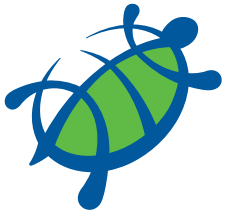
Estonian Health Insurance Fund Yearbook 2013



Estonian
Health Insurance
Fund

The turtle is the symbol of the Estonian Health Insurance Fund.

Why does the turtle symbolise health insurance, i.e. the Health Insurance Fund?

In many cultures the turtle symbolises the creation of the Earth, representing longevity and persistence in striving towards goals. The turtle is mocked because of its slowness, but health insurance is a conservative area. Progress is calculated and persistent, which symbolises the reliability of the Health Insurance Fund and the entire system. The shield protects the turtle from unexpected threats. The Health Insurance Fund wants to offer the same kind of protection to the insured

Estonian
Health Insurance
Fund

Annual Report of the Estonian Health Insurance Fund

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Start of financial year:	1 January 2013
End of financial year:	31 December 2013
Principal activity:	National health insurance
Management Board:	Tanel Ross (Chairman)
	Mari Mathiesen
	Kuldar Kuremaa
Auditor:	KPMG Baltics OÜ

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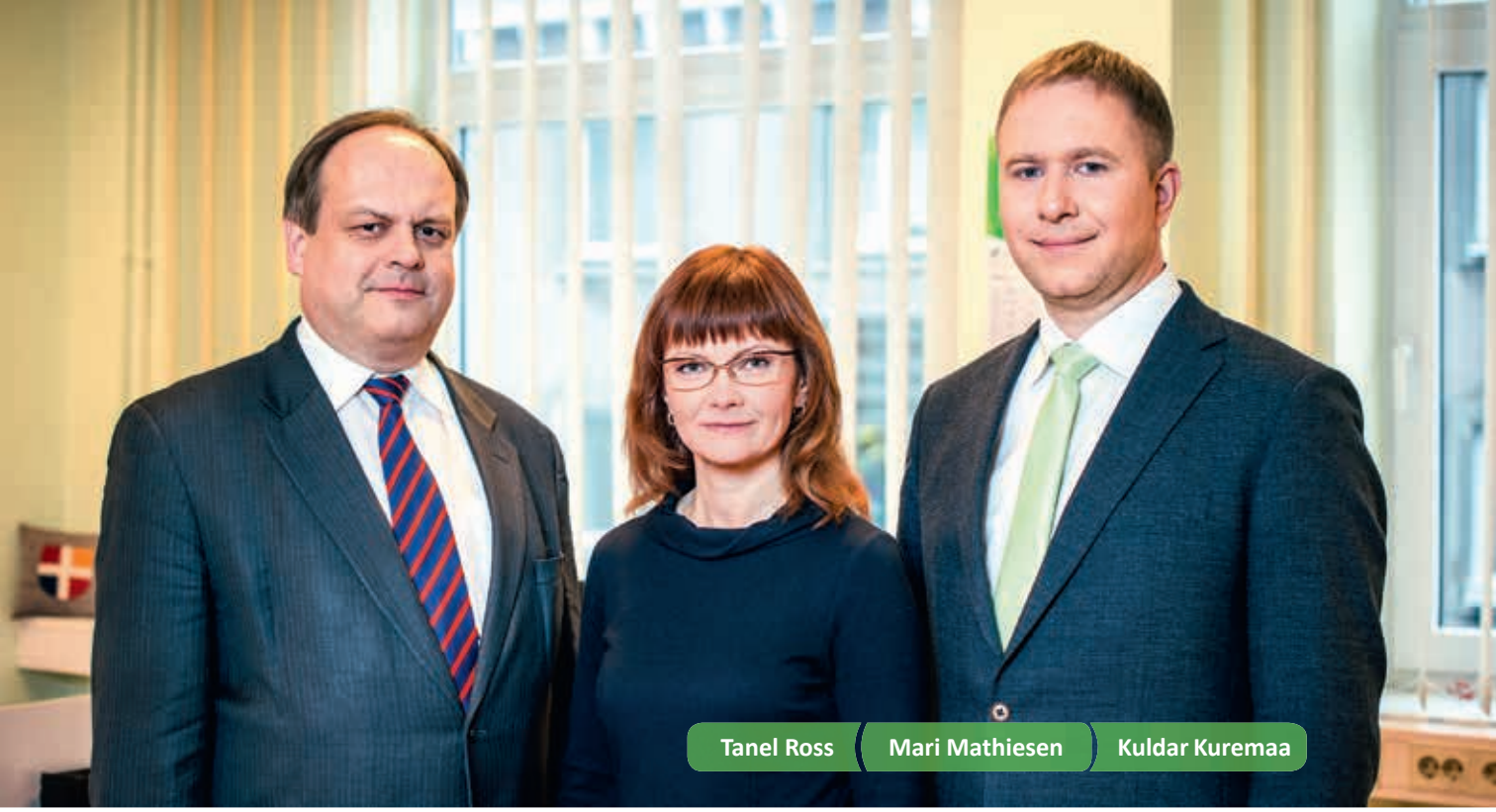


Statement by the Management Board – 2013 in Estonian health insurance

2013 was a successful and busy year for the Estonian Health Insurance Fund (EHIF). In the first half of the year we thoroughly updated the development plan of the EHIF, setting several important goals for the coming years. The development plan is the starting point of our work and gives us clear guidelines of how we'll be planning our resources and what we want to achieve over the next four years. Our activities are planned according to the development plan.

Our goals is to guarantee the necessary medical services to people

The main goal of the EHIF is to guarantee the accessibility of quality and necessary health insurance benefits to the insured persons.

One important priority in this regard is ensuring the sustainable development of primary care – the services of family physicians must be accessible to all insured persons and their quality must be high. Offering patients adequate advice, diagnoses and effective coordination of treatment processes at the level of primary care allows us to focus on activities of high added value in specialised medical care, which is what hospitals have been established for. We will increase the role of primary care with motivational financing, constant updating of services and creation of additional options for family physicians.

A new option offered in the previous year was financing a second family nurse – this option was used considerably more than we forecast, which confirms that it was necessary. A family nurse offers independent appointments or is the member of the family physician's team who provides nursing care, which covers advising, teaching and instructing patients and giving practical assistance to the family physician in carrying out health checks, monitoring patients suffering from chronic illnesses and giving advice about viral infections.

The implementation and development of the e-consultation service is also important. e-consultations in urology and endocrinology were added to the list of health services at the start of the year. Adding more specialities was analysed with the Estonian Society of Family Physicians and as a result, family physicians will be able to consult with pulmonology, rheumatology and ear-nose-throat specialists from 2014. This gives family physicians additional options for consulting their colleagues in specialised medicine, provides the patients with more convenient services and guarantees faster commencement of treatment if necessary.

