127	6,079,229	6,276,578	103.2%	111.5%
Premiums paid by persons covered as insured under a contract	0	17,109	25,200	27,493	109.1%	160.7%
Amounts due from other persons	14,938	16,917	16,000	11,005	68.8%	65.1%
Financial income	20,652	25,531	35,000	31,078	88.8%	121.7%
Other revenues	3,738	1,453	11,610	3,975	34.2%	273.6%
TOTAL BUDGET REVENUE	**5,099,324**	**5,690,137**	**6,167,039**	**6,350,129**	**103.0%**	**111.6%**
BENEFIT EXPENDITURE						
Health benefits	3,025,728	3,583,963	4,079,624	4,059,759	99.5%	113.3%
Disease prevention	42,400	45,547	64,000	60,480	94.5%	132.8%
General medical care	400,225	454,694	502,209	491,661	97.9%	108.1%
Specialized medical care	2,310,635	2,840,898	3,242,739	3,238,607	99.9%	114.0%
Nursing care	49,006	75,019	95,712	95,177	99.4%	126.9%
Dental care	223,462	167,805	174,964	173,834	99.4%	103.6%
Health promotion expenses	13,218	13,800	14,000	13,480	96.3%	97.7%
Drugs reimbursed for the insured	772,368	682,937	815,924	863,847	105.9%	126.5%
Expenditure on temporary incapacity benefits	819,257	923,929	973,242	1,101,980	113.2%	119.3%
Other cash benefits		67,476	156,293	72,437	46.3%	107.4%
Other benefit expenses	17,368	20,089	38,144	25,486	66.8%	126.9%
Total benefit expenditure	**4,647,939**	**5,292,194**	**6,077,227**	**6,136,989**	**101.0%**	**116.0%**
OPERATING EXPENSES (in EEK thousand)						
Personnel and administrative expenses	42,796	43,960	49,789	44,773	89.9%	101.8%
salaries and wages	32,058	32,940	37,295	33,545	89.9%	101.8%
incl. Management Board remuneration	1,829	1,719	2,113	1,699	80.4%	98.8%
unemployment insurance premiums	158	149	187	158	84.5%	106.0%
social tax payments	10,580	10,871	12,307	11,070	89.9%	101.8%
Overhead expenses	14,047	15,705	17,562	16,236	92.4%	103.4%
IT expenses	14,561	12,428	11,965	9,096	76.0%	73.2%
Claim administration expenses	1,284					
Development expenses	2,465	3,103	4,578	4,169	91.1%	134.4%
training	1,668	1,748	2,005	1,756	87.6%	100.5%
consultation	797	1,355	2,573	2,413	93.8%	178.1%
Financial expenses	514	601	888	898	101.1%	149.4%
Other operating expenses	7,287	10,828	5,030	4,940	98.2%	45.6%
pre-printed forms and publications	476	1,057	1,602	1,082	67.5%	102.4%
supervision of the health insurance system	527	1,066	1,475	945	64.1%	88.6%
public relations/ public information	1,185	752	1,030	914	88.7%	121.5%
other expenses	5,099	7,953	923	1,999	216.6%	25.1%
Total operating expenses	82,954	86,625	89,812	80,112	89.2%	92.5%
TOTAL BUDGET EXPENDITURE	**4,730,893**	**5,378,819**	**6,167,039**	**6,217,101**	**100.8%**	**115.6%**
Appropriations	368,431	311,318		133,028		42.7%
Provision for legal reserve	225,597	77,956				0.0%
Provision for risk reserve	142,834					
Retained earnings		233,362		133,028		57.0%
TOTAL	**5,099,324**	**5,690,137**	**6,167,039**	**6,350,129**	**103.0%**	**111.6%**

Revenue

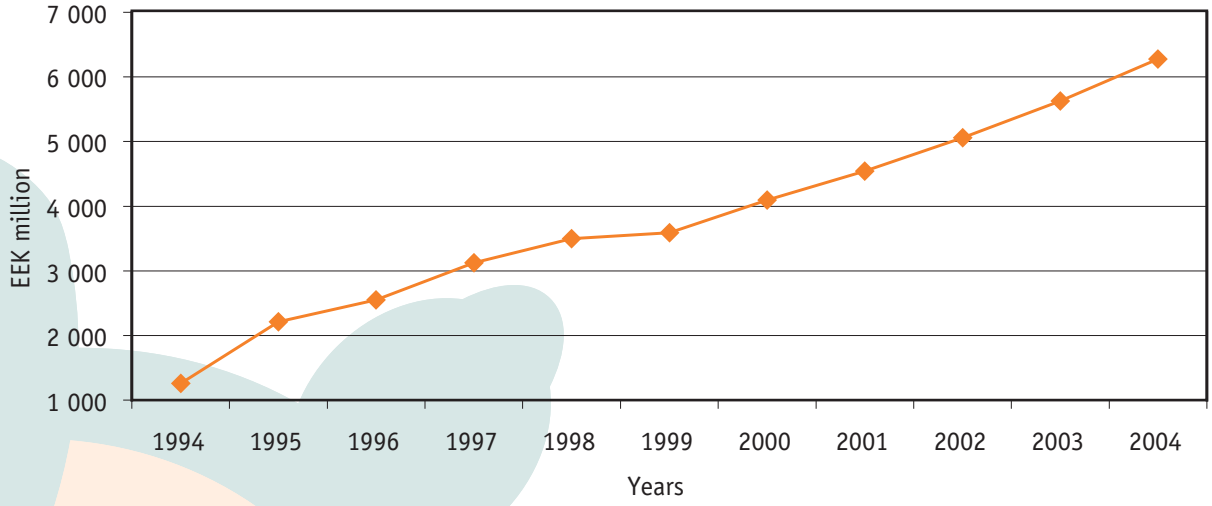
Table 10. Revenue

Revenue (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Social tax revenue	5,059,996	5,629,127	6,079,229	6,276,578	103%	112%
Premiums paid by persons covered as insured under a contract	0	17,109	25,200	27,493	109%	161%
Amounts due from other persons	14,938	16,917	16,000	11,005	69%	65%
Financial income	20,652	25,531	35,000	31,078	89%	122%
Other revenues	3,738	1,453	11,610	3,975	34%	274%
Total	**5,099,324**	**5,690,137**	**6,167,039**	**6,350,129**	**103%**	**112%**

Social tax revenue

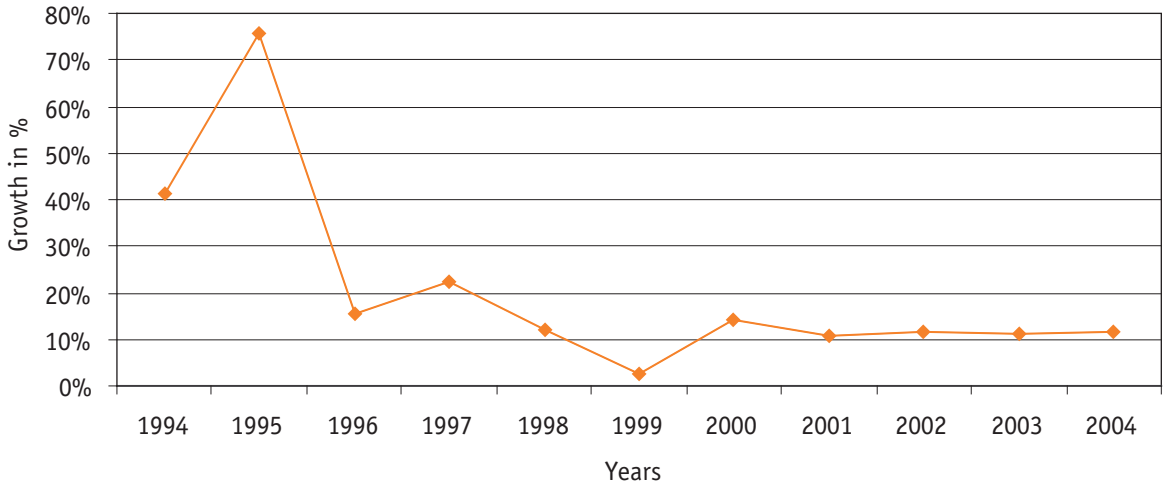
Revenue from the health insurance portion of social tax for the 2004 budget was projected to be EEK 6,079.229 million. The actual inflow was EEK 6,276.578 million. Revenues received in excess of the budgeted amount account for 3.2 percent or EEK 197.349 million.

Chart 4. Inflows in social tax by years (in EEK 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. At the end of 2004, on the initiative of the Tax Board, the EHIF entered into cooperation agreements with 10 organisations and agencies to combat the underreporting of payrolls by employers.

Chart 5. Increase in social tax inflows from 1994 to 2004



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 109 percent of the budget. Persons without medical coverage can insure themselves by making an insurance contract with the EHIF and paying monthly premiums.

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. The agreement between the Estonian Ministry of Social Affairs and the Ministry of Defence of the Russian Federation concerning transition to the insurance principle for medical servicing of the non-working retirees of the armed forces of the Russian Federation living in Estonia took effect in May 2003.

Amounts due form other persons

The budget was implemented at 69 percent. The low implementation rate can be attributed to the decision of the Supreme Court en banc, stating that § 4(2) of the Estonian Health Insurance Fund Act is in contravention of § 32 of the Constitution, read in conjunction with § 11.

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. Pursuant to the decision of the Supreme Court, the EHIF withdrew the claims in the amount of about EEK 4 million against entities in arrears, because further processing of claims appeared to be legally ungrounded.

Financial income

Interest income amounted to EEK 7.556 million in 2004 and income from the revaluation of bonds to fair value totalled to EEK 23.522 million.

The liquid resources of the EHIF are divided into two: liquidity portfolio and investments in legal reserve.

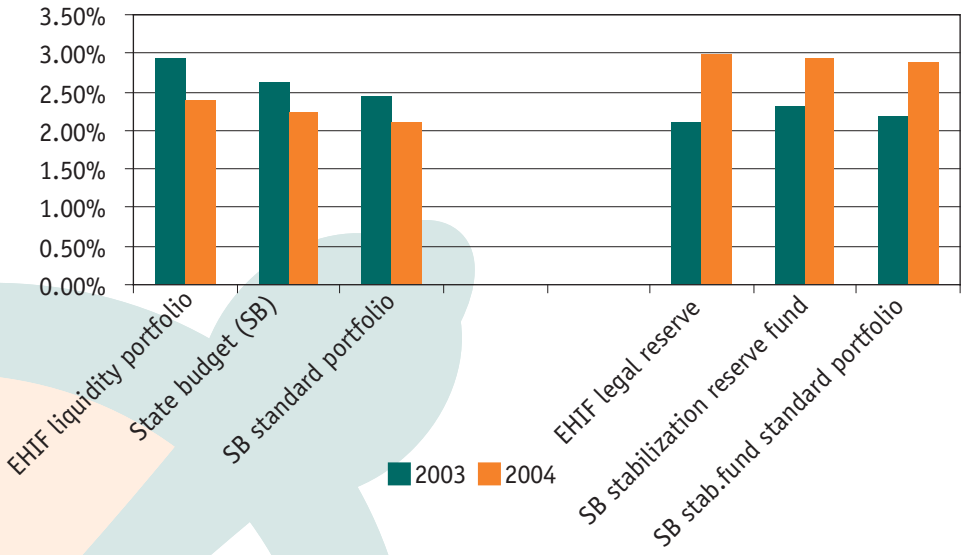
Table 11. Main indicators for liquidity portfolio and investments in legal reserve, 2004

	Liquidity portfolio	Investment in legal reserve
Fund volume at cost	855,075,606	427,798,360
Fund volume at market value	854,704,995	433,367,165
Realized gain/loss from beginning of year	18,833,463	9,785,937
Gain/loss on revaluation	-370,611	5,568,804
Annualized 30-day yield	2.39%	2.28%
Annualized 90-day yield	2.39%	3.61%
Yield from beginning of year (on a yearly basis)	2.38%	2.97%
Average duration of investment (on a yearly basis)	0.228	1.147

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, 0.23 years and a somewhat longer time horizon for the legal reserve - 1.15 years. The composition of instruments in either portfolio is also different: the liquidity portfolio contains local deposits and commercial paper, while 83 percent of legal reserve investments are bonds of high-rated European issuers and the rest is investment in the commercial paper of Estonian banks. 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 6. Rate of return on the EHIF and national reserves: comparison of 2003 and 2004 data



Other revenues

Other revenue mainly consists of the proceeds from the sale of fixed assets amounting to EEK 2.485 million. In the first half of 2004, the EHIF sold a building in Kuressaare recorded on its balance sheet. Underspending is due to the fact that bills for the medical services rendered to persons insured by other EU member states and reported under other revenues are submitted to the other states only in 2005.

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 12. Breakdown of expenditure by year (in %)

	2002	2003	2004	Variation 2004 / 2003
Benefit expenditure	91.15	93.01	96.64	3.6
Operating expenses	1.63	1.52	1.26	-0.3
Retained earnings	7.23	5.47	2.09	-3.4

I Expenditure on health insurance benefits

Substantial changes took place in the expenditure on health insurance benefits in 2004:
Spending on medical services

- Funding for specialized medical care grew by 14 percent in 2004 and the caseload increased by 1 percent.
- Nursing care services were up 27 percent over 2003, due to an increase in the volume of outpatient or home care services. Home nursing and home care for cancer patients represent 40 percent of all nursing cases.
- Outpatient and day surgeries have increased by 1 percent and accounted for 32 percent of all surgeries in 2004.

Prescription drugs

- The total amount of drugs reimbursed for the insured in 2004 was EEK 863.847 million, accounting for 106 percent of the budgeted amount. Overspending on drug benefits was due to the following reasons:
  - Striking growth in drug benefits in March and April 2004, before Estonia's accession to the EU, caused by the substantially increased usage and purchase volume of certain medications, in the fear that they might be removed from sale;
  - Amendments to the Health Insurance Act effective 1 August 2004, which significantly increased the number of beneficiaries for prescription drugs reimbursed at 100 % and 90 %;
  - Non-concluded price agreements on covered prescription drugs;
  - Media reports on the new method for calculating the reference prices, effective in January 2005, incited drug-buying fever and led to the expenditures on drug benefits rise in excess of 70 percent in December 2004.

Benefits for incapacity for work

Compared to 2003, the expenditure on benefits for temporary incapacity for work increased by 19 percent.
Constant growth in this cost category over the period 2001-2004 is triggered by:

- increase in average daily earnings due to the continued growth in gross wages;
- increase in the number of days of incapacity, conditioned by:
  - continued growth in the number of the working insured;
  - changes in the age structure of the workforce;
  - the 2002 amendments to the Health Insurance Act;
  - changes in the economic environment.

1. Health benefits

Table 13. Implementation of the health benefits budget in 2003-2004

Health benefits (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Disease prevention	45,547	64,000	60,480	95%	133%
General medical care	454,694	502,209	491,661	98%	108%
Specialized medical care	2,840,898	3,242,739	3,238,607	100%	114%
Nursing care	75,019	95,712	95,177	99%	127%
Dental care	167,805	174,964	173,834	99%	104%
Total	**3,583,963**	**4,079,624**	**4,059,759**	**100%**	**113%**

Of the total health expenditure, 43 percent was paid for outpatient services and 57 percent for inpatient services (hospital care) for the insured.

Table 14. Expenditure on outpatient and inpatient health services

Benefits for outpatient and inpatient services (in EEK thousand)	2003 actual	2004 actual	2004 actual/ 2003 actual %
Disease prevention	45,547	60,480	133%
General medical care	454,694	491,661	108%
Outpatient specialized medical care	811,732	973,210	120%
Centrally contracted outpatient health services	23,656	27,431	116%
Community-based nursing care	6,452	13,408	208%
Dental care	167,805	173,834	104%
Total benefits for outpatient health services	**1,509,886**	**1,740,024**	**115%**
Centrally contracted inpatient health services	25,165	22,836	91%
Inpatient specialised medical care	1,944,334	2,178,610	112%
Hospital-based nursing care	68,567	81,769	119%
Total benefits for inpatient health services	2,038,066	2,283,215	112%
Expense of emergency response	36,011	36,520	101%
Total benefits for outpatient and inpatient health services	**3,583,963**	**4,059,759**	**113%**

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 64 million budgeted for disease prevention, the EHIF expended EEK 60.48 million, which accounts for 95 percent of the estimated amount.

Table 15. Disease prevention projects and other prevention activities

Prevention activity (in EEK thousand)	2004 budget	2004 actual	2004 actual/ 2004 budget
School health	34,902	34,115	98%
Reproductive health of young people	4,773	4,992	105%
Early detection of breast cancer	7,650	7,666	100%
Screening for phenylketonuria and hypothyrosis	885	858	97%
Prenatal diagnosis of hereditary diseases	7,249	6,715	93%
Early detection of osteoporosis	1,100	870	79%
Prevention of heart diseases	3,704	2,640	71%
Immunization against hepatitis B	1,744	1,467	84%
Early detection of cervical cancer	1,726	985	57%
Other prevention programmes	267	172	64%
Total	**64,000**	**60,480**	**95%**

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, but due to insufficient public notification, participation in the screening programme was considerably lower than expected.
Immunization against hepatitis B of children born in 1991, which was started in the autumn of 2003, was terminated. The immunization coverage level was lower than expected, because immunization for hepatitis B is voluntary and can be promoted only through collaboration between children, parents, family physicians, school doctors and nurses. Also medical students were vaccinated against hepatitis B.

156 of the planned 200 family practices were involved in the project on cardiovascular disease prevention, and this is why only 59 percent of the planned target group was studied.
Completion of the project on osteoporosis prevention was affected by the specific nature of the target group and the availability of testing opportunities in Tallinn, Tartu and Pärnu. Movement therapy has not been successfully introduced under the project.

Table 16. Results of the disease prevention programmes in 2004

Prevention activity	Target group covered 2003	Target group planned 2004	Target group covered 2004	Percentage of the planned target group	Results
School health	207,612	198,995	193,804	97%	Vocational schools were covered with school health services primarily in the second half-year.
Reproductive health of young people and prevention of sexually transmitted diseases (STD)	22,676	2, 000	23,821, of which 7,736 screened for STD	99%, plus 8379 telephone consultations	Primary appointments -18 %; male patients - 4 %. An STD detected on 715 occasions (9%), pregnancy detected on 82 occasions and 229 women referred for abortion in the age group 15-19 years.
Early detection of breast cancer	17,457	18,500	1, 932	102%	644 screened women (4%) were referred for 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	14,000	14,489	104%	No deviations from the standards were observed in the course of screening.
Prenatal diagnosis of hereditary diseases	1,135	1,310	1,293	99%	Fetal chromosome abnormality was detected in 33 cases.
Early detection of osteoporosis	1,334	2,000	1,616	81%	Osteoporosis was detected in 29% and osteopenia in 51% of the screened persons.
Prevention of cardiovascular diseases (CVD)	10,986	16,150	9,538	59%	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, 1st half-year/ 2nd half-year	55,966	18,370	15,758	86%	Immunization level depends on the collaboration between school health promoters, family physicians and parents.
Early detection of cervical cancer	3,822	9,400	5,339	57%	Detection rate was over 1.5 cases per 1000 screened women; early-stage cancer cases accounted for over 70 %.
Hearing screening for the newly born	-	700	516	74%	No deviations from the standard were observed in the course of screening.

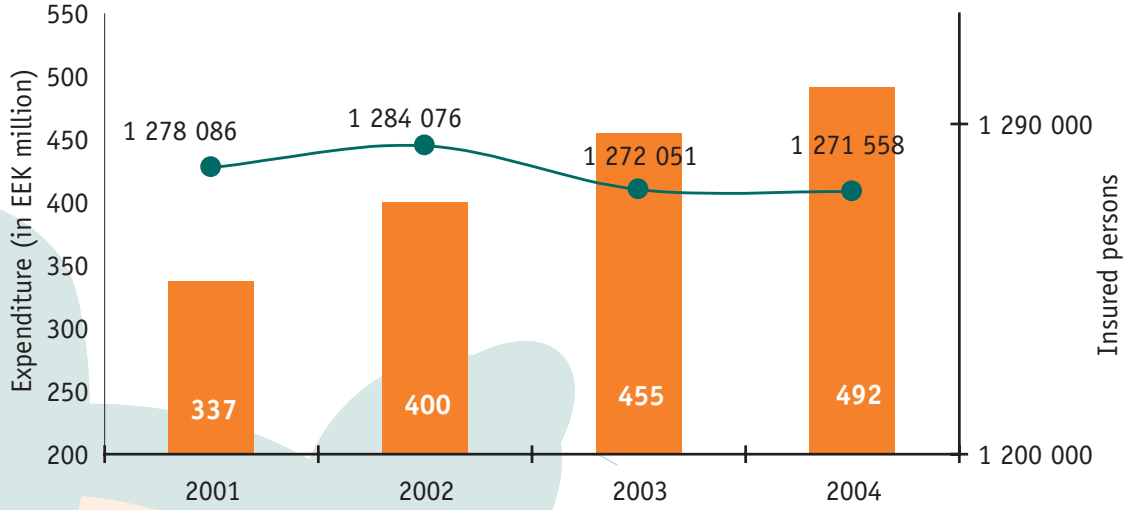
General medical care

Table 17. Expenditure on general medical care in 2004 compared to 2003

Budget for general medical services (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 / 2004 budget %	2004 / 2003 %
Base fee	56,284	63,024	62,148	99%	110%
Distance allowance	2,007	2,125	2,022	95%	101%
Qualification allowance	8,656	9,420	9,123	97%	105%
Capitation fee (under age 2)	7,823	13,410	12,845	96%	164%
Capitation fee (aged 2 -70)	279,373	290,736	292,910	101%	105%
Capitation fee (over age 70)	44,429	46,936	46,197	98%	104%
Medical tests fund	56,122	71,972	66,416	92%	118%
General medical care reserve		4,586			
Total	**454,694**	**502,209**	**491,661**	**98%**	**108%**

Expenditure on general medical care amounted to EEK 491.661 million in 2004. The increase in expenditure over the previous fiscal year was EEK 36.967 million (8 %). Expenditure on general medical services has been steadily growing over years, due to a rise in the reference prices for base fees and capitation fees, while the number of the insured has remained the same.

Chart 7. Number of the insured and expenditure on general medical care from 2001 to 2004



In 2004, base fees were paid to 783 family practices in the total amount of EEK 62.148 million. Compared to 2003, the base fee expenses grew by 10 percent or by nearly EEK 6 million. 52 family practices were allocated base fees with the payment coefficient 1.5, because the family physician patient list covers a vast territory and the physician sees patients in two or more separately located offices.
Supplementary distance allowance was paid to 175 family physicians in 2003 and 2004.
Capitation fee budget was implemented at nearly 100 percent, whereas the funds paid in capitation fee increased by EEK 20 million due to a rise in the reference price for capitation fees as compared with 2003.
The budget for medical tests was implemented at 92 percent, whereas there was an increase of EEK 10 million over the 2003 funding level. EEK 5.556 million of the resources allocated to the medical tests fund in 2004 were left unused, the main reasons being the limited travel opportunities of rural population due to a

lower income level and the lower number of patients referred by "rural" family physicians for further medical examination. Supplementary allowance for family physician qualifications was paid to 761 physicians or 97 percent of the family physicians with a patient list.

Table 18. General medical care in 2003-2004

Number of family practices and patients	2003 actual	2004 actual	2004/ 2003 %
Base fee (practices)	796	783	98%
Distance allowance (practices)	175	175	100%
Qualification allowance (practices)	796	761	96%
Capitation fee for under age 2 (persons)	24,631	23,890	97%
Capitation fee for aged 2-70 years (persons)	1,100,478	1,099,346	100%
Capitation fee for over age 70 (persons)	146,965	150,351	102%
Patients (insured) in total	1,272,074	1,273,587	100%
Average patient list (persons)	1,598	1,627	102%

The average list size per family physician was 1,627 persons in 2004, which has increased over the previous fiscal year. In one year, on the average 29 patients have been added to the list, accounting for a 2 percent increase.
At the end of 2004, there were 47 lists with fewer than 1,200 patients (incl. 8 lists with less than 1000 patients due to the size of the area) and 217 lists with above 2,000 patients (incl. 2 lists with over 3000 patients).

During the inspection of patient lists of acceptable size (1600± 400) and of lists with over 2000 patients, no difference was observed in respect of accessibility to primary care – in either case, about 45 percent of patients with a chronic condition and wishing to consult a primary care physician were seen by the physician on the same day and 24 percent were seen on the following day. Accessibility was far better in terms of lists with less than 1200 patients, where 75 percent of patients were seen by the physician on the same day.

Outpatient and inpatient specialized medical care (excl. centrally contracted services)

The expenditure of the Estonian Health Insurance Fund for therapeutic services in outpatient and inpatient specialized medical care (excl. centrally contracted health services) amounted to EEK 3,188.34 million in 2004, of which outpatient (incl. day cases) health services accounted for 31 percent and inpatient health services for 69 percent.
During 2004, the EHIF assumed an obligation to pay for 2,630,323 treated cases, of which outpatient cases (incl. day cases) account for 90 percent and inpatient cases for 10 percent. Since 2004, the budgeted and actual expense of emergency response by hospitals is reported under outpatient and inpatient specialized medical care.