Updating the list of health services was last year's most noteworthy process in specialised medical care. There are always more proposals and expectations regarding the financing of services that can be covered by the health insurance budget, which is why processing any suggested amendments to the list is a very important and thorough task. The duration of an appointment with a medical specialist was increased in the list of health services that took effect in the beginning of 2013 to allow doctors to deal with their patients more thoroughly. New treatment options were added in orthopaedics, radiation therapy and rehabilitation. It is also positive that we managed to increase the number of endoprosthetic replacements and shortened waiting times.

The lists of services provided in various specialties (psychiatry, neurology, neurosurgery and cardiac surgery) were updated with the relative specialists during the last year. This required a lot of work by a number medical and financial specialists in hospitals, which they did in addition to their daily work. However, as a result of their efforts the aforementioned specialties have been thoroughly updated in our service list as of 2014 in such a manner that they take account of the developments in evidence-based treatment standards, which help us guarantee more successful treatment of patients.

The increase in social tax collected in 2014 and the resulting increase in the budget of the EHIF made it possible for us to plan additional options for the insured with the help of our partners in almost all of the areas financed by the EHIF. The improvement of our financial status certainly offers positive outputs, but we are still very serious about our obligation to manage the EHIF's budget successfully and sustainably.

As a result of this the EHIF's budget for this period was planned last year in such a manner that the best evidence-based and cost-efficient options for contemporary health insurance benefits are guaranteed in all areas.

More than a hundred applications were submitted for amendment to the list of health services last year, both in the categories of price changes and the addition of new services, and the Supervisory Board approved 59 of these applications by the end of the year. The reference prices of health services were also changed in the list as a result of the collective agreement. Adding so many new services to the list was possible for the first time and it broadened the quantity and content of the services provided to the insured.

In addition to health services, the EHIF also wants to guarantee people with support in buying the necessary pharmaceuticals and medical equipment. In terms of medical equipment, the EHIF started reimbursing syringe needles to insulin users and expanded the terms for reimbursement of glucometer test strips, orthoses and wound bandages. The decisions with which the special disposable lancets, used by diabetics for blood tests to measure their blood sugar, were added to the list from 2014 were also prepared in the last year. This means that all of the equipment required for monitoring the disease is now reimbursed in addition to the pharmaceuticals.

In the area of pharmaceuticals, we had quite a few discussions about innovative reimbursement mechanisms. Due to the increasingly higher price of new pharmaceuticals and the inevitable risk that they're not suitable for some patients, or don't work, we see the need for the implementation of so-called risk hedging schemes. Put simply, this means that if a pharmaceutical doesn't work, the cost of it will be paid by the manufacturer. Last year we prepared such schemes for three new pharmaceuticals, which we started reimbursing in 2014. We will now monitor how such payment schemes work in practice and continue developing them.

It's important to note that the out-of-pocket expenses of people in purchasing prescription pharmaceuticals is decreasing due to successful information work. People are buying increasingly more pharmaceuticals on the basis of the active ingredient, which means that they're not spending in vain, and this also helps improve treatment consistency, which in its turn contributes to the improvement of public health.

An activity aimed at the insured persons last year that also deserves a mention is the European Union directive implemented in the end of the year, which created additional opportunities for insured persons in the Member States

to use health services in other European Union Member States. Another goal of the directive is to guarantee the safety and quality of cross-border health services and to promote cross-border cooperation in the area of healthcare. We made several changes in our procedures and organisation of work for the implementation of the directive to guarantee that the reimbursement procedure meets all requirements. We also put a great emphasis on informing people of the new treatment opportunities.

Partners

Due to the expiry of the contract period of the hospitals listed in the Hospital Network Development Plan and the partners selected by the EHIF, one of the keywords in 2013 in the area of partners was the preparation of the new contract period for financing treatment, which is something that the EHIF dealt with extensively at all possible levels throughout the past year.

The new general terms and conditions of the contract were prepared in such a manner that they reflect our priorities regarding the insured persons in the provision of quality medical services, making services accessible to people and guaranteeing the effective implementation of the health information system. We also prepared the migration to the new system for managing the partners of the EHIF in the new year. Previously, the regional departments of the EHIF entered into separate contracts with hospitals for serving the insured persons in their region, but every medical institution now has one contract with the EHIF and one contract manager appointed by the EHIF.

Detailed principles of geographic accessibility were developed in order to plan contract volumes, and a precise and uniform basis was introduced for assessing the demand for services.

The EHIF is the financier of health services, which means that assessing the quality of the services provided and making proposals for improvement is extremely important for us. More than 12,000 cases where treatment was provided by our partners were analysed on the basis of medical records for this purpose. We give our partners systematic feedback on the basis of the analysis. We also ordered five clinical audits from recognised experts, which will be the basis for the preparation of further action plans. We prepared the Estonian Clinical Audit Handbook with the Faculty of Medicine of the University of Tartu in order to create a uniform and clear audit framework. In the future, we're planning to contribute to the training of auditors to support the emergence of a network of competent auditors and to ensure that audits are carried out according to uniform quality standards.

Three Estonian clinical guidelines were being prepared in cooperation with the Faculty of Medicine of the University of Tartu on the basis of the updated Estonian Handbook for Guideline Development and all three will be completed in 2014. The development of three more clinical guidelines with the representatives of various specialties and of patents associations was also initiated.

We believe that the creation and implementation of a comprehensive quality system in Estonian healthcare is extremely important in the development of the quality of healthcare. The Council of Treatment Quality Indicators was created with the Faculty of Medicine of the University of Tartu for this purpose in the end of the last year. The goal of the Council's activities is the consistent improvement of the quality of the services provided to patients by the development of principles and methods for selecting the indicators that characterise treatment quality, which support the development of a comprehensive quality system in the area of healthcare in Estonia and approving the clinical indicators that are evidence-based, consider the local conditions and must be implemented.

Our contribution to the development of the health system

The activities of the EHIF comply with the health policy goals of the state and support them. As one of the main financiers of the health system, we want to be an active partner and adviser to all parties engaged in healthcare in the establishment of health policy goals and in supporting the functioning and development of the system.

In 2013 we were an active participant in the activities of the cooperation contracts entered into with more than twenty parties and contributed to the performance of the collective agreement entered into with health professionals.

The experts of the EHIF have submitted their proposals regarding the reform of insurance for incapacity for work and supported the creation of the work register. We have also made proposals during the hospital network development process.

A contemporary IT infrastructure that functions without problems helps guarantee better treatment quality and an expedient use of the health insurance resource. We have entered into a cooperation agreement with the Estonian e-Health Foundation and will consequently contribute strongly to the development of the e-services of the health system in the coming years. Guaranteeing the good performance of the digital prescription centres that was transferred to the EHIF's area of responsibility in 2013 and establishment of further development trends are also important.

A well-functioning organisation helps achieve goals and guarantees the best services for clients.

In order to guarantee that the staff of the EHIF are motivated and realise how important they are for their employer, and to guarantee the competitiveness of the staff on the salary market, we modernised the payroll system of the EHIF with the assistance of recruitment company Fontes.

We changed our performance management in such a manner that all risks that affect the organisation's operations are described on a process-basis alongside the activities required for their management. This makes it possible to take account of them to a considerably larger extent when future developments are planned.