Table 19. Expenditure on outpatient and inpatient specialized medical care by specialty (incl. emergency response expense)

Outpatient and inpatient specialized medical care (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Surgery	602,904	671,130	692,436	103%	115%
Otorhinolaryngology	91,774	107,654	102,884	96%	112%
Neurology	104,458	114,777	112,389	98%	108%
Ophthalmology	111,160	130,046	122,511	94%	110%
Orthopaedics	275,141	294,490	289,233	98%	105%
Oncology	169,248	213,116	222,520	104%	131%
Obstetrics and gynaecology	300,283	348,988	343,367	98%	114%
Pulmonology	71,468	75,691	84,873	112%	119%
Dermato-venerology	32,978	38,143	38,745	102%	117%
Paediatrics	140 417	148,019	146,334	99%	104%
Psychiatrics	132,976	153,300	148,023	97%	111%
Infectious diseases	31,619	36,067	38,164	106%	121%
Internal diseases	632,175	735,597	737,144	100%	117%
Primary follow-up care	7,437	14,682	10,004	68%	135%
Rehabilitation	46,097	57,886	57,415	99%	125%
Unspecified specialties	5,931	5,601	5,778	103%	97%
Emergency response expense	36,011	38,613	36,520	95%	101%
Total outpatient and inpatient specialized medical care	**2,792,077**	**3,183,800**	**3,188,340**	**100%**	**114%**

Table 20. Caseload in outpatient and inpatient specialised medical care

Cases in outpatient and inpatient specialized medical care	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Surgery	343,959	348,405	340,715	98%	99%
Otorhinolaryngology	191,005	196,828	192,314	98%	101%
Neurology	132,778	130,611	129,388	99%	97%
Ophthalmology	264,164	276,104	272,731	99%	103%
Orthopaedics	217,937	220,654	216,460	98%	99%
Oncology	73,797	75,451	77,959	103%	106%
Obstetrics and gynaecology	470,874	481,674	467,137	97%	99%
Pulmonology	55,849	58,143	54,531	94%	98%
Dermato-venerology	151,211	159,142	157,317	99%	104%
Paediatrics	124,158	123,584	134,709	109%	108%
Psychiatrics	172,640	179,777	181,728	101%	105%
Infectious diseases	20,517	20,552	20,620	100%	101%
Internal diseases	334,130	337,168	329,114	98%	98%
Primary follow-up care	1,320	2,177	1,469	67%	111%
Rehabilitation	30,968	34,270	37,777	110%	122%
Unspecified specialties	16,854	18,649	16,317	87%	97%
Emergency response expense			37		
Total outpatient and inpatient specialized medical care	**2,602,161**	**2,663,189**	**2,630,323**	**99%**	**101%**

Compared with the respective budget in 2003, financial resources increased by 14 percent and the caseload grew by 1 percent in 2004. Thus the reference prices that rose on 1 July 2003 have remarkably affected the 2004 expenditure on treatment costs.
Rise in costs for infectious diseases, pulmonology and dermato-venerology and primary follow-up care is due to an increase in the reference prices of a patient day. In the said specialties, the patient day is a significant part of service, leading to increased resource costs in these specialties.
In oncology, a 31 percent rise in expenditure is due to amendments to the list of health services enforced at the beginning of 2004 and a significant increase in the reference prices of two complex oncological services (cytostatic treatment sessions). In addition, increased treatment costs in oncology arise from a 6 percent increase in the number of cases treated during 2004.
Compared with 2003, more cases were treated in 9 out of the 16 main specialties in 2004, incl. oncology, paediatrics, rehabilitation, psychiatrics, dermato-venerology and other specialties.

The 2004 budget for outpatient and inpatient specialized medical care has been overspent by EEK 4.54 million, thus expenditures have been implemented at 100 percent, but there is a 1 percent underspending for caseload. The overspending on expenses is offset by underspending on centrally contracted health services.

Treatment costs exceed the budgeted amounts in 6 main specialties (surgical specialties, oncology, pulmonology, dermato-venerology, infectious diseases and unspecified specialties). The caseload in oncology, paediatrics, psychiatrics and rehabilitation is higher than estimated. In the rest of the cases the treatment costs and the number of treated cases are equal to or below the budgeted amounts.

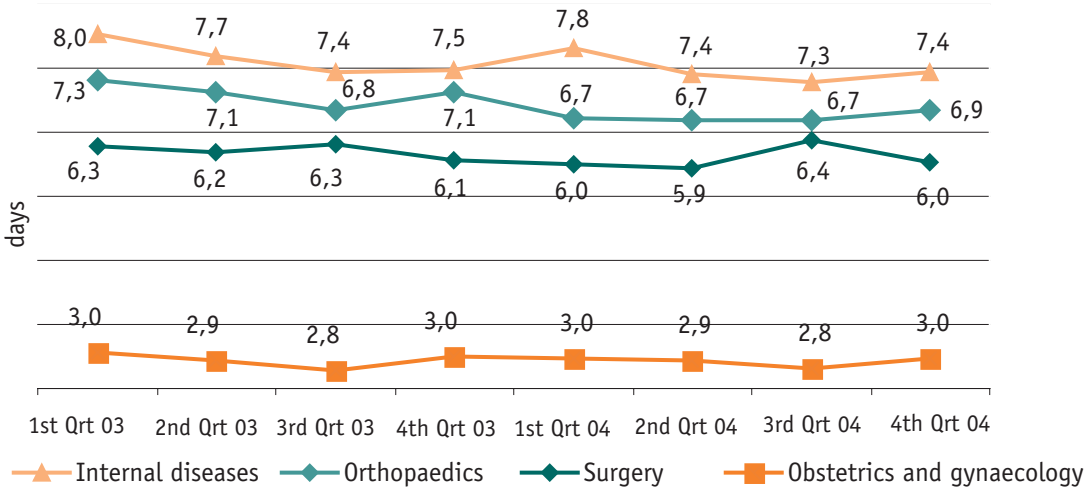
Table 21. Major indicators for therapeutic services in outpatient and inpatient specialized medical care (excl. emergency response expense) in 2004 and 2003

Indicator	2003 actual		2004 actual		2004/2003 actual (%)	
	outpatient	inpatient	outpatient	inpatient	outpatient	inpatient
Treatment cost (in EEK thousand)	811,732	1,944,334	973,210	2,178,610	120%	112%
Number of cases	2,345,164	256,997	2,379,939	250,384	101%	97%
Average cost per case (EEK)	346	7,566	409	8,701	118%	115%
Emergency care as a percentage of treatment cost	13.9	56.6	15.0	60.0	1.1%	3.4%
Emergency care as a percentage of treated cases	14.1	51.1	14.4	54.9	0.3%	3.8%
Average duration of treatment (days)		6.8		6.6		97%
Hospital patient days		1,759,032		1,660,307		94%
Outpatient appointments	3,234,385		3,152,033		98%	
Ratio of outpatient appointments to treated cases	1.38		1.32		96%	
Surgeries	41,871	93,078	4, 694	90,628	100%	97%

Increase in the average cost per case is triggered by a rise in the reference prices of health services that occurred in the second half of 2003 as well as a structural increase in the cost of treatment cases.
Compared with 2003, the proportion of emergency care in outpatient services has grown by 1.1 percent and in inpatient services by 3.4 percent. Increase in outpatient and inpatient cases subject to emergency care accounts for 0.3 percent and 3.8 percent respectively.
The average length of stay in hospital as well as the number of hospital patient days have declined, by 3

percent and 6 percent respectively.
As regards the length of stay in hospital in the four main resource-intensive specialties, we can observe a somewhat longer stay in three specialties (internal diseases, orthopaedics, obstetrics and gynaecology) in the last quarter of either year. At the same time, there has been a certain drop-off in surgery. Variations in the average duration of treatment across quarters and specialties are due to an increase in the reference prices of specific bed days over the second half-year of 2003, seasonal differences, proportion of emergency and regular care in the specialties, effect of the introduction of the DRG-based system since 1 April 2004.

Chart 8. Change in the average duration of inpatient treatment by quarters, 2003-2004 (in days)



The total number of outpatient appointments in 2004 dropped by 2.5 percent as compared to 2003. The number of appointments per outpatient case has also fallen, referring to fewer subsequent appointments during a course of treatment.
With regard to the change in the number of outpatient appointments per 1000 insured, expressed as a percentage, the decrease in Estonia as a whole is 2 percent. By the EHIF regional departments, the change in outpatient appointments per 1000 insured in the years 2003 and 2004 is shown in the table below.

Table 22. Change in the number of appointments and surgeries in 2004 as compared to 2003 by the EHIF regional departments (data per 1000 insured)

Regional Department	2003	2004	04/03 %	2003	2004	04/03 %	2003	2004	04/03 %
	Appointments			Total surgeries			Surgeries in hospital		
Harju	2,875	2,769	-3.7%	101	98	-2.3%	70	68	-3.3%
Pärnu	2,151	2,185	1.6%	105	107	2.0%	74	77	4.0%
Tartu	2,108	2,109	0.0%	117	112	-4.4%	74	71	-3.4%
Viru	2,662	2,589	-2.7%	103	102	-0.5%	78	74	-4.7%
EHIF in total	**2,529**	**2,479**	**-2.0%**	**106**	**104**	**-1.9%**	**73**	**71**	**-2.6%**

The total number of surgeries has fallen by 1.9 percent in 2004, whereas the number of surgeries performed in hospital has dropped by about 3 percent. The number of outpatient surgeries has remained on the 2003 level. The upward trend in outpatient and day surgeries continued also in 2004, when 32 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 and 31 percent in 2003.

Table 23. Comparison, between 2003 and 2004, of the actual use of funds for special cases and the effective caseload

Special cases	2003 actual treatment cost (EEK '000)	treated cases	2004 actual treatment cost (EEK '000)	treated cases	2003/2004 treatment cost (%)	caseload (%)
Endoprostheses	110,572	2,684	109,710	2,469	99%	92%
Cataract operations	60,568	7,992	63,771	8,161	105%	102%
Cardiac surgeries	74,106	809	84,045	811	113%	100%
Deliveries	78,180	12,730	88,831	13,508	114%	106%

In 2004, the EHIF financed 215 planned endoprosthetic surgeries, which makes 8 percent less than in 2003. Since this kind of surgery is fairly expensive (the average cost per case is about EEK 45,000), the EHIF used the funds saved as a result of reduction in the number of endoprosthetic surgeries to finance emergency cases (e.g. cardiac surgeries). However, this prolonged waiting lists for endoprosthetic surgeries beyond three years in some regional departments.

Centrally contracted health services

The EHIF paid EEK 50.267 million for centrally contracted health services in 2004 (85 percent of the budgeted amounts for the year).

Table 24. Implementation of the budget for centrally contracted health services in 2004

Centrally contracted health services (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Bone marrow transplants	2,521	4,400	4,958	113%	197%
Regular treatment in a foreign state	2,015	7,500	1,554	21%	77%
Peritoneal dialysis	21,220	24,400	23,280	95%	110%
Emergency transportation of the insured (airplane, helicopter)	1,301	2,700	1,742	65%	134%
Medical check-ups for young athletes	2,436	4,400	4,151	94%	170%
Oncological treatment sessions*	13,406				0%
Haematological treatment sessions	5,722	10,200	9,241	91%	161%
Antidotes and serums	200	200	200	100%	100%
Payments of response allowance*	36,011	0	0		0%
Artificial urinary sphincters	0	587	587	100%	
Cochlear implants	0	4,554	4,554	100%	
Total	**84,832**	**58,941**	**50,267**	**85%**	**59%**

* Funds for oncological treatment sessions and the 24-hour emergency response allowance are included in the budget for specialized medical care since 2004.

Underspending on centrally contracted health services is due to lower spending on scheduled treatment in a foreign state and emergency transportation of the insured by air. Demand for bone marrow transplants in the 4th quarter of 2004 proved to exceed the proposed budget, and these costs were offset by unused resources for haematological treatment sessions. The funds allocated for centrally contracted health services but left unused were deployed to cover overspending on specialized medical care.
Compared with 2003, spending on centrally purchased services (excl. scheduled treatment in a foreign country) has grown in 2004, caused primarily by the growth in the average cost per case and the total number of cases treated. Caseload has significantly increased in medical check-ups for young athletes and

haematological treatment sessions.
The majority of patients needing peritoneal dialysis are on the waiting list for kidney transplants, thus the demand for peritoneal dialysis services is affected by the availability of donor kidneys and possibilities for a kidney transplant.
27 persons were referred for treatment in a foreign state in 2004, of which 17 were children. Treatment was provided to 9 insured patients, incl. 5 children. The treatment of the remaining persons has been postponed to 2005 for reasons not depending on the EHIF.

Nursing care

One of the priorities of the EHIF in 2004 was to support the development of the nursing care system. In 2004, the EHIF paid EEK 95.177 million in nursing care, which makes 99 percent of the budget. Compared with 2003, spending on nursing care has increased by 27 percent or in excess of EEK 20 million.

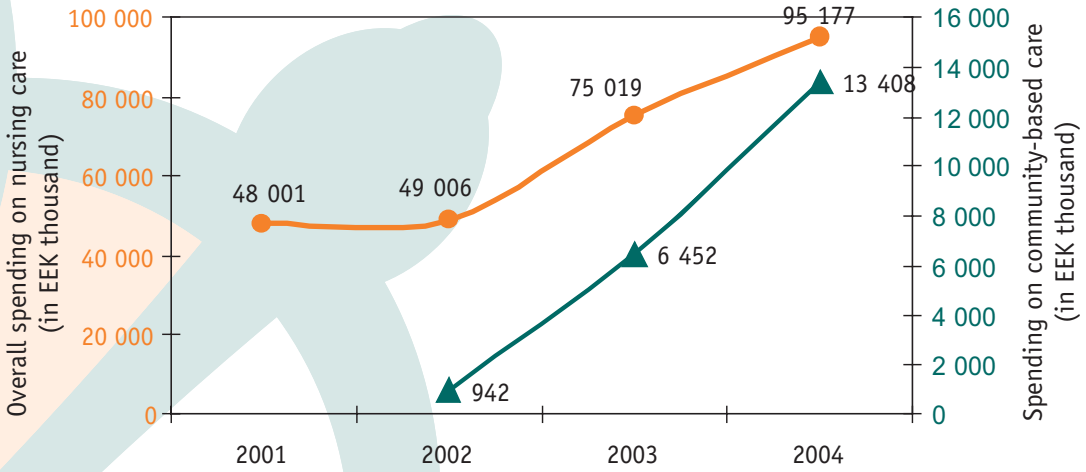
Table 25. Implementation of the budget for nursing care in 2004

Outpatient and inpatient nursing care (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual / 2004 budget %	2004 actual/ 2003 actual %
Inpatient nursing care	68,567	88,216	81,769	93%	119%
Outpatient nursing care	6,452	7,496	13,408	179%	208%
Total	**75,019**	**95,712**	**95,177**	**99%**	**127%**

Significant increase in the budget for nursing care will help ensure the continued development of nursing services, because hospitals outside the hospitals network development plan have also started to provide nursing services. In 2003, providers of home nursing services started to operation.
The main reasons for increased spending on nursing care in 2004 include first and foremost the rise in the cost of a nursing day on 1 July 2003 and the inclusion of geriatric assessment in the list of health services.