A good level of customer service is an important factor that affects the awareness of people and their satisfaction with the health insurance system. This is why we consistently analyse the quality of our services and contribute to the development of a friendly and successful customer service. Last year's results of the regular determination of the customer service index among Estonian companies indicated that the level of our customer service is one of the best in the public sector.

The auditors of Bureau Veritas also audited our management system last year. We received confirmation that the EHIF's management system complies with the requirements of the ISO 9001:2008 management system standards.

New activities in 2014

Our main priorities in 2014 include a comprehensive review of the customer service areas to guarantee the best customer service and develop indicators for a consistent monitoring of the service level; the harmonised organisation of waiting times to ensure that the actual waiting time as well as the need for financial resources to cover it are understandable and assessable; updating the terms and conditions of primary medical care contracts similarly to the updating of the terms and conditions of specialised medical care contracts last year by increasing the focus on service quality. The goals in the area of e-solutions are completion of the implementation of the electronic certificate for incapacity for work and supporting the continued development of the health information system. ■

Tanel Ross
Chairman of the Management Board

Mari Mathiesen
Member of the Management Board

Kuldar Kuremaa
Member of the Management Board

Management report

Health insurance system

The solidary health insurance system organised by the public Estonian Health Insurance Fund holds the central position in the Estonian heath system. The EHIF pays for the health services of all persons covered with health insurance in Estonia, finances the purchases of pharmaceuticals and medical aids, and pays various types of financial benefits. Contracts are entered into with family physicians and medical institutions for the provision of health services. The needs of insured persons and the expedient use of health insurance funds are taken into account when services are purchased and contracts are entered into. The EHIF does not intervene in the management of medical institutions to ensure that financing is impartial.

The health insurance system is financed from the social tax. A solidary health insurance system is used in Estonia: all insured persons get the same kind of medical care irrespective of the size of their contribution, personal health risks or age.

The Estonian health insurance system follows internationally approved principles:

- as much of the population as possible must be covered with health insurance;
- the scope of health insurance must be as wide as possible, i.e. based on the principle of solidarity, health insurance must offer a package of health services that is as comprehensive, coherent and modern as possible;
- health insurance must be as far-reaching as possible, i.e. the out-of-pocket expenses of persons in the total cost of treatment has to be optimal and protect the person against the risk of poverty.

The present health insurance system, which guarantees solidarity and regional equality, has been in effect since 2002 when the new Health Insurance Act entered into force.

Role of the EHIF

The main goal of the EHIF is to guarantee that the various health insurance benefits, incl. medical care, pharmaceuticals and medical equipment as well as benefits for temporary incapacity for work, dental care and other financial benefits are accessible to the insured persons. Another goal is to promote health and develop the quality of health services.

The EHIF plays the role of the purchaser in the provision of the services that meet the needs of the insured persons and in guaranteeing the equal regional accessibility of diagnostics and treatment by assuming the obligation to pay the fees on behalf of the insured persons. Instead of being the passive payer, the role of the EHIF is to be the strategic buyer.

In strategic purchasing, we proceed from the framework of the Health Insurance Act and we can speak about the following options in purchasing health services:

- selection of health services, so-called package of services financed by health insurance;
- design of the prices of health services;
- terms and conditions of the treatment financing contract and legal provisions;
- selection of contractual partners and negotiations about contract volumes; and
- checking that financing is justified.

The **mission of the Health Insurance Fund** is to organise health insurance in such a manner that ensures the equal treatment of insured persons and the timely accessibility of needs-based, high-quality and cost-efficient health services, medical equipment, pharmaceuticals and financial benefits are guaranteed.

The **vision of the Health Insurance Fund** is to create a sense of security in people concerning their potential health problems and any treatment they may need.

The **core values of the Health Insurance Fund** are:

- **innovation** – we target out activities at continuous and sustainable development, relying on competent, loyal and result-oriented employees;
- **consideration** – we are open and friendly, and our decision-making is transparent and considerate of others; and
- **cooperation** – we create an atmosphere of trust within our organisation and in relations with our partners and clients.

Organisation and management

The highest body of the EHIF is a 15-member Supervisory Board. Five of them represent employer organisations, five are representatives of the organisations of the insured persons and five represent the state. The Minister of Social Affairs is the representative of the Supervisory Board. A Management Board consisting of three members manages the EHIF. The EHIF had 211 employees as at 31 December 2013.

The tasks of the EHIF for the achievement of health insurance goals include assessing the need for medical care, modernising the package of health services, designing the budget that would guarantee the accessibility of health insurance benefit and enter into contracts for the provision of health services with medical institutions in order to ensure that the necessary services are provided. The EHIF works closely with all partners in the health system in order to use the resources better in the interests of the insured persons.

As required by law the EHIF checks that health insurance finances are used for their designated purposes, incl. the quality and justification of the services purchased. For this purpose, we check medical invoices and documents – a total of ca 12,000 medical files and records. We support the preparation of clinical guidelines and we commission clinical audits. We have introduced the performance pay system for family physicians, which is aimed at guaranteeing that disease prevention and the quality of monitoring chronic diseases at the level of primary care, i.e. by family physicians and nurses, is based on the same principles across Estonia.

The EHIF finances projects specifically aimed at health promotion and disease prevention on the basis of the Health Insurance Act, proceeding from the provisions of the Public Health Development Plan approved by the Government as well as in the Development Plan of the Health Insurance Fund. According to the analysis of the loss of life years due to disease, the biggest loss of health is caused by cardiovascular diseases, malignant tumours, injuries and poisoning. All of this has an impact on the costs incurred by the EHIF in regard to health services, pharmaceuticals and incapacity for work. Health promotion and prevention can help avoid some of these problems or reduce the losses they cause. ■

Table 1 gives an overview of the key indicators of the EHIF (see p. 8).

Table 1. Key indicators 2009-2013

2009	2010	2011	2012	2013	Change compared to 2012	
Number of insured persons at year end	1,276,366	1,256,240	1,245,469	1237104	1,231,203	0%
Revenue (thousand euros)	730,501	694,438	735,112	783,131	836,892	7%
Health insurance expenditure (thousand euros)	764,336	693,377	718,418	773,575	830,419	7%
Operating expenses of EHIF (thousand euros)	6,842	6,888	7,080	7,331	7,937	8%
Health insurance expenditure as percentage of GDP (%)*	5.5	4.8	4.4	4.4	4.5	2%
Health service indicators						
Number of insured persons who used specialised medical care	800,578	797,048	807,875	795,581	796,698	0%
Average length of stay (days)	6.1	6.1	6.0	6.1	6.0	-2%
Emergency care as a percentage of expenses of specialised medical care (%)						
outpatient care	17	18	18	17	17	0%
day care	9	9	7	8	8	0%
inpatient care	67	67	64	66	64	-2%
Average cost per case in specialised medical care (euros)						
outpatient care	44	43	45	52	57	10%
day care	449	404	371	435	456	5%
inpatient care	1,011	982	1,008	1,124	1,178	5%
Family physician appointments per 1000 insured persons	3,895	3,831	4,228	4,364	4,302	-1%
Referrals for treatment abroad and benefits arising from EU legislation (thousand euros)	4,352	3,810	8,210	7,193	7,847	9%
Indicators of benefits for pharmaceuticals						
Number of reimbursed prescriptions	6,435,700	6,689,886	6,945,735	7,438,670	7,625,135	3%
Number of insured persons who used reimbursed pharmaceuticals	829,748	822,440	841,533	841,387	848,636	1%
Average cost of reimbursed prescription for EHIF (euros)	13.7	13.6	13.2	13.3	13.6	2%
Average cost of reimbursed prescription for patient (euros)	8.1	7.7	7.0	6.6	6.4	-2%
Indicators of benefits for incapacity for work						
Number of days of incapacity for work for which benefits were paid by EHIF	7,379,379	4,600,139	4,937,836	4,954,761	5,228,586	6%
Cost per day of incapacity for work benefit (euros)	19.1	17.7	16.4	17.0	18.0	6%