Taking a look on the period 2001-2004, the overall spending on nursing care has increased by more than EEK 47 million, while the provision of community-based nursing care has developed especially fast.

Chart 9. Overall spending on nursing care compared with spending on community-based nursing care in 2001-2004



In 2004, geriatric assessment was introduced as a new service and the cost of this service across the four regional departments of the EHIF amounted to EEK 533,000. The purpose of geriatric assessment is to evaluate the needs of older persons and offer them proper nursing care. A more accurate assessment of needs and the provision of services according to those needs help maintain the purposeful and cost-effective delivery of services.

Table 26. Nursing care: caseload and average cost in 2003 and 2004

	2003 cases	2004 cases	2004 / 2003 cases	2003 average cost per case	2004 average cost per case	2004 / 2003 average cost per case
Community-based nursing care	4,150	8,115	196%	1,468	1,652	113%
Institutional nursing care	10,613	10,107	95%	6,495	8,090	125%
Total	**1, 763**	**18,222**	**123%**	**5,082**	**5,223**	**103%**

The proportion of community-based nursing care has increased remarkably: home health services – home nursing and home care for cancer patients – accounted for 40 percent of all nursing care in 2004.

As regards the average cost per case in 2004, the most striking is the growth in the cost of institutional care: in 2003, the average cost per case was EEK 6,495 and in 2004 it was EEK 8,090, thus spending on a treated patient has increased by 25 percent or by EEK 1595.

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 27. Implementation of the 2004 budget for dental benefits

Dental care (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Dental treatment in children	130,539	132,630	133,949	101 %	103 %
Orthodontia	19,781	22,987	21,387	93 %	108 %
Dental diseases prevention	12,512	14,886	12,574	84 %	100 %
Emergency dental care to adults	4,973	4,461	5,924	133 %	119 %
Total	**167,805**	**174,964**	**173,834**	**99 %**	**104 %**

Altogether, the EHIF paid EEK 173.834 million for dental services in kind during 2004, which accounts for 99 percent of the budget amount in 2004 and exceeds that of 2003 by 4 percent.
EEK 167.91 million was paid for the dental care (incl. dental treatment, orthodontia and prevention of dental diseases) of persons under age 19, which represents 98 percent of the 2004 budget.
The EHIF paid EEK 5.924 million in 2004 for emergency medical care for adults (tooth extraction, abscess opening). The amount exceeds the 2004 budget by 33 percent and the 2003 expenditure by 19 percent.

2. Health promotion expenses

The purpose of health promotion is to shape the behaviour and lifestyle of people so that they would value and promote human health, and to create environments that support good health practices.
Of the 76 projects subject to funding in 2004, 75 projects (99 %) were implemented. Of the total EEK 14 million allocated to health promotion, EEK 13.48 million (96.3 percent) were utilized.

Table 28. Implementation of the 2004 health promotion budget (in EEK thousand)

Health promotion activity	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget
Prevention of cardio-vascular diseases	1,588	1,289	1,289	100%
Prevention of home and leisure injuries and intoxication	2,474	3,115	2,950	95%
Prevention of malignant tumours	1,700	1,589	1,574	99%
Prevention of mental problems	1,844	1,849	1,847	100%
Prevention of infections diseases, incl. sexually transmitted diseases	1,430	1,055	1,020	97%
Projects targeted at various priority areas	4,764	5,103	4,800	94%
Total	**13,800**	**14,000**	**13,480**	**96%**

One project on trauma prevention remained unaccomplished in 2004. The project was targeted at visually disabled persons and the main reasons for non-implementation were corporate reorganisation and the preparation of new facilities specifically adjusted for the visually disabled.
Only the 1st stage of the multi-sector project on the development of an indicator system relating to healthy nutrition was completed in 2004, because several uncertainties about the viability of the project occurred, and the project can be implemented in the future along with the "Strategy for the prevention of cardio-vascular diseases", or the "Development Plan for Estonian Food". This explains the underspending in these areas.

Table 29. Indicators for the 2004 project activities

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

The financial audit of the 2004 health promotion projects (20 percent of funded projects) and the content evaluation of the projects (10 percent of funded projects), as well as the analysis of project effectiveness will be carried out in the 1st quarter of 2005.
According to the amendments to the Public Procurement Act, funding for health promotion projects will be transferred to procurement basis in 2005. The earlier project funding system based on citizen-initiated project applications will be converted into a centrally planned commissioning and monitoring system of activities. Introduction of the centrally planned system is more complicated in administrative terms, but it also enables to finance activities in areas which are evidence-based and cost-effective and conducive to proposed systemic changes in the state. According to principles of public procurement, we will ensure the best possible use of health promotion resources, which remain below the funding levels of previous years.

3. Expenditure on drug benefits

Spending on covered prescription drugs is an open commitment for the EHIF. In order to adjust this expenditure in compliance with the currently effective laws and regulations, the only action the EHIF can take is to influence through feedback the prescribing practices of doctors. Other 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 863.847 million (105.9 % of annual budget) in 2004. Compared with 2003, spending on drug benefits grew by EEK 180.91 million.

Table 30. Implementation of the 2004 budget for drug benefits

Drugs reimbursed for the insured (in EEK thousand)	2003 actual	2004 actual	2004 actual/ 2003 actual %
Drugs reimbursed at 100 %	214,113	301,219	141 %
Drugs reimbursed at 90 %	261,493	320,779	123 %
Drugs reimbursed at 75 %	78,604	81,678	104 %
Drugs reimbursed at 50 %	123,956	156,323	126 %
Drugs reimbursed under special conditions	4,771	3,848	81 %
Total drugs reimbursed for the insured	**682,937**	**863,847**	**126 %**

One of the reasons for a striking increase in drug benefit expenditure in 2004 is the unusually low drug utilization in the 1st quarter of 2003 due to massive purchases of prescription drugs at the end of 2002 in the fear that the new Health Insurance Act enters into force and the active ingredient based reference prices are established. Thus, the costs associated with drug benefits declined primarily in January and February 2003, but coupled with the completed reforms made an impact on annual outturn.

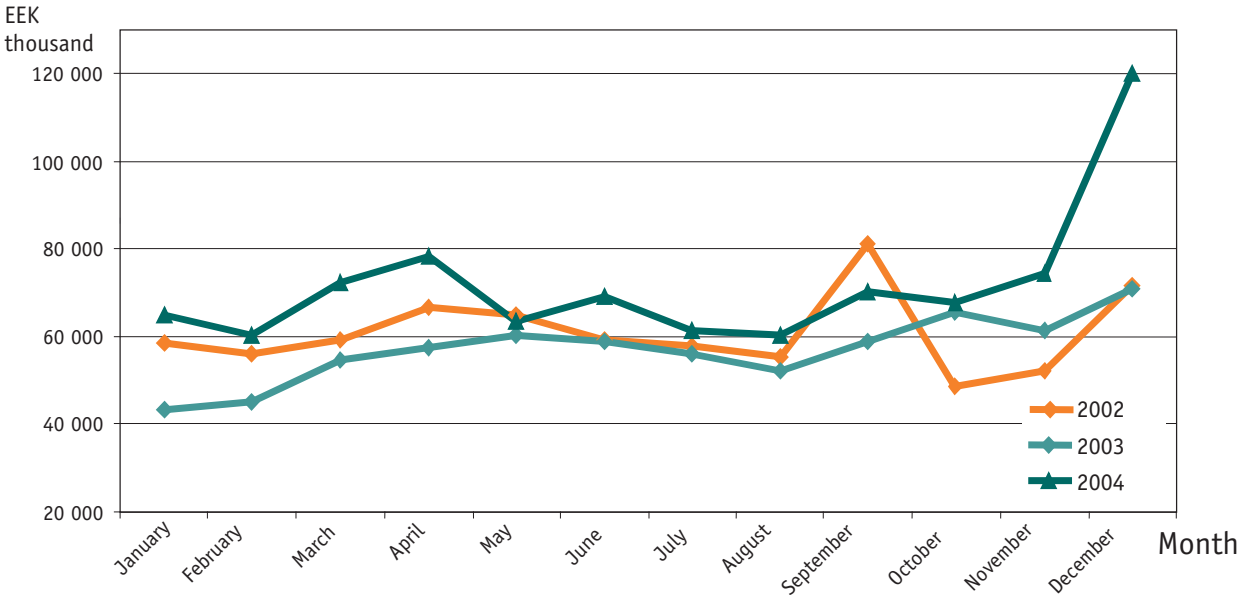
The 2004 data confirm the experience of other countries that there is only a temporary drop-off in the growth of drug benefits after large-scale reforms (establishment of reference prices and preferred drug lists, review of reimbursement rates), which reverses in the course of time without any additional measures.

Overspending on drug benefits can be explained by the following reasons:

- Considerable growth in drug benefits in March and April 2004, caused by a substantial increase in the purchases and usage of certain medicines before Estonia's accession to the EU, in the fear that they are removed from sale. If in February the EHIF paid EEK 60 million in drug benefits, then in March the respective amount was EEK 72 million and in April even 78 million.
- On 1 August 2004, amendments to the Health Insurance Act came into effect bringing about an essential increase in the EHIF expenditure on drug benefits in respect of the following groups of insured persons:
  - Children under age 4 – all drugs included in the drug list are reimbursed at 100 percent;
  - Children aged 4 to 16 years – drugs with a 75 % discount rate included in the drug list are reimbursed at 90 percent (until now only children under age 10 were qualified);
  - persons retired before attaining the age of 63 years - entitled to reimbursement at 90 percent for drugs with a 75 % discount rate included in the drug list.
- Lots of non-concluded price agreements on reimbursed drugs (the process became more intensive only in the 4th quarter);
- 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 2003, the decline in drug expenditure conditioned by the change of seasons took place in June, but in 2004 the sudden fall in expenditure occurred in the month of May already. This is obviously due to the acquisition of drug piles in March and April, prior to accession to the EU.

Chart 10. Seasonal aspects of expenditure on drug benefits in 2002-2004



Until then the month with the biggest expense on drug benefits through ages was September 2002, i.e. the month preceding the entry into force of the new Health Insurance Act. December 2004 exceeds the monthly record by nearly EEK 39 million or by 50 percent.

The number of EHIF-reimbursed prescriptions keeps increasing. In 2004, the number of covered prescriptions grew by 20 percent as compared to 2003. With reference to the EU member states, drug usage in the treatment of chronic diseases has been lower for years in Estonia, thus a rise in the number of prescription could be anticipated, furthermore, the acquisition of drug stockpiles in December partially accounts for the increase.

Drug benefits per insured person have also increased substantially. In 2003, the EHIF reimbursed an average of EEK 539 per patient per month, but in 2004 the respective amount was EEK 678 (growth of 26 percent). The average prescription cost in 2004 was EEK 180, the same for 2003 was EEK 171. Rise in the average cost of prescriptions is caused primarily by the rise in the proportion of medicines reimbursed at 100 percent.

Table 31. Number and average cost of prescriptions reimbursed by the EHIF in 2003 and 2004

Prescriptions	2003 prescriptions	2003 average cost	2004 prescriptions	2004 average cost
Reimbursed at 100 %	316,735	676	427,868	704
Reimbursed at 90 %	1,347,902	194	1,645,021	195
Reimbursed at 75 %	411,539	191	436,781	187
Reimbursed at 50 %	1,936,813	64	2,265,551	69
TOTAL	**4,012,989**	**171**	**4,775,220**	**180**

It appears from the detailed analysis of drug benefits that the biggest costs in 2004 were associated with medications used for the treatment of cardiac and vascular diseases, diabetes, bronchial asthma, cancer and primary hypercholesterolemia.
As expected, the biggest amount of covered drugs is related to the diagnosis of hypertension, which is included in the list of drugs with a 75 % or a 90 % discount rate. 199,070 patients used drugs for curing hypertension and their benefits account for 54 percent of all abovementioned drugs reimbursed by the EHIF. Cardiac and vascular diseases constitute the primary cause of death in Estonia and according to the expert group of the Estonian Society of Cardiology, the actual number of patients in need of pharmaceutical therapy is estimated to be 338,000. Thus, we see it as positive that the number of patients receiving treatment has risen by 7 percent as compared to 2003 and the number of prescriptions has risen by 24 percent, which in turns reflects improvements in therapeutic continuity referred to as a major problem for years.
Among the prescription drugs reimbursed at a rate of 100 percent, the first place in 2004 was overwhelmingly occupied by insulin preparations used for the treatment of diabetes, accounting for 33 percent of expenditure in the respective category.
Analysing the spending on drug benefits by different reimbursement rates, the biggest cost item is still the drugs with the reimbursement rate of 90 % - such drugs were reimbursed at a total cost of EEK 320.779 million, representing 37 percent of total costs.
The biggest growth, however, has taken place in respect of drugs reimbursed at 100 percent. This category mainly contains expensive medicines, which do not have generic alternatives. Another important factor here is the fact that the process of concluding price agreements has turned out to be slower than intended. These circumstances have caused the continued growth in the proportion of medicines reimbursed at 100 percent. A sudden increase in the proportion of these drugs could be anticipated in the light of amendments to the Health Insurance Act effective since August 2004. The proportion of drugs reimbursed at 100 percent as a percentage of total drug benefits expenditure has grown as follows:

- 32 % in January 2004,
- 34 % in June 2004,
- 36 % in September 2004,
- 38 % in December 2004.