* The indicators for 2009-2012 have been revised according to the GDP as adjusted by Statistics Estonia.

Strategic Goals and Their Achievement

Scorecard

Goal	Weight Objective	Performance indicator	Unit	Comments
	6.0	Satisfaction of insured persons with health system	%	Satisfaction of the insured person with the health system as determined in the course of a general survey
1. We guarantee the accessibility of health insurance benefits by using health insurance finances expediently				
	10.0	Satisfaction with accessibility of medical care	%	One part of the general survey.
	8.0	Reducing the out-of-pocket expenses of patients in purchasing pharmaceuticals in the list of pharmaceuticals subject to reimbursement	%	The out-of-pocket expenses of patients are not higher than the level in the first 9 months of 2012.
	10.0	Volume inflation of a case	%	Percentage of the volume inflation of cases of specialised medical (all types of care in total) care compared to the previous period.
	7.0	Maximum waiting time for	aeg	We will shorten the maximum waiting time for endoprosthetic replacement endoprosthetic replacements.
2. We support quality in the health system				
	5.0	Satisfaction with quality of medical care	%	One part of the general survey of the population.
	5.0	Involving the insured persons in activities that	%	Coverage of all high-risk hypertension conditions in the make it possible to improve monitoring chronic diseases quality system of family physicians (last year's result +1%).
	5.0	Number of clinical audits	pcs	Number of clinical audits carried out.
	5.0	Number of checked cases	number	Number of cases checked on random basis.
	5.0	Number of clinical guidelines	number	Number of new clinical guidelines according to the
3. We shape people's awareness and steer their health behaviour				
	5.0	Coverage of children with prophylactic dental check-ups	%	% of children according to birth year who have had prophylactic check-ups.
	5.0	Awareness of insured persons of their rights	%	% of the responding insured persons who were aware of their rights in the following areas: primary medical care, specialised medical care, incapacity for work benefits, reimbursed pharmaceuticals, scope of health insurance.
	5.0	Noticeability of social campaigns	%	The level of noticeability is measured in the target group after the campaign.
	5.0	Cancer screening coverage	%	Coverage is measured on the basis of the health insurance database as a % of the persons invited to screening in the relevant year, who have been screened in the last three years.
4. We develop our organisation				
	3.0	Employee satisfaction with the management and organisation of work of EHIF	%	% of employees who are satisfied according to the survey.
	3.0	Awareness of insured persons of their rights	%	Averages are calculated on the basis of the statements about a manager made in the satisfaction survey and these averages are added up. The share of the sum in in the maximum possible score is then calculated and the result is the management index %.
	3.0	Noticeability of social campaigns	%	The service level of the customer service bureau, customer helpline and responding to e-mails is measured by the mystery shopping method.
	5.0	Cancer screening coverage		Compliance with the criteria of the IT Baseline Security System ISKR in regard to critical services (insurance inspection, prescription centre).
Total	**100.0**			

2012 Activity	2013 Objective	2013 Activity	Achieve-, ment %	Achievement of objectives
67	67	61	5.5	The results of the survey 'Opinion of Population of Health and Medical Care 2013' indicate that satisfaction with the health system has remained at the same level as in previous years, but the intended objective was not achieved.
55	58	47	8.1	Satisfaction with the accessibility of medical care has decreased compared to 2012. The main reason given is the long waiting time for outpatient appointments with medical specialists.
	33.5	32.1	8.0	The objective in terms of the out-of-pocket expenses of pharmaceuticals was achieved and the result is even better than expected – 32.1% in the end of 2013.
1	<2	1.8	10.0	The volume inflation of a case is under control and remains below 2 for the year (actual 1.8).
2.5 y	1.5 y	1.5 y	7.0	We have managed to keep the waiting time for endoprosthetic replacement at the level established by the Supervisory Board (1.5 years).
78	78	74	4.7	Satisfaction with the quality of medical care has remained high according to the survey 'Opinion of Population of Health and Medical Care 2013'. However, the goal set for 2013 (78%) was not achieved.
	64	67	5.0	The coverage of hypertension patients with the activities serving as the basis for the quality system indicators was 67% (objective: 64%).
5	5	5	5.0	Five clinical audits were carried out in 2013: quality of independent antenatal obstetric care quality and justification of treatment for stroke, treatment of bariatric patients, treatment of patients with melanoma, and activities of family nurses in monitoring and giving advice to hypertension patients.
	12,000	12,055	5.0	12,055 cases were checked in 2013 in the course of target selections. Observations, precepts and claims were presented as a result.
	3	6	5.0	Six Estonian clinical guidelines were being prepared in 2013. Three of them have reached the final stages and the areas of treatment of the other three have been approved by the Clinical Guideline Advisory Board.
	40	29.6	3.7	The measures for sending children to prophylactic dental check-ups did not yield the expected results and the established goal was not achieved – the result was 29.6%.
78	53	54	5.0	The awareness of the insured persons assessed in the course of the general survey met expectations. Fewer people are aware of the fees the family physician or a health service provider may charge from people as well as of the rules followed in the calculation of the incapacity for work benefit.
85	50	90	5.0	The noticeability of the 'Reasonable Use of Pharmaceuticals Campaign' carried out in the end of 2013 was at record levels with 90%.
breast cancer 66%; cervical cancer 71%	breast cancer 67%; cervical cancer 72%	breast cancer 71%; cervical cancer 72%	5.0	The share of women covered with cancer screening increased last year, which suggests that the awareness of the insured persons has increased as a result of information work.
89	93	89	2.9	The satisfaction of the employees of the EHIF with management and organisation of work in 2013 remained at 89%, which indicates that the EHIF is a stable organisation and employer.
	81	81	3.0	The first targeted management index was achieved, which gives reason to believe that management decisions are well-considered and reasonable.
	95	96	3.0	The level of customer service remained high, reaching 96% in 2013.
	K3	K3	5.0	In 2013 we also managed to guarantee the performance of our information systems at the level that corresponds to the objective.
			95.9	

Family physician is the patient's primary adviser in the health system

■ **Kaija Lukka,** Health Specialist

■ **Tatjana Šitova,** Head of Health Insurance Benefits Bureau

Family physicians have an important role in the Estonian health system. A family health centre is the first place that patients go to with their health concerns and family physicians and nurses deal with various areas of work from disease prevention to diagnosing and treating patients. Giving advice in various health issues and coordinating the treatment of patients is an important part of the work of family physicians and nurses.

The development of primary health care, i.e. family healthcare, and increasing the role of family physicians in our health system is an important strategic goal of the EHIF. The key words in this area last year were development of the family nursing and e-consultation services and updating the list of the health services of the EHIF with family physicians. Analysing the accessibility of medical care and perfecting the quality system were also important.

Clear criteria for assessment of performance

As the first person contacted by patients in the health system, it is extremely important that they get an appointment with their family physician within optimal time. This is why we're constantly monitoring the accessibility of the services of family physicians. At least once every three years, we pay a visit to every family health centre and analyse their work. Solutions to any problems that might be found are developed in cooperation with the family physicians and suggestions are also made for the better organisation of work.

The family physician's performance system is an extremely important tool for the development of the quality of a family physician's work and assessing their performance. Forty six indicators for assessment of the performance of doctors have been developed with family physicians. The emphasis in quality criteria has been placed on the effectiveness of monitoring chronic diseases, prevention and regular health checks of children. Approximately 97% of family physicians took part in the family physician's performance system last

year. The share of family physicians receiving the performance pay has also increased year on year, and the monitoring of chronic diseases has improved.

In order to reduce the expenses incurred by patients when buying pharmaceuticals, it is important to ensure that they are aware of the active ingredients and options. This is why we keep emphasising the importance of issuing active ingredient-based prescriptions and the need to advise patients in the selection of pharmaceuticals. Two indicators were introduced to the performance system in 2013 regarding the prescriptions issued to hypertension patients. The implementation of the new performance indicators has motivated family physicians who issue more active ingredient-based prescriptions, which in their turn has helped reduce the expenses incurred by patients when buying pharmaceuticals.

The role of family nurses is growing

The family nurse provides nursing care independently or with the family physician – gives the patient advice in the case of acute illness; monitors the status of chronically ill patients; carries out tests and treatment procedures; advises on nutrition, work and organisation of life, and on the use of OTC pharmaceuticals. Family nurses also carry out preventive health checks and advise parents on the health education of their children.

The share of family nurses in monitoring patients with chronic illnesses and acute health disorders as well as in consulting and prevention has increased in recent years. The implementation of the additional allowance for the second family nurse from 2013 is an important change in financing family medicine. Certain conditions must be met in order to receive the allowance for the second family nurse. These conditions concern the hours of independent appointments with family nurses, the total working hours of the nurses and the compliance of the family physician's place of practice with requirements. Employing a second family nurse in a practice improves the accessibility of family medicine considerably, as it helps the family physician dedicate more time to each patient and also gives more time for general nursing advice. 182 family physicians employed a second nurse during the year, which covers 23% of all lists of family physicians. Since the employment of a second family nurse has proven to be more popular than expected, the role of family nurses in family healthcare has already increased significantly in 2013. One of the goals of the EHIF is to continue increasing the role of family nurses in the work of family health centres.

Cooperation improves treatment quality

The cooperation of family physicians with medical specialists is extremely important in offering timely and

quality health services to people. Since 2013, family physicians can ask specialists for advice and treatment recommendations with the help of the e-consultation service in order to improve cooperation between specialists and family physicians. The purpose of the service is to improve the accessibility of treatment and to make it possible to refer patients quickly to specialists. The e-consultation service also improves the quality of the information passed on by family physicians to specialists and in some cases, it won't be necessary for the patients to go from one doctor to another themselves, but the parties can agree on the need to visit a specialist in advance.

Specific requirements have been established for e-consultation referrals in five specialities. The requirements are necessary to make the referrals more to the point and to inform family physicians about the expectations of specialists regarding preliminary information and the tests that have already been carried out. The service became available in the specialities of urology and endocrinology in 2013. The requirements for referrals with pulmonologists, rheumatologists and otorihnolaryngologists were agreed on by 2014. The requirements for referrals in paediatrics, neurology, cardiology and haematology should be developed by 2015.

The development of the family doctor's performance system and extending the list of the health services of primary medical care enable family physicians to improve the quality of their work and give them more options for the successful treatment of patients. ■

Treatment quality, development of e-services and guaranteeing the accessibility of services are top priorities in financing contracts

Monika Lipson, Health Specialist

The Health Insurance Act and the Estonian Health Insurance Fund Act stipulate that the objective of the EHIF is to guarantee medical care at a good level across Estonia in accordance with the principles of solidary health insurance. Five-year framework contracts are entered into for this purpose with family physicians, regional and central hospitals, and general hospitals operating in countries. Comprehensive specialised medical care across Estonia is guaranteed via these hospitals. In addition to scheduled medical care, this also guarantees security for all emergency medical cases. These hospitals are therefore listed in the regulation of the Government of the Republic, which sets forth the Hospital Network Development Plan, and the EHIF is obliged to enter into treatment financing contracts with them.

The new five-year contract period for the hospitals covered by the Hospital Network Development Plan started in 2014. We prepared for the new contract period throughout 2013. The updated general terms and conditions of the treatment financing contract, which apply to all contractual specialised medical care and nursing care partners of the EHIF, were completed by the end of the year as a result of the thorough work carried out by the workgroups of the EHIF and the Estonian Hospitals Association.

One of the most important goals of the new contract period according to the general development goals of the EHIF and the agreements made with the Estonian Hospitals Association is the development of the quality management system of hospitals. Consistent adherence to clinical standards that spare the patient and are both cost-efficient and evidence-based is very important. Medical institutions must guarantee sufficient infrastructure and staff for this purpose. Quality management activities cover the organisation's quality management system, control mechanisms of specific clinical activities, regular evaluation of processes and results, feedback, and registration and analysis of the side-effects and complications of treatment.

Data that can be analysed are a precondition of quality. This is why we and the hospitals agreed to contribute considerably more to the development of the health information system, submit data systematically and

create a well-functioning contemporary system in cooperation with all parties. The EHIF and the hospitals have also set themselves the goal of transferring fully to electronic referrals in the coming years.

The new contracts also specify the waiting time management requirements to guarantee people with better access to services and to improve the cooperation between the EHIF and the hospitals in coordinating the length of waiting time. All parties to the health system are interested in providing timely care to people who need health services. This helps avoid complications and the resulting more expensive treatment, and also guarantees people's satisfaction with the health system. Adhering to the maximum length of waiting time and submitting the relevant reports in all specialties included in the contract is an obligation of the service provider. According to the contract that entered into force in 2014, medical institutions are obliged to keep the waiting lists open for at least four months, or for at least three months in specialties where referrals are not required (gynaecology, eye and skin diseases, psychiatry, tuberculosis). Another agreement that was made is that the provision of services outside the contract with the EHIF must not deteriorate the accessibility of the service for the insured persons waiting for them.