In terms of money, this means an overall spending of EEK 301.219 million, which exceeds the respective spending in the previous year by EEK 87.106 million.
Drugs reimbursed at 50 percent are not subject to a reference price or a price agreement, as a rule, and the prescriptions with a 50 % discount rate are subject to reimbursement by the EHIF to a maximum of EEK 200 per prescription. Therefore the rise in the price of these medicines has had little impact on the average prescription cost so far. The situation changed on 1 August 2004, when the same drugs were reimbursed at 100 percent for children under age 4. Increase in the price of these drugs will significantly influence the overall drug benefits budget.
The proportion of drugs reimbursed at 75 % and 50 % has been relatively stable, accounting for 9 percent and 18 percent of the overall spending, respectively.
The EHIF reimbursed, on an exceptional basis, the prescription drugs for a total cost of EEK 3.848 million in 2004, which accounts for 0.45 percent of the overall spending and is the only benefit cost category that decreased during 2004.

4. Expenditure on temporary incapacity benefits

In the 2004 budget, EEK 973.242 million were appropriated for the benefits for temporary incapacity for work. The actual spending in 2004 exceeds the budget by 13 percent or by EEK 128.738 million.
Spending on benefits for temporary incapacity for work increased by 19 percent in 2004, as compared to 2003.

Table 32. Expenditure on incapacity benefits in 2003 and 2004

Expenditure on incapacity benefits (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %
Sickness benefits	604,217	625,249	723,458	116%
Nursing benefits	91,877	98,685	104,890	106%
Maternity benefits	204,727	228,993	253,219	111%
Work injury benefits	23,108	20,315	20,413	100%
Total	**923,929**	**973,242**	**1,101,980**	**113%**

Since 2001, spending on the benefits for temporary incapacity for work has been growing. Over the four years, spending on sickness benefits has grown on average by 13 percent, on nursing benefits by 7 percent, on maternity benefits by 20 percent, on work injury benefits by 2 percent.
Of all expenditure on incapacity benefits, sickness benefits account for 65 percent, maternity benefits for 23 percent, nursing benefits for 10 percent and work injury benefits for 2 percent. Such breakdown of expenditure on incapacity benefits has been comparatively stable over the years.

Table 33. Spending on benefits for incapacity for work, 2001- 2004

Expenditure on incapacity benefits (in EEK thousand)		2001	2002	2003	2004	2002/ 2001	2003/ 2002	2004/ 2003
Sickness benefit	Number of certificates of incapacity for work	357,439	345,554	382,685	412,363	-3%	11%	8%
	Number of days	4,550,804	4,503,983	4,732,748	5,222,195	-1%	5%	10%
	Benefit amount	499,097	529,829	604,217	723,458	6%	14%	20%
	Average earnings per day	110	118	128	139	7%	9%	9%
	Average length of sick leave	12.7	13.0	12.4	12.7	2%	-5%	2%
Maternity benefit	Number of certificates of incapacity for work	10,623	12,330	11,241	11,537	16%	-9%	3%
	Number of days	1,059,199	1,177,729	1,252,850	1,356,258	11%	6%	8%
	Benefit amount	148,353	182,022	204,727	253,219	23%	12%	24%
	Average earnings per day	140	155	163	187	10%	6%	14%
	Average length of sick leave	99.7	95.5	111.5	117.6	-4%	17%	5%
Nursing benefit	Number of certificates of incapacity for work	73,929	64,445	69,184	73,325	-13%	7%	6%
	Number of days	633,256	557,545	585,269	624,096	-12%	5%	7%
	Benefit amount	86,802	82,229	91,877	104,890	-5%	12%	14%
	Average earnings per day	137	147	157	168	8%	6%	7%
	Average length of sick leave	8.6	8.7	8.5	8.5	1%	-2%	1%
Work injury benefit	Number of certificates of incapacity for work	6,870	7,572	6,871	5,863	10%	-9%	-15%
	Number of days	151,097	171,850	146,411	118,941	14%	-15%	-19%
	Benefit amount	19,976	25,177	23,108	20,413	26%	-8%	-12%
	Average earnings per day	132	147	158	172	11%	8%	9%
	Average length of sick leave	22.0	22.7	21.3	20.3	3%	-6%	-5%
Total benefits	Number of sick certificates of incapacity for work	448,861	429,901	469,981	503,088	-4%	9%	7%
	Number of days	6,394,356	6,411,107	6,717,278	7,321,490	0.3%	5%	9%
	Benefit amount	754,228	819,257	923,929	1,101,980	9%	13%	19%
	Average earnings per day	118	128	138	151	8%	8%	9%
	Average length of sick leave	14.2	14.9	14.3	14.6	5%	-4%	2%

Of all spending on incapacity benefits, 99 percent is expenditure on benefits for employees working under employment contract. Expenditure on the self-employed represents about 1 percent of total expenditure. Such breakdown of spending has been stable throughout 2001-2004.
The average expenditure per calendar day in 2004 for a self-employed person was EEK 57, for an employer – EEK 141. Increase from 2001 through 2004 has been 18 percent and 8 percent respectively.

The continued growth in spending on benefits for temporary incapacity for work from 2001 to 2004 has been caused by:

- Growth in the average earnings per day triggered by constant rise in gross wages;
- Growth in the number of days of incapacity, triggered by:
  - increase in the number of the working insured;
  - changes in the age structure of workforce;
  - the 2002 amendments to the Health Insurance Act;
  - changes in the economic environment.

Growth in the average earnings per day

A rise in gross wages over the years, on average by 9 percent 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.[2] The earnings per calendar day of the insured applying for maternity benefit are nearly 30 percent higher than the earnings of the insured applying for sickness benefit, because the women delivering today mostly have higher education, they are somewhat older and better off.[3]

Increase in days of incapacity for work

In 2003 and 2004, the days of incapacity in a year grew by 5 percent and 9 percent, respectively.

Increase in the number of maternity benefits days is due to more births.
In 2004, 11,537 certificates for maternity leave[4] were filed with the EHIF for reimbursement, which is 3 percent more than in 2003.
Increase in the number of women giving birth has been promoted by the payment of parental allowance to women who have given birth, as well as a bigger generation of women reaching the reproductive age and the fact that women who postponed delivery in the 1990s give birth now.[5]

Increase in the number of nursing benefit days since 2003 is caused by the growing number of deliveries since 1998. In 2000, the birth rate in Estonia grew by 7 percent as compared to 1998, children born during this period fell to the age group 3 to 5 years in 2003.

The number of benefit days related to work injury have decreased since 2003 due to the amendment effective 1 July 2003, according to which accidents that happen on way to work are not regarded as work accidents.

Increase in the number of sickness benefits days is due to the following:

- Increase in the number of working insured

In 2001-2002 the number of insured in employment remained stable, making on average 45 percent of all insured. In 2003-2004, the number of working insured grew by 1-2 percent due to the effect of an increase in employed workforce[6] and it now represents 47 percent of all persons covered by health insurance.

Table 34. Number of the insured and their proportion of the insured in employment (2001-2004)

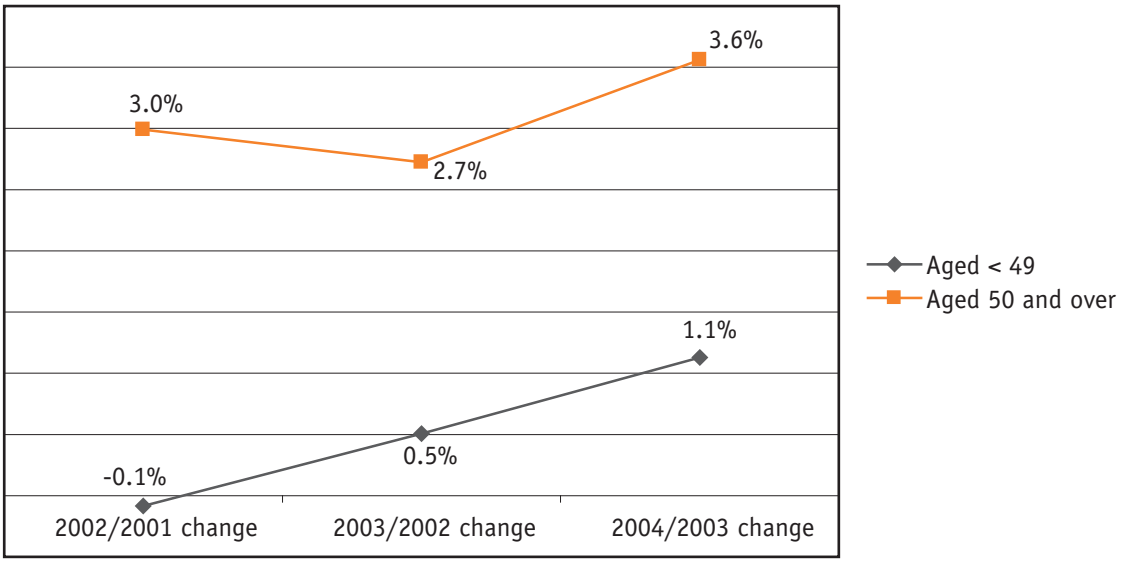
Persons / Year	2001	2002	2003	2004	2002/ 2001	2003/ 2002	2004/ 2003
Number of the insured	1,278,086	1,284,076	1,272,051	1,271,558	0%	-1%	0%
Insured in employment	574,284	578,578	585,139	595,734	1%	1%	2%
Insured in employment as a percentage of all insured	45%	45%	46%	47%			

[2] Since 1 April 2003 the amount of benefit for incapacity for work is calculated on the basis of the aggregate amount of social tax calculated or paid for a person during the whole preceding calendar year. In previous years, the calculation of benefit was based on the wage data for the last 6 calendar months furnished by the employer.
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.
[3] Estonian Statistical Yearbook 2004, p. 13, p. 35.
[4] The number of certificates comprises also extension certificates.
[5] Estonian Statistical Yearbook 2004.
[6] Employment has increased by 1-1.5 % in 2001-2004 (Data from the Labour Force Survey, 3rd quarter 2004).

Changes in the age structure of the working insured

Increase in the number of sickness benefit days is facilitated by a slow but stable change in the age structure of employees. The working insured of 50 years and over account for approximately 29 percent of all insured in employment and growth in the said age group is about 3 times as fast as that in the age group < 49 (see Chart 11). At the same time the average length of a sick leave increases along with an increase in age. The average length of a sick leave of employees under 50 years of age is 8.9 days, in case of employees over 50 years of age it is 12.8 days.

Chart 11. Increase in the proportion of the working insured



Increased average length of sick leave in older age groups can be explained by the fact that older people are ill with more serious and longer-lasting illnesses. For instance, vascular diseases, musculo-sceletal diseases and connective tissue diseases and tumours are causes for sickness leave more often after 45 years of age.

Amendments to the Health Insurance Act

In 2002, the provision of the Health Insurance Act that entitled employees to be absent from work, with prior notification of the employer, for health reasons or for nursing a child under age 14 for three days per calendar year without a proper certificate of incapacity for work, was repealed.
Since it is not possible any more to use such "health days" in case of a lighter illness and right to stay away from work is only secured by a medical certificate, it constitutes another reason for an increase in the number of sickness benefit days.

Changes in the economic environment

An ever more stabilizing business environment has brought about a decline in unemployment.[7] Fear to lose a job has subsided and in case of illness people ask the doctor, as a rule, to issue a medical certificate.
Since the rate of sickness benefit is fairly favourable (80 % of the average earnings per calendar day) and the benefit is paid from the 2nd day of illness, it definitely contributes to the use of certificates of incapacity for work.[8]

During 2004, 51 employers requested that the EHIF verify the issue of 140 certificates of incapacity for work, of which 4 certificates were regarded to be ungrounded as a result of inspection by the EHIF.
The ex-post verification as to whether the issuing of the certificate of incapacity for work was justified is complicated if not impossible for the EHIF, because a person has usually recovered and inspection is limited to the examination of documents to find out if the doctor has completed the documents correctly, whether the documents record the grounds for the case and whether the grounds are justified.

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[7] In 2001-2003, employment grew by 1-1.5 percent every year (www.stat.ee).
[8] The EHIF pays benefit for temporary incapacity for work to an insured person as a percentage of his average earnings per calendar day, as follows:
1) 80 % in the event of receiving inpatient health care or nursing a child under 12 years of age in hospital;
2) 80 % in the event of nursing a child under 3 years of age or a disabled child under 16 years of age when the person nursing the child is him/herself ill or is receiving obstetrical care;
3) 80 % in the event of receiving outpatient health care, nursing a family member who is ill at home, temporary release from the performance of his duties, or quarantine.
4) 100 % in the event of nursing a child under 12 years of age at home;
5) 100 % in the event of pregnancy and maternity leave;
6) 100 % in the event of adoptive parents leave;
7) 100 % in the event of an illness or inquiry caused as a result of an occupational disease or an accident at work;
8) 100 % in the event of preventing a criminal offence, protecting national or public interests or saving a human life.

5. Other cash benefits

a) Dental benefits for adults

Overall, the EHIF paid EEK 69.617 million in dental benefits in cash in 2004. Compared to 2003, the budget increased by 7 percent.

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

- EEK 150 for a person aged 19 and over
- EEK 450 for a pregnant woman
- EEK 300 for persons with an increased need for dental treatment
- EEK 300 for a mother with a child under 1 year of age
- EEK 2000 spread over a period of 3 years as reimbursement for dentures to an insured person aged at least 63 years and to a old-age pensioner who may be younger than 63.

Table 35. Implementation of the 2004 budget for dental benefits

Dental benefits (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget	Increase 2003/2004
Denture benefit	39,464	94,608	41,357	44 %	105 %
Dental treatment benefit	25,890	59,685	28,260	47 %	109 %
Total	**65,354**	**154,293**	**69,617**	**45 %**	**107 %**

The amendment effective on 1 August 2004 enlarged the circle of applicants for dentures by old-age pensioners as defined by the State Pension Insurance Act. This did not bring about an expected increase in the number of applicants for denture benefits.

Awareness of people of their eligibility for dental benefits has increased. In 2003, only 43 percent of respondents knew their right to apply for dental care benefits, but in 2004 this awareness had increased by 72 percent. However, irrespective of increase in awareness, the number of applicants for dental benefits has increased by only 1 percent and the percentage of eligible applicants for dentures has remained on the 2003 level. In 2004, 10 percent of those eligible applied for denture benefits and 18 percent applied for dental benefits. The respective indicators for 2003 were 10 percent and 17 percent.

Table 36. Number of dental benefit cases

Number of dental benefit cases	Estimated cases in 2003	Actual cases in 2003	Estimated cases in 2004	Actual cases in 2004	Performance level for 2004
Denture benefit	47,320	23,992	52,561	27,851	53%
Dental treatment benefit	592,484	161,917	331,577	177,914	54%
Total	**639,804**	**185,909**	**384,138**	**205,765**	**54%**

b) additional drug benefit

In 2004, the EHIF paid EEK 2.82 million in additional drug benefits to 704 persons.

Table 37. Implementation of the budget for additional drug benefits in 2004

	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Additional drug benefit (in EEK thousand)	2,122	2,000	2,820	141%	133%

The insured became entitled to additional drug benefits on 1 January 2003, when § 47 of the Health Insurance Act entered into force. Additional drug benefit 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 EEK 6,000 per calendar year on buying drugs included in the EHIF drug list, to receive additional monetary benefit. The maximum additional benefit per person per calendar year is EEK 9,500.

Additional drug benefit 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 additional drug benefits grew by 33 percent in 2004, exceeding the budgeted amounts, as compared with 2003 when the right to receive additional drug benefit was enforced. Such a big increase allows for a conclusion that there is sufficient awareness of a new additional benefit.

6. Other benefit expenses

Health insurance benefits arising from international health agreements

The Republic of Estonia has concluded agreements on social security (incl. health insurance) with Latvia, Lithuania, Sweden and Finland. The agreement with Sweden covered only medical care. Under the agreements the insured citizens of those states were entitled to emergency care during their stay in Estonia, on the account of EHIF resources. International agreements were effective till 1 May 2004 or the date when Estonia became a full member of the European Union.

The EHIF forecasted expenditure on medical services arising from international agreements on health insurance on the basis of expenses incurred in relation with international agreements in the years preceding 1 May 2004 and the forecast amounted to EEK 480,000. The EHIF paid EEK 495,000 to Estonian health care institutions for the emergency care provided to the insured from the countries covered by international agreements. At this, EEK 246,000 were paid for the emergency care for Finnish citizens, EEK 206,000 for care for Swedish citizens, EEK 29,000 for care for Latvian citizens and EEK 14,000 for care for Lithuanian citizens.

Benefits for the Estonian insured in other EU member states

Since 1 May 2004, delivery of and payment for emergency care and medical 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 Council Regulation (EEC) No 574/72 laying down the procedure for implementing Regulation (EEC) No 1408/71.

Health insurance benefits under these regulations are an open commitment for the EHIF. From the day when Estonia became a member of the EU, the persons insured by the EHIF are entitled to:

- emergency care during their temporary stay in another member state, and since 1 June 2004 any needed medical care;
- any medical care if residing in a member state.

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

It was extremely difficult to estimate respective expenditures for 2004, because the EHIF lacked relevant statistics, prior experience and international practice in this field. Therefore the EHIF relied on the statistics of international agreements and appropriated EEK 12.086 million for those expenditures. Actual expenditure in 2004 was EEK 1.856 million.

Medical device benefits

Table 38. Implementation of the budget for medical device benefits in 2004

Medical device benefits (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Primary prostheses and orthoses	6,201	7,560	7,560	100%	122%
Diabetes test strips	6,139	6,300	7,870	125%	128%
Stoma appliances	5,904	6,300	7,230	115%	122%
Spacer devices	0	400	94	24%	
Other devices	425	5,018	381	8%	90%
Total	**18,669**	**25,578**	**23,135**	**90%**	**124%**

In 2004, the EHIF reimbursed medical devices for EEK 23.135 million (90 percent of the 2004 budget). Underspending on medical devices is due to lower spending on spacers and other devices. The funds unused for other devices were allocated for diabetes test strips, for which there was an increased demand.

1183 insured persons received benefits for primary prostheses and orthoses, of which 271 persons received benefits for primary prostheses and 912 persons for post-trauma or surgery orthoses, of whom 238 were children. In 2003, only 739 persons received benefits for prostheses and orthoses. Thus, the number of recipients of orthoses has increased by 94 percent owing to the increased awareness of the insured.

A major cost element over the years has been the diabetes test strips. The higher expenditure here has been caused by an increase in the number of diabetics belonging to the concessionary group. In 2003, there were 3,960 test strip users, but by the end of 2004 the number of users had risen by 24 percent, amounting to 4,899 persons.

A 15 percent overspending on stoma appliances is mainly due to the inclusion of two new appliances on the list of medical devices and the increased quantity of appliances sold per person per calendar year. Amendments to the regulation took effect in the 2nd quarter of 2004 and therefore an additional spending of EEK 1.1 million on stoma appliances was offset by underspending on other medical devices. In 2004, medical device benefits were awarded to 1281 persons with a stoma (to 1,110 insured persons in 2003).

Spacer devices have been reimbursed for asthmatic children since 2003. Until 2004, they were reimbursed on the account of funds appropriated for other medical devices. In preparing the 2004 budget, spacers were forecasted for 800 patients, but actually were reimbursed for 201 patients.

From the budget line of other medical devices, the EHIF reimbursed the compression burn garments (implemented at 85 percent of the budget), therapeutic contact lenses (implemented at 81 percent of the budget) and from the 2nd quarter also disposable bladder catheters as a new benefit. Underspending on other medical devices is mainly due to lower demand for disposable bladder catheters (4.3 percent of the budget).

II Operating expenses

The EHIF expended EEK 80.112 million on the administration of medical benefits in 2004. The budget for operating expenses was implemented at 89 percent.

7. Personnel and administrative expenses

Table 39. Implementation of the budget for personnel expenses

Personnel expenses, (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Total salaries	32,058	32,940	37,295	33,545	90%	102%
Basic salary	26,067	27,159	30,005	27,686	92%	102%
Performance pay	4,159	4,059	5,172	4,157	80%	102%
Management Board remuneration (basic and performance-related)	1,829	1,719	2,113	1,699	80%	99%
Supervisory Board remuneration	3	3	5	3	60%	100%
Unemployment insurance premiums	158	149	187	158	84%	106%
Social tax payments	10,580	10,871	12,307	11,070	90%	102%
Total	**42,796**	**43,960**	**49,789**	**44,773**	**90%**	**102%**

Personnel expenses include 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 2004 budget for personnel expenses was implemented at 90 percent. 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 structural changes in departments.

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 40. Examples of service volumes in the EHIF in 2002- 2004

	2002	2003	2004	2004 / 2003
Medical bills processed	6,512,890	5,889,696	3,879,592	66%
Covered prescriptions processed	4,118,000	4,012,989	4,775,221	119%
Certificates of incapacity for work processed	444,364	639,882	506,355	79%
Treatment records inspected	5,966	14,186	13,400	94%
Contract annexes administered	1,321	1,112	1,120	101%

* 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 2004 the resources required for EHIF business processes dropped by 4 man years. By the end of 2003, the resource need had decreased by 42 man years, as compared with 2002.

Table 41. Resource needs of the EHIF in 2003-2005

Business processes and required resources	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 for health insurance benefits	3	4	4	0
Administration of health services contracts	12	7	9	2
Processing of health insurance benefits	62	43	56	13
Processing of covered drugs	10	3	8	5
Processing of medical services	15	6	10	4
Processing of incapacity benefits	24	23	25	2
Processing of cash benefits	10	10	12	2
Processing of other health services	3	1	1	0
Benefit inspection	49	41	35	-6
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 processibility	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 decline is mainly due to the standardisation and automation of business processes. In the light of re-arrangements concerning business processes, the EHIF is aiming at the predominance of highly qualified personnel over the staff performing routine tasks.

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 in the EHIF and promote the preventive monitoring of agreements.

There is also a growing need for resources for the development of health insurance benefits. Benefit development entails the development of the services price list, clinical guidelines, complex prices (DRG), the harmonisation of principles with the EU, etc. 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 has decreased as a result of introduction of electronic controls. Application of electronic controls enables to reduce the volume of medical documentation subject to examination and at the same time improves the quality of control.

8. Overhead expenses

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

Table 42. Implementation of the overhead budget

Overhead (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Office expense	3,604	3,626	4,297	3,292	77%	91%
Facilities maintenance	5,980	7,614	8,027	7,650	95%	100%
Supplies and equipment	1,413	1,458	1,264	1,446	114%	99%
Vehicle maintenance	1,872	1,846	1,891	1,703	90%	92%
Business travel	280	461	987	793	80%	172%
Other overhead expenses	898	700	1,096	1,352	123%	193%
Total	**14,047**	**15,705**	**17,562**	**16,236**	**92%**	**103%**

The overhead of EEK 16.236 million represents 92 percent of the budgeted amount. The implementation of the budget by cost category is different. Supplies and equipment and miscellaneous operating expenses were overspent. Business travel, office expenses and vehicle maintenance were underspent.
Office expenses include stationery, postage and communications expenses and expenses for newspapers and publications. Expenditure on postage and communications is below the budgeted amount.
Supplies and equipment includes furnishings (furniture), office equipment and maintenance and repairs of equipment. Budget implementation is comparable with that of previous years, but the 2004 budget has been overspent by 14 percent.
Business travel expenses include the reimbursement of costs incurred in relation with business trips, including car allowance. Business travel expenses have doubled as compared with 2003, but they still remain below the budgeted cost, accounting for 82 percent of the estimated amount. The reason for underspending on business travel is the lower than anticipated cost of business trips relating to the preparation for accession to the EU.
Other expenses include expenses incurred in relation with recruitment, health services and other outsourced services (incl. translation service), representation and fringe benefit costs.

9. Information technology (IT) expenses

Table 43. Implementation of the IT budget

Information technology (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Personal hardware and software	921	1,776	1,311	2,187	167%	123%
Information systems development	4,163	3,596	4,000	1,214	30%	34%
Information systems maintenance	9,008	6,688	6,114	5,196	85%	78%
Other IT expenses	469	368	540	499	92%	136%
Total	**14,561**	**12,428**	**11,965**	**9,096**	**76%**	**73%**

The budget for IT was implemented at 76 percent.
Overspending on personal hardware and software is due to the acquisition of a new data repository in order to ensure the smooth running of business processes in the light of constantly growing data volumes.
We intended to launch in 2004 the projects on e-certificates of incapacity for work and the register of the insured. However, we succeeded in completing only the analytical stage in 2004, and the project expenses were carried forward to 2005, thus the IT development costs were not incurred to the planned extent.

Major IT development programmes in 2004 included:
- electronic processing of medical bills and covered prescriptions;
- partial transition to the system of diagnosis-specific funding (DRG-based system).

10. Development expenses

Table 44. Implementation of the development budget

Development expense (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget%	2004 actual / 2003 actual %
Training	1,668	1,748	2,005	1,756	88%	100%
Consultations	797	1,355	2,573	2,413	94%	178%
Business consultation	341	1,022	1,833	2,048	112%	200%
Legal consultation	456	333	740	365	49%	110%
Total	**2,465**	**3,103**	**4,578**	**4,169**	**91%**	**134%**

Development costs account for 91 percent of the budgeted amount.

Training costs account for 88 percent of the budgeted amount. Underspending is due to the postponement of training programmes on competence assessment and on the introduction of IT-related development projects. In 2004, training was 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 exchange between partners.

Outsourcing for consultation services (mainly committees, expert evaluations, advisory bodies and working groups) are reported under expenditure on business consultations. The budget has been implemented at 112 percent. In relation with the development of an activity-based costing model, the funds appropriated for the price list were exceeded by 64 percent. Of EEK 460,000 foreseen for the complex prices, EEK 435,000 were actually utilized.

Table 45. Implementation of the budget for business consultations

Business consultations (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %
Price list	55	492	575	941	164%
Complex prices for health services	0	195	460	435	95%
Treatment instructions	0	137	400	279	70%
List of covered prescription drugs	33	68	53	35	66%
Health services	0	48	137	115	84%
Other	253	82	208	243	117%
Total	**341**	**1,022**	**1,833**	**2,048**	**112%**

Expenditure on legal consultations was related to legislation and contracts as well as the list of covered prescription drugs (bills, expertise). Legal consultation was underspent, making only 49 percent of the budgeted amount. Underspending is due to the lower volume of court cases against the insured and fewer statutory disputes on decisions made on the funding of medical services by health services providers (only one dispute).