The new contracts also attempt to provide a better regulation of administrative obligations and increase the flexibility of contract management. Significant changes in the organisation of work regarding the management of treatment financing contracts have been made in order to make the information exchange and cooperation between the EHIF and its partners more systematic and coordinated. All contractual partners therefore have just one communication channel – the contract manager. The manager is the partner's first point of contact in all issues concerning the planning, monitoring and implementation of the contracts with the EHIF. ■

Clinical audit improves treatment quality

■ **Ulla Raid,** Chief Health Specialist

Monitoring, assessing and improving the quality of health services requires cooperation between all of the organisations participating in the health system. The EHIF has to ensure the expedient use of health insurance recourses as well as the quality and justification of services. The EHIF has commissioned five clinical audits per year since 2002.

A clinical audit is a quality improvement process aimed at improving the treatment of patients and treatment results, evaluating them systematically according to certain criteria and implementing necessary changes at the level of individuals, structural units/institutions or services[1]. A clinical audit is just a possible tool for improving the quality of healthcare. Medical records and clinical standards of the relevant diseases, which are based on clinical guidelines and legislation, are compared by experts of the relevant specialties and, increasingly more often, by multi-professional teams during an audit. The results are used to improve the quality of healthcare in all medical institutions via self-analysis and introduction of good practice.

The methodology of clinical guidelines has been consistently updated in recent years and this, in its turn, created the need for the harmonisation of the clinical audit methodology and streamlining the area. The development project 'Updating the Handbook for Guideline Development' was launched for this purpose in 2012 and it covered four of the main areas of activity: updating the handbook, developing the web-based audit environment and testing it with audits, and training for target and associated groups.

The first major activity of the project was the quality seminar held in April 2013, which attracted more than 100 specialists who encounter this topic in medical institutions and elsewhere in their work. The main speaker at the seminar was Dr Charles Shaw from England, who gave an overview of treatment quality and patient safety, and introduced the strategies and methods of quality work. We also gave an overview of Estonia's experience in the performance of clinical audits and the EHIF introduced the principles of the updated handbook of clinical audits to a broader audience.

[1] *National Institute for Health and Clinical Excellence (NICE)*

Several good ideas for revising the audit handbook were received from the workgroup of the Faculty of Medicine of the University of Tartu in autumn 2013. The updated handbook supports the different stakeholders of the health system in carrying out clinical audits by providing them with contemporary methodological guidelines for selecting the topic of the audit, auditing, presenting and evaluating the results, and planning improvement activities. The handbook focusses on the standard-based audit, as this is the most common method in both international and Estonian audit practice. The handbook was also approved by the Council of the Faculty of Medicine of the University of Tartu last November and by the Management Board of the EHIF in December. The handbook will be published in 2014 on the website www.ravijuhend.ee. The web environment developed within the scope of the project, where auditors can enter the data to be analysed in the course of the audit and the results they have found, has proven its usefulness and is therefore developed further.

The continuation of in-service training in clinical audits in cooperation with the Faculty of Medicine is important for the development of a network of competent auditors in Estonia and for carrying out internal audits in medical institutions. Learning from experience, i.e. gaining new knowledge in the course of planning and carrying out audits, can be considered equally important. It does lengthen the process, but creates more extensive knowledge.

It is important for us that our contractual partners are fully committed to the elimination of the problems found in the course of audits. This is the reason why the part of the treatment financing contract that concerns the quality guarantees was updated and implemented from 2014. In addition to acknowledging the results of compliance assessment, it is also important to see what happens with the suggestions in the future, how practices are changed and how follow-up audits are carried out.

The goal for the coming years is to develop the preparation of plans of measures for solving the problems identified during audits in medical institutions and monitoring the implementation of these plans. This requires common understanding and cooperation from the EHIF and its partners, because the purpose of the inspections is not to punish, but to ensure that the services offered to patients are evidence-based and of high quality. ■

Broader options for patients to seek treatment outside Estonia

■ **Anette Soosaar,** Head of Foreign Relations Department

The European Cross-Border Healthcare Directive, or the obligation of Member States to pay the insured persons of their country benefits for the necessary health services provided to them in another EU Member State, received a lot of attention in the European Union, incl. Estonia, in the previous year.

Unlike the medical care received in Estonia, whereby the EHIF takes over the obligation to pay the medical institution for the health services provided and the person themselves does not have to pay anything, payment for health services received in foreign countries must initially be made by the person themselves and they can then apply for reimbursement of the expenses by the Estonian Health Insurance Fund pursuant to the prices given in the EHIF's list of health services. Patients only have the right to claim reimbursement of the health services that they're entitled to receive at the expense of the EHIF also in Estonia and if the cost of the health service received is higher than the price indicated in the EHIF's list of health services, the patient will have to cover the difference themselves.

The goal is to give people more choice

The objective of the directive is to give citizens of EU Member States more choice, improve the accessibility of health services, help guarantee the safety and quality of cross-border health services and promote cross-border cooperation in the area of healthcare. In this context the directive has also broadened the options of insured persons in Estonia and improved the accessibility of quality medical care.

The option to receive medical care outside Estonia is nothing new in itself and all of the regulations that already enabled cross-border treatment will remain in force after the implementation of the directive. Insured persons in Estonia also have the right to request the EHIF's preliminary consent to take over the obligation to pay for the treatment in regard to the services the person needs, but that cannot be provided to them in Estonia or that cannot be provided to them within the time period that is medically justified. Insured persons are also entitled to necessary medical care during their temporary stay in a European Union Member State

on the basis of the European health insurance card.

No major changes forecast at first

Looking at the context of the broadening of cross-border treatment options, we must keep in mind that both international and Estonian experience indicates that as a rule, the volume of cross-border health services are very modest compared to the domestic volume of services. This is also understandable, as using medical care in a health system that differs from the one of your own country, incl. in a different language and legal environment, is certainly not an easy decision (e.g. the share of scheduled treatment abroad in the Estonian health insurance budget in 2012 was a little under 0.3%).

This is why the EHIF did not expect the implementation of the directive to bring about any significant changes in patient mobility and the resources of the health system (at least not at first), or to have an impact on the accessibility of medical care in Estonia, when it planned the division of its health insurance budget. However, we will certainly analyse the impact of the directive and if necessary, we can establish justified restrictions on the cross-border provision of services.

Domestic implementation of benefits is possible

In the case of the directive it is important to keep in mind that it does not establish any obligations or demands on the national organisation of the health systems of the Member States, but it may have an impact on the internal situation in the Member States via the common market. This is why the Health Insurance Act now contains the provision that the cost of a health service provided by a contractual partner of the EHIF under limited conditions outside the general waiting list is compensated nationally. This legal amendment stipulates that the Minister of Social Affairs may, with its regulation and on the proposal of the Supervisory Board of the EHIF, establish the procedure for compensation of treatment in the cases where the insured person was provided with health service by a contractual partner of the EHIF operating in Estonia outside the waiting list. However, it must be emphasised that we always evaluate the impact on the accessibility of treatment and on the health insurance budget as a whole when we make the relevant proposals within the scope of the Act. Considering the principles of the solidary national health insurance provided in Estonia is extremely important when such proposals are made. We make every effort to ensure that quality health services are equally available to everyone in Estonia irrespective of the person's age, financial situation or location. We make sure that treatment is accessible to all insured persons with the shortest possible waiting time and by partners that provide quality services. The contractual partners of the EHIF in their turn have to guarantee that insured persons will be seen by medical specialists within the scope of the permitted waiting time. Not a single decision may therefore worsen the accessibility of the health services needed by people as a whole. ■

Involving stakeholders in decision-making processes is important in increasing the transparency of the system

- **Kersti Esnar,** Head of Pricing Unit
- **Erki Laidmäe,** Head of Pharmaceutical Department

Every year the EHIF faces the complicated task of finding a compromise between the finances provided for in the budget and the needs expressed by physicians, hospitals and patients, so as to agree on and define the insurance benefit package for the coming period. Finances are also required for staff costs and infrastructure developments. The decisions to finance new health services, medical equipment and pharmaceuticals (hereinafter jointly referred to as services) have a direct impact on patients.

Expansion of the insurance package and modernisation of the provided services must be constant in order to guarantee the competitiveness of Estonian medicine and its compliance with the needs of patients. On the other hand, we must keep in mind that new pharmaceuticals or medical equipment often play a major role in the prices of new services. Their cost keeps going up and this has led to a rapid increase of expenses in healthcare. This in its turn is the cause of the constantly increasing trend in the world, whereby the balance between the possible benefits and the additional expenses required for their achievement are carefully evaluated according to a definite methodology.

We proceed from the interests of all patients

Focussing on patients is one of the most important aspects when the EHIF makes its decisions. However, we must keep in mind that financing decisions must take account of the interests of all patients at the same time and they cannot proceed solely from a specific patient or group of patients. These decisions are therefore never easy to make; they create questions among partners and are sometimes criticised.

The Health Insurance Act determines the criteria for decisions on financing new services. This is a discretionary decision which requires consideration of whether the service, pharmaceutical or equipment is medically

effective enough; whether the balance between its benefit for the patient's health and the cost of adding the service, pharmaceutical or equipment is acceptable; whether there are alternative ways of achieving the same objective and how much such alternatives cost; and whether the health insurance budget can sustain the additional cost.

Updating the list of services will become more transparent

The EHIF has been working on changing the process of adding new health services to the list as of 2014. The goal of the changes is to considerably increase the transparency of decision making by involving more different stakeholders in the process that precedes the decision. The first steps towards the publication of materials have been taken – the summaries of the services processed in 2013 by evaluated criteria are available on the website of the EHIF. All materials related to the submitted service applications will be made public in the future – the applications themselves, submitted additional data, medical evidence, cost-effectiveness analysis impact on health insurance budget and assessment of necessity for society, extracts from minutes of meetings and also the decision (including reasons). Different stakeholders can therefore keep an eye on how their applications are being processed and review all the materials that serve as the input for making the decision. It is also possible to ask specifying questions, apply for submission of additional materials and much more.

The situation that tends to prevail in medicine all over the world is that there is never enough money even if financing is increased. Financing healthcare will always remain something that requires a separate approach, but the most important thing is to ensure that resources are allocated fairly and efficiently. It is therefore necessary to ensure that the principles we follow in making financing decisions are as harmonised as possible. Since improving people's understanding of the necessity and nature of principles is also important, the EHIF wishes to continue explaining them to the general public. We're hoping that explaining the principles on which our decisions are based and publishing the materials of the processes will increase the reassurance that the interests of patients are considered as much as possible when decisions are made. ■

High-quality treatment must be equally accessible to everyone

- **Anneli Taal,** Head of Treatment Financing Unit
- **Kaljo Poldov,** Head of Pärnu Department

Health insurance in Estonia follows the principle of solidarity: the amount of benefits paid by the EHIF in the event of illness does not depend on the amount of social tax paid on behalf of the specific insured person. The health insurance money collected as social tax is a common asset of the insured persons and the EHIF also uses the social tax paid for employed persons to pay for children and pensioners, who don't contribute to social tax. The Health Insurance Act states that the EHIF is obliged to guarantee that treatment is equally accessible to insured persons in all regions.

The accessibility of treatment has different dimensions – one of them is temporal accessibility, which indicates how quickly a person receives the necessary health service . The second dimension is geographic accessibility, which means that similar treatment must be equally accessible to insured persons whether they live in Narva, Võru or Haapsalu. The optimality and quality of the service provision, the location of the insured persons by county (i.e. population density) and current use of series (incl. mobility of insured persons) are also considered.

Organisation of medical care must guarantee quality

Optimality and quality are achievable when a doctor is guaranteed a sufficient workload in the place where the service is provided. The EHIF guarantees the accessibility of specialised medical care at a location if there is the need for at least one full-time specialist in the region. The number of medical specialists is the one that is very limited in Estonia, which is why we need to avoid the situation where a specialist's working hours are spent on commuting instead of seeing patients. Moreover, going for an appointment with a medical specialist alone is not enough to get treatment. Doctors also need modern medical technology in order to help patients, which cannot be taken to every location in Estonia, as technology is expensive and the number of its users is limited – for example, there are very few radiologists, radiology nurses and laboratory specialists in Estonia. The only way to offer the insured persons contemporary medical services is to carefully select the

services the provision of which is practical as well as where to offer them.

Accessibility levels are an important tool of planning the need for services

Four accessibility levels have therefore been determined in outpatient medical care, which consider the geographic location of the insured persons, demand for treatment (evaluated on the basis of current use and waiting time data) as well as an optimal organisation of medical care that allows for the provision of contemporary treatment.

Specialities that must be accessible to people in every county are on the fourth, the broadest accessibility level. Specialties on the third level must at least be accessible in larger counties (Tartu, Harju, Ida-Viru and Pärnu counties). Specialties on the second level must be accessible in at least two places in Estonia (Tallinn and Tartu) and specialities of the narrowest level in one medical institution in Estonia. For example, services in the specialties of eye and skin diseases; gynaecology; ear, nose and throat diseases; psychiatry; general surgery; rehabilitation and internal diseases must be accessible in every county; outpatient services in the specialties of cardiac and vascular surgery and oncology must be accessible in the two largest centres in Estonia, i.e. Tartu and Tallinn. A more detailed overview is given in Table 2.

The EHIF proceeded from the aforementioned principle of geographic accessibility when it entered into contracts with medical institutions for the year 2014 and selected the locations where specialised outpatient medical care is provided. In order to guarantee the implementation of the principles of geographic accessibility in the contracts entered into with medical institutions, we also defined the minimum volumes of the EHIF's contracts in terms of specialities and types of care, which guarantee the service provider's economic sustainability and prevents the fragmentation of healthcare resources.