11. Financial expenses

Table 46. Implementation of the budget for financial expenses

Financial expense (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Bank charges	435	495	790	804	102%	162%
National Treasury administration costs	50	77	66	66	100%	86%
Other financial expenses	29	29	32	28	88%	97%
Total	**514**	**601**	**888**	**898**	**101%**	**149%**

The budget for financial expenditure (bank charges and charges for the administration of the legal reserve and other financial expenses) has been implemented at 101 percent.
Other financial expenses consist mainly of foreign currency translation losses.

12. Other operating expenses

Table 47. Implementation of the budget for other operating expenses

Other operating expenses (in EEK thousand)	2002 actual	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %	2004 actual/ 2003 actual %
Pre-printed forms and publications	476	1,057	1,602	1,082	68%	102%
Supervision	527	1,066	1,475	945	64%	89%
Public relations/ public information	1,185	752	1,030	914	89%	122%
Other expenses	5,099	7,953	923	1,999	217%	25%
Total	**7,287**	**10,828**	**5,030**	**4,940**	**98%**	**46%**

Expenditure on other operating expenses was implemented at 98 percent.

68 percent of the budget for pre-printed forms and publications was implemented. In preparing the 2004 budget, the price of the pre-printed prescription forms was estimated to be 1.5 times higher than the actual price.

Expenditure on supervision in 2004 included the financial audit, the internal audit and the clinical audits. Budget for internal audit was not implemented and budget for health insurance supervision was implemented only partially.
The budget for internal audit included risk assessment and an external audit for the inspection of EHIF processes. In 2004 there was no need for an external audit and risk assessment was also conducted with own resources and the budget funds remained unused.

Table 48. Implementation of the supervision budget

Supervision (in EEK thousand)	2003 actual	2004 budget	2004 actual	2004 actual/ 2004 budget %
Internal audit	89	200	0	0%
Health insurance	586	935	672	72%
Financial audit	391	340	273	80%
Total	**1,066**	**1,475**	**945**	**64%**

Expenditure on public relations and public information consists of health services flyers, The Estonian Health Insurance Fund Gazette and other information materials, 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 EEK 1.168 million 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.
In 2003, claims worth of EEK 2.863 million were established as uncollectible and claims worth of EEK 4.37 million were established as doubtful and were written off.

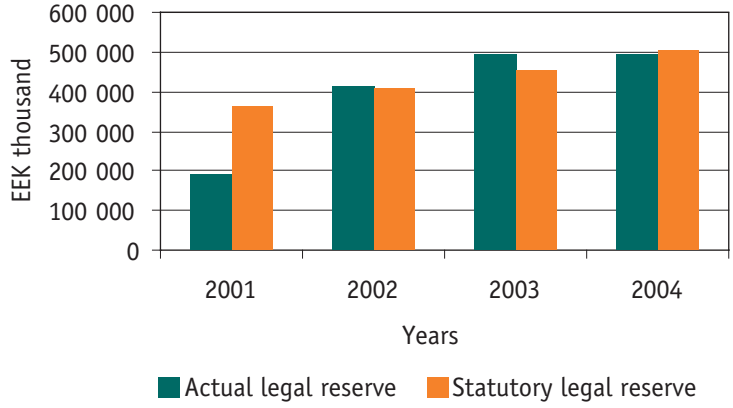
13. Legal reserve

The legal reserve equalled 8 percent of the budget in 2004. Amendments to the Estonian Health Insurance Fund Act were adopted on 16 December 2004, establishing that the legal reserve be 6 percent of the budget volume. The amendment took effect on 1 May 2005.

As of 31 December 2004, the legal reserve of the EHIF was EEK 493.363 million. Pursuant to the decision of the EHIF Supervisory Board, EEK 70 million from the legal reserve will be utilized in 2005.

The legal reserve will be EEK 423.363 million in 2005. No provisions for the legal reserve have been appropriated in the 2005 budget.

Chart 12. Legal reserve in 2001-2004 (in EEK thousand)



14. Risk reserve

The risk reserve equals 2 percent of the health insurance budget of the EHIF.
As of 31 December 2004, the EHIF risk reserve was EEK 146.148 million. The 2005 budget does not foresee provisions for the risk reserve.

Chart 13. Risk reserve in 2001-2004 (in EEK thousand)

15. Retained earnings

As of 31 December 2004, the retained earnings of the EHIF constituted EEK 874.986 million. The retained earnings have been formed from:

1) retained earnings of EEK 233.362 million from the 2003 fiscal year;
2) inflows in social tax, which exceeded the estimated amounts by EEK 197.349 million (3.2 %) in 2004. The EHIF used part of this surplus for covering the overspending on drugs and incapacity benefits. As a result, the retained earnings for the 2004 fiscal year are EEK 133.028 million.
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 EEK 502.617 million transferred by the Tax and Customs Board and by EEK 5.979 million transferred by the Social Insurance Board. Increase in the retained earnings for the previous periods does not increase real cash flows.

According to the decision of the EHIF Supervisory Board, EEK 228.399 million will be paid to the health service providers under health funding contracts for the specialized medical services rendered to the insured in 2005 on the account of the retained earnings from earlier periods.

Annual Accounts for 2004

Statement by the Management Board

The Management Board declares its responsibility for the accuracy of the Estonian Health Insurance Fund's annual accounts for 2004 as set out on pages 55 to 72 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 and the revenue and expenditure of the Estonian Health Insurance Fund;
- all relevant circumstances, which have occurred before the completion of the report, i.e., 31.03.2005, 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**	.....	.....

Balance sheet

ASSETS	Balance sheet 31.12.2003 adjusted	Balance sheet 31.12.2004	Note
Current assets			
Cash and bank accounts	212,300,600	394,103,852	2
Shares and other securities	753,997,276	601,400,250	3
Customer receivables			
Accounts receivable	7,847,431	3,654,406	
Allowance for uncollectible accounts	-4,358,753	-506,915	
Total	3,488,678	3,147,491	
Other receivables			
Other short-term receivables	34,114,253	19,890,058	4,8
Accrued income			
Interest receivable	357,369	501,545	
Other accrued income	591,813,797	618,974,027	5
Total	592,171,166	619,475,572	
Prepayments			
Other prepaid expenses	858,910	1,386,019	
Inventories			
Goods for resale	153,602	102,059	6
Total current assets	**1,597,084,485**	**1,639,505,301**	
Fixed assets			
Long-term financial investments			
Shares	180,000	90,000	3
Long-term securities and bonds	192,484,978	297,876,520	3
Other long-term receivables	27,666,206	19,703,862	7,8
Total	220,331,184	317,670,382	
Tangible fixed assets			
Land and buildings	3,178,768	2,995,841	
Machinery and equipment	8,474,822	7,653,338	
Other inventories	16,123,017	13,150,525	
Accumulated depreciation	-21,073,112	-15,493,633	
Total	6,703,495	8,306,071	9
Intangible fixed assets			
Purchased licences	1,896,948	1,230,171	9
Total fixed assets	228,931,627	327,206,624	
TOTAL ASSETS	**1,826,016,112**	**1,966,711,925**	

LIABILITIES AND EQUITY CAPITAL	31.12.2003 adjusted	31.12.2004	Note
Liabilities			
Current liabilities			
Debts			
Unsecured debt obligations	1,772,225	1,879,244	10
Supplier payables			
Accounts payable for medical care services	317,867,386	279,644,391	
Accounts payable for medicinal products subject to discount	50,626,211	106,175,460	
Supplier payables for health insurance benefits	39,598,933	22,826,243	
Other supplier payables	2,081,276	3,831,736	
Total supplier payables	410,173,806	412,477,830	
Taxes payable	24,429,271	31,231,806	11
Accrued expenses			
Employee-related liabilities	5,728,728	6,241,161	
Other accrued expenses	292,983	194,889	
Total	6,021,711	6,436,050	
Short-term provisions	64,443	0	
Total current liabilities	442,461,457	452,024,931	
Long-term liabilities	2,085,284	190,051	10
Total liabilities	444,546,741	452 ,14,982	
Equity capital			
Reserve			
Reserves	561,555,528	639,511,528	
Net surplus/deficit			
Net surplus/deficit for previous periods*	508,595,726	741,957,843	
Net surplus/deficit for financial year	311,318,117	133,027,572	
Total equity capital	1,381,469,371	1,514,496,943	
TOTAL LIABILITIES AND EQUITY CAPITAL	**1,826,016,112**	**1,966,711,925**	

* The annual accounts for 2004 adjust the retained earnings for 2003, because the accounting policies applied by the Tax and Customs Board have been changed. The net result of previous periods comprises the balance of EEK 502,617,091 transferred by the Tax and Customs Board and EEK 5,978,635 of prepaid rental charges transferred by the Social Insurance Board. (In addition, see point 15 on page 54, Retained earnings.)

Statement of revenue and expenditure

Statement of revenue and expenditure

	2003 adjusted	2004	Note
Revenue from the health insurance part of social tax and claims collected from other persons	5,646,042,950	6,287,583,244	12
Revenue from grant financing	432,042	0	
Expenditure on health insurance	-5,292,194,090	-6,136,989,416	13
Gross surplus/deficit	354,280,901	150,593,828	
General administrative expenditure	-75,195,385	-74,273,641	14
Revenue from grant financing	-432,042	0	
Other operating revenue	18,562,438	31,467,195	
Other operating costs	-10,827,869	-4,940,145	
Operating surplus/deficit	286,388,043	102,847,236	
Financial revenue	25,855,405	31,078,423	
Financial expenses	-925,331	-898,087	
Net deficit/surplus for financial year	311,318,117	133,027,572	

Cash flow statement

Cash flow from operating activities	2003	2004
Social tax received	5,621,542,666	6,250,504,965
Payments to suppliers	-5,264,596,923	- 6,164,534,965
Personnel expenses paid	-32,043,420	- 33,020,981
Taxes paid on personnel expenses	-11,100,488	- 11,389,140
Other revenue received	67,857,298	89,175,888
Other expenses paid	-44,108	-563,855
Total cash from operating activities	**381,615,025**	**130,171,912**
Cash flow from investing activities		
Purchase of fixed assets	-2,498,712	- 7,311,403
Proceeds from disposals of foxed assets	15,543	2,484,987
Proceeds form disposals of short-term financial assets	1,598,848,301	1,735,449,750
Purchase of short term financial assets	-2,016,720,691	-1,577,391,651
Proceeds from long-term financial assets	309,226,737	586,960,637
Purchase of long-term financial assets	-367,212,075	- 688,560,980
Total cash flow from investing activities	**-478,340,895**	**51,631,340**
Total cash flow	-96,725,870	181,803,252
Cash and cash equivalents at the beginning of period	309,026,470	212,300,600
Change in cash and cash equivalents	-96,725,870	181,803,252
Cash and cash equivalents at the end of period	212.300,600	394,103,852
incl. short-term deposits	180,000,000	372,000,000

Statement of changes in equity

Legal reserve	20003 adjusted	2004
Legal reserve at the beginning of the year	189,810,061	561,555,528
Formation	371,745,467	77,956,000
Reserves at the end of the year	561,555,528	639,511,528
Net surplus/deficit for previous periods		
At the beginning of the year	371,745,467	819,913,843
Adjustment of net surplus/deficit for previous periods*	508,595,726	0
Payment to form legal reserve	-371,745,467	- 77,956,000
Net surplus/deficit for financial year	311,318,117	133,027,572
At the end of the year	**819,913,843**	**874,985,415**
Equity at the beginning of the year	561,555,528	1,381,469,371
Equity at the end of the year	1,381,469,371	1,514,496,943

* The annual accounts for 2004 adjust the retained earnings for 2003, because the accounting policies applied by the Tax and Customs Board have been changed. The net result of previous periods comprises the balance of EEK 502,617,091 transferred by the Tax and Customs Board and EEK 5,978,635 of prepaid rental charges transferred by the Social Insurance Board. (In addition, see point 15 on page 54, Retained earnings.)

Notes to the Annual Accounts

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

General principles

The annual accounts of the EHIF have been drawn up in accordance with the Accounting Act of Estonia and the generally accepted accounting principles based on internationally recognised accounting and reporting policies.
The financial year began on January 1, 2003 and ended on December 31, 2003. The figures in the annual accounts have been given in Estonian kroons.

Economic transactions are recorded at actual value according to the historical cost principle at the time of effecting. Financial statements are prepared on the basis of the accrual method.

Changes in the accounting policies

According to § 14 (1) of the General Rules for Government Accounting, the taxes are recognised in the statement of revenue and expenditure and balance sheet of the government accounting entity, who is designated as the recipient of the tax by the law. Therefore, the accounting policies of the Tax and Customs Board changed in 2004 and the data for the previous period were adjusted as follows to ensure comparability:

- Other accrued income (social tax receivables) +501,274,937 (EEK)
- Other long-term receivables
  (social tax receivables and prepayment for rent) + 7,320,789 (EEK)
- Net surplus/deficit for previous periods +508,595,726 (EEK)

Layouts used for reporting purposes

The balance sheet layout specified in the Accounting Act is used for the purpose of drawing up the annual accounts. 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.

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.

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.

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. In the cases where reliable assessment of the just value is not possible, the short-term financial investments are assessed on the balance sheet at their adjusted acquisition cost.

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 EEK. 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 EEK 10,000.
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.

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 § 39^1 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 size of the risk reserve shall be 2 % of the health insurance budget of the Health Insurance Fund.
- The funds of the risk reserve may be used upon a decision of the supervisory board of the Health Insurance Fund.

The EHIF 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 Fund Act by adding § 39^1 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 8 % of the budget (6 % as of 1.01.2005). 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.

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.

Note 2. Cash and bank accounts

	31.12.2003	31.12.2004
Deposits at call	32,300,600	22,103,852
Fixed term deposits	180,000,000	372,000,000
Total cash and bank accounts	212,300,600	394,103,852
Fixed term deposits:		
due within 1 month	180,000,000	260,000,000
due within 1 to 3 months	0	112,000,000
Total	**180,000,000**	**372,000,000**

Note 3. Shares and other securities

Short-term investments

Bond	Date of acquisition	Maturity date	Underlying currency	Acquisition value	Just value	Rate of return
Bond of Sampo Pank	16.06.2004	16.06.2005	EEK	19,486,320	19,777,970	2,60%
Bond of ANZ Bank	31.08.2004	23.02.2005	EUR	49,007,713	49,347,193	2,15%
Bond of the Government of the Netherlands	26.07.2004	31.03.2005	EUR	37,007,636	37,370,593	2,14%
Bond of the Government of France	11.10.2004	26.05.2005	EUR	46,310,511	46,552,766	2,16%
Bond of the Government of Belgium	1.10.2004	14.07.2005	EUR	46,133,468	46,416,837	2,20%
Bond of the Government of Belgium	31.12.2004	15.09.2005	EUR	55,466,734	55,476,929	2,17%
Bond of Rabobank	1.10.2004	9.09.2005	EUR	31,908,111	32,192,141	2,32%
Bond of KFW	12.10.2004	28.11.2005	EUR	19,615,204	19,576,455	2,43%
Bond of Eesti Ühispank	1.03.2004	1.03.2005	EEK	4,877,845	4,981,203	2,47%
Bond of Eesti Ühispank	26.03.2002	1.04.2005	EEK	10,000,000	10,456,565	5,15%
Bond of Eesti Ühispank	21.11.2002	1.04.2005	EEK	20,593,740	20,913,131	3,80%
Bond of Eesti Ühispank	13.02.2003	1.04.2005	EEK	10,436,663	10,456,565	3,50%
Bond of Eesti Ühispank	1.03.2004	1.04.2005	EEK	15,417,750	15,684,848	2,44%
Bond of ABN Amro	23.01.2004	23.01.2008	EUR	31,263,551	31,422,035	2,19%
General Electric KP	10.05.2004	4.05.2011	EUR	15,608,561	15,636,411	2,24%
Bond of Hansapank	19.10.2004	19.10.2009	EEK	31,426,147	31,489,496	2,41%
Bond of Citigroup	3.11.2004	3.06.2011	EUR	24,974,477	25,032,380	2,24%
Bond of Citigroup	16.01.2004	10.11.2008	EUR	31,243,210	31,368,809	2,21%
Bond of Sampo Pank	16.06.2004	16.06.2005	EEK	15,589,056	15,822,566	2,60%
Bond of the Government of France	8.10.2004	15.09.2005	EUR	61,273,763	61,642,337	2,26%
Bond of Eesti Ühispank	14.06.2004	14.06.2005	EEK	19,495,940	19,783,020	2,55%
Total				**597,136,400**	**601,400,250**	

Interest as of 31.12.2004 is also reflected in the just value of the securities.
Bonds maturing in 2005 and bonds acquired for the purpose of contributing to the risk reserve, which, in the opinion of the EHIF, shall probably be redeemed in 2005 are recognised as short-term investments.

Long-term investments
The Estonian Health Insurance Fund has acquired shares with the following nominal values:

	Shares of AS Viimsi Haigla (at cost)		Shares of AS Pärnu Mudaravila (at cost)	
	2003	2004	2003	2004
Balance at the beginning of year	90,000	90,000	90,000	90,000
Balance at the end of year	90,000	90,000	90,000	-

Shares of AS Pärnu Mudaravila were sold in 2004. Trade value of the shares was EEK 198,000, trading profit was EEK 108,000.
The Estonian Health Insurance Fund owns less than 20 % of the shares of AS Viimsi Haigla.

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

Bond	Date of acquisition	Maturity date	Underlying currency	Acquisition value	Just value	Rate of return
Bond of the Government of the Netherlands	2.02.2004	15.01.2006	EUR	41,729,589	42,856,756	2,45%
Bond of KFW	8.06.2004	18.08.2006	EUR	30,917,682	31,342,073	2,84%
European Investment Bank KP	6.08.2004	21.11.2008	EUR	15,650,266	15,728,467	6,34%
European Investment Bank KP	21.06.2004	21.11.2008	EUR	15,648,303	15,728,467	6,34%
Bond of Merrill Lynch	27.04.2004	22.07.2014	EUR	31,315,431	31,445,545	2,65%
Bond of Merrill Lynch	6.08.2004	22.07.2014	EUR	16,349,560	16,508,911	2,63%
Bond of the Government of Belgium	6.10.2004	28.03.2007	EUR	33,904,618	35,277,653	2,71%
Bond of the Government of Italy	10.11.2004	1.09.2006	EUR	28,296,250	28,571,692	2,50%
Bond of West LB	5.11.2004	5.11.2007	EUR	46,794,756	47,115,784	2,86%
Bond of the Government of Germany	17.11.2004	17.08.2007	EUR	32,860,989	33,301,172	2,58%
Total				**293,467,444**	**297,876,520**	

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

Note 4. Other short-term receivables

	31.12.2003	31.12.2004
Claim to the Russian Federation	17,018,111	3,344,237
Claim to Tallinn Diagnostic Centre	9,541,194	9,541,194
Short-term part of loans granted (see Note 8)	6,870,483	6,763,042
Claims for reimbursement of maintenance costs	53,243	103,719
Contractual claims against insured persons	84,807	191,245
Allowance for doubtful receivables	0	-53,379
Treatment of the conscripts and re-vindication of medicinal products from the army units according to the agreement	546,415	0
Total	**34,114,253**	**19,890,058**

The social department at the Embassy of the Russian Federation shall pay the debt in accordance with the prior agreement within 15 months as of January 2004.

Note 5. Other accrued income

As of 31.12.2004 other accrued income includes health insurance income from social tax paid by taxpayers, but not transferred by the Estonian Tax and Customs Board in the amount of EEK 618,974,027 (EEK 591,813,797 as of 31.12.2003).

Note 6. Inventories

As of 31.12.2004, the Estonian Health Insurance Fund has purchased pre-printed prescription forms costing EEK 102,059 (EEK 153,602 as of 31.12.2003).
No inventory discounts have been made in 2004.

Note 7. Miscellaneous long-term receivables

	31.12.2003	31.12.2004
Long-term part of loans granted to health care institutions by the EHIF (see Note 8)	20,345,417	13,582,375
Long-term tax claim against the Tax and Customs Board	1,342,154	254,823
Long-term part of the amount paid to the Social Insurance Board for renovating the premises of the Pärnu Department and the Rapla Office	5,978,635	5,866,664
Total	**27,666,206**	

Note 8. Loans granted by the Estonian Health Insurance Fund

As of 31.12.2003

Health care institution	Loan balance as of 31.12.2003	incl. the short-term part of the loan	incl. the long-term part of the loan	Balance of unpaid interest as of 31.12.2003
SA Põhja-Eesti Regionaalhaigla	23,680,168	5,400,000	18,280,168	0
incl. under previous contracts				
Mustamäe Hospital	13,033,500	3,600,000	9,433,500	0
Estonian Oncological Centre	10,646,668	1,800,000	8,846,668	0
AS Ida-Tallinna Keskhaigla	3,535,732	1,470,483	2,065,249	190,333
Total	**27,215,900**	**6,870,483**	**20,345,417**	**190,333**

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	1,363,042	702,207	171,100
Total	**20,345,417**	**6,763,042**	**13,582,375**	**171,100**

Note 9. Fixed assets

Tangible fixed assets

Fixed assets group	Land and buildings	Machinery and equipment	Other inventories	Total
Acquisition value				
31.12.2003	3,178,768	8,474,822	16,123,017	27,776,607
Purchase of fixed assets	495,841	2,542,089	2,500,985	5,538,915
Fixed assets sold / written off / transferred	-678,768	-3,363,573	-5,473,477	-9,515,818
31.12.2004	2,995,841	7,653,338	13,150,525	23,799,704
Accumulated depreciation				
31.12.2003	2,010,915	6,787,312	12,274,885	21,073,112
Calculated depreciation	141,878	727,854	2,474,315	3,344,048
Fixed assets sold / written off / transferred	-147,607	-3,320,319	-5,455,600	-8,923,526
31.12.2004	2,005,185	4,194,847	9,293,601	15,493,633
Residual value				
31.12.2003	1 167,853	1,687,510	3,848,132	6,703,495
31.12.2004	990,656	3,458,491	3,856,924	8,306,071

Intangible fixed assets

Fixed assets group	Purchased licences
Acquisition value	
31.12.2003	7,949,651
Fixed assets written off	-322,340
31.12.2004	7,627,311
Accumulated depreciation	
31.12.2003	6,052,704
Calculated depreciation	567,721
Fixed assets written off	-223,285
31.12.2004	6,397,140
Residual value	
31.12.2003	1,896,947
31.12.2004	1,230,171

Note 10. Leased assets

Financial lease

The following table contains information on the current financial lease contracts (servers have been leased)

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	5,280,178	91,253
Depreciation calculated for the accounting year	1,712,490	68,440
Paid during the accounting year, incl.	1,712,934	59,553
Advance deposition		
repayments	1,712,934	59,553
Interest calculated for the accounting year	146,711	8,163
Balance of liability as of 31.12.2004, incl.	1,946,099	123,196
repayments during the next accounting year (without interest)	1,814,768	64,476

Operating lease

The revenue and expenditure account includes operating lease payments in the total amount of EEK 6,760,626, whereof EEK 566,625 were paid for the lease of means of transport and EEK 1,222,975 for the operating lease of computer equipment; EEK 4, 971,026 were paid for leased rooms. Total amount of payments for operating lease in 2005 was EEK 6,715,899.

Note 11. Taxes payable

Tax	31.12.2003	31.12.2004
Income tax	20,969,517	27,636,215
Social tax	3,273,648	3,363,265
Turnover tax	5,370	29,898
Income tax from fringe benefits	52,920	51,039
Unemployment insurance premium	83,917	96,597
Mandatory funded pension premiums	43,899	54,792
Total	**24,429,271**	**31,231,806**

The individual income tax arrears include individual income tax in the amount of EEK 26,474,659 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 EEK 610,147 calculated from the holiday pay not disbursed to the employees

Note 12. Revenue from principal activity (thousand EEK)

Revenue from principal activity	2003	2004
Health insurance part of social tax	5,629,126,298	6,276,577,865
Revenue claimed from other persons	16,916,652	11,005,379
Total	**5,646,042,950**	**6,287,583,244**

Note 13. Health insurance benefits expenditure

Health insurance benefits expenditure	2003	2004
Health care services benefits	3,583,962,989	4,059,758,040
incl. Disease prevention	45,547,199	60,479,775
General medical care	454,694,606	491,660,720
Specialised medical care	2,840,896,937	3,238,606,621
Long-term nursing care	75,019,049	95,176,938
Dental care service benefits	167,805,198	173,833,986
Health promotion expenses	13,800,037	13,480,490
Medicinal products compensated for to the insured	682,936,833	863,847,683
Expenditure on benefits for temporary incapacity for work	923,928,846	1,101,979,611
Other expenditure on health insurance benefits	20,089,143	25,486,576
Health care services benefits arising from international agreements	1,419,827	2,351,862
Benefit for medical devices	18,669,316	23,134,714
Other monetary benefits	67,476,242	72,437,016
Total expenditure on health insurance benefits	**5,292,194,090**	**6,136,989,416**

Note 14. General administrative expenditure

General administrative expenditure	2003	2004
Personnel and administrative expenditure	43,960,323	44,772,187
remuneration	32,939,554	33,544,307
incl. remuneration of the Members of the Management Board	1,718,730	1,698,504
incl. remuneration of the Members of the Supervisory Board	3,019	2,896
unemployment insurance premium	149,476	158,225
social tax	10,871,293	11,069,655
Management costs	15,704,556	16,235,941
Information technology costs	12,427,678	9,096,303
Development costs	3,102,828	4,169,210
Total general administrative expenditure	**75,195,385**	**74,273,641**

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 2004 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 2004.
The annual report, 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
Chairman of the Management Board	**Hannes Danilov**	.....	.....
Member of the Management Board	**Arvi Vask**	.....	.....
Member of the Management Board	**Maigi Pärnik-Pernik**	.....	.....

Supervisory Board:

Jaak Aab	.....	.....
Aivar Sõerd	.....	.....
Mai Treial	.....	.....
Katrin Saluvere	.....	.....
Ene Tomberg	.....	.....
Sven Pärn	.....	.....
Senta Michelson	.....	.....
Harri Taliga	.....	.....
Peeter Ross	.....	.....
Toomas Annus	.....	.....
Meelis Virkebau	.....	.....
Kaido Kotkas	.....	.....
Sandor Liive	.....	.....
Toomas Niinemäe	.....	.....