There are plans to also define the principles of the geographic accessibility of inpatient and day care in greater detail in 2014. ■

Table 2. Results of definition of geographic accessibility of outpatient specialised medical care

Main specialty*	Level I	Level II	Level III	Level IV
Surgery	Organ transplants	Cardiac surgery Paediatric surgery Neurosurgery Maxillofacial surgery Thoracic surgery Vascular surgery	Urology	General surgery
Internal diseases	Bone marrow transplant	Haematology Other nephrology Peritoneal dialysis	Endocrinology Gastroenterology Cardiology Rheumatology	Internal diseases
Oncology		Oncology		
Neurology			Neurology	
Orthopaedics			Orthopaedics	
Pulmonology			Pulmonology	
Paediatrics			Paediatrics	
Infectious diseases			Infectious diseases	
Otology, rhinology and laryngology				Otorhinolaryngology
Ophthalmology				Ophthalmology
Obstetric care and gynaecology				Gynaecology
Dermatovenerology				Dermatovenerology
Psychiatry				Psychiatry
Rehabilitation				Rehabilitation

* The contractual specialties of the EHIF

Innovative IT solutions are an important part of the national insurance system's development

- **Raimo Laus,** Head of Information Technology Department
- **Kaie Mõtte,** Development Manager

The EHIF has always tried to offer simple solutions to insured persons in order to improve the accessibility of health insurance benefits. The introduction of various electronic solutions will help optimise the resources in the interests of the insured persons as well as our partners, and increases satisfaction with the quality of the services on offer.

The software solution of the digital prescription was introduced all over Estonia in 2010 and in 2013, the EHIF started hosting the environment of the digital prescription in its own infrastructure in order to considerably reduce the cost of administering the digital prescription and to improve its accessibility and performance at the same time. We managed to achieve the goals set for the project and the digital prescription is now working fully in the EHIF's area of responsibility. The plans for 2014 are to develop the additional software services of the digital prescription and to offer additional functionalities for the different users of the system.

2013 was the year of active preparation for the transfer to the electronic certificate of incapacity for work. The precondition for its introduction is that at least 95% of all certificates of incapacity for work are electronically prepared by doctors. This in its turn also gives employers the opportunity to add their data to the certificates electronically. Ca 3000 employers will be interfaced with the system by January 2014 and they will forward ca 20% of all certificates of incapacity for work via electronic channels. By the beginning of 2014, we will have reached the stage where technical developments have largely been completed and the legal amendment for the implementation of the electronic certificate of incapacity for work is being enforced.

The costs incurred and the time spent by doctors on issuing these certificates on paper will decrease as a result of the transfer to the electronic certificate. The insured persons will also receive their benefits quicker, employers will no longer be obliged to submit the certificates on paper, which means they will have to spend less money and time on submitting data to the EFIF by post.

The Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare was implemented in Estonia in 2013. This created a significant additional change for patients in how cross-border medical care is compensated to patients – in the future, they can also receive compensation for scheduled treatment in another Member State in addition to emergency medical care. Medical costs are compensated on the basis of the prices of the services effective in Estonia. The average duration of processing benefits in the electronic environment using the developed solution is 90 days. We continue looking for solutions to making the processing of cross-border health services as similar as possible to the domestic process in order to make it simpler and pay the benefits out faster,

In 2013 we procured and installed a video conference solution in order to optimise our work. The solution allows us to have interactive meetings with the different departments of the EHIF (both with the centre and regions as well as all departments in the same video room at the same time). This solution can also be used to make video conference calls with systems outside the EHIF – video conferences have already taken place between the EHIF and the University of Tartu, and the EHIF and the healthcare conference held in Kazan. The video conference solution also helps to considerably save time on holding meetings in the EHIF – we all win from this solution.

Last year the EHIF made a considerable contribution of its knowledge and time to the activities of the various subprojects of the national health information system. Above all, the EHIF is interested in the comprehensive and fast launch of the digital registration and e-referral centre. As a member of the steering group of the said project, we initiated the stage of specification of the project's goals and general principles in order to achieve a common vision of all parties of the values to be achieved with the information system. The principles were collected and approved, and the focus in 2014 will be on the detailed analysis and realisation of the information system. ■

Opinions of residents play an important role in setting the strategic goals of the Health Insurance Fund

Katrin Romanenkov, Public Relations Manager

People's opinion of the Estonian health insurance system and general satisfaction with the health system are important indicators in measuring the performance of the EHIF and an input for our future plans. This is why feedback and satisfaction polls are integral parts of the strategic management of the EHIF. We're collecting regular feedback from the insured persons, contractual partners in specialised medical care, family physicians and employers.

Every year we and the Ministry of Social Affairs carry out a nationwide survey where we ask people to assess their satisfaction with the Estonian health system and the accessibility and quality of services, and to describe their expectations regarding health services and their financing. All of the surveys commissioned by the EHIF can be viewed on our website.

It's a pleasure to say that in the last five years, people's opinion of the Estonian health system has not changed significantly and the organisation and quality of medical care are still highly rated. The survey carried out by the research company Saar & Poll in the end of 2013 indicated that 61% of the Estonian population consider the organisation of healthcare good and ca ¾ of people have a high opinion of the quality of medical care. The aspect rated the highest in the organisation of healthcare is that the number of doctors in Estonia is sufficient and that the accessibility of services is therefore relatively good. People are also satisfied with the caring and attentive attitude of doctors and their high level of competency. The system of pharmaceuticals subject to reimbursement is also a positive mentioned in the case of healthcare organisation.

Efficient organisation of waiting lists a priority

On the other hand, people still see room for development when it comes to the accessibility of specialised medical care. People often find that the waiting time for an appointment with a specialist is too long. They are also unhappy with the failure to adhere to waiting times and the fact that it's sometimes impossible to register for an appointment with a doctor. Ca one-fifth of people have had to wait more than two months for an appointment with a medical specialist and one-third have experienced the situation where registration for an appointment started from a certain date or weekday. It is obvious that the situation where a person feels that the national health system is not supporting

them when they need it and help is delayed is not reassuring for people with health concerns. This is why we're very serious about solving the problems related to the waiting times for appointments with medical specialists.

Since an efficient organisation of waiting times covers all the parties of the system – the financier, i.e. the EHIF, the organisation of work in medical institutions, the national health and education policy (i.e. whether we have enough qualified doctors and nurses) – then there are no quick and easy solutions. The EHIF itself has taken several concrete steps to better organise the waiting times of medical specialists. We've considerably improved the reports on monitoring the waiting times of medical institutions, which allows us to better analyse the reasons of the long waiting times and find solutions in cooperation with the medical institutions. We've also taken significant steps to improve the system of family medicine. The family physician is every person's first contact in the health system and the development of primary medical care is one of the priorities of the EHIF. We put a lot of emphasis on the development of e-consultations and e-referrals, and the general terms and conditions of the treatment financing contracts entered into with hospitals were thoroughly updated in the previous year. The motivation of hospitals to steer more of their resources towards outpatient appointments with medical specialists via improved financing models has also been increased since 2014. The development of family healthcare as well as cooperation with contractual partners in specialised medicine represent an ongoing process, which will have a certain place among the strategic goals of the EHIF also in the coming years.

However, when it comes to the context of accessibility, it must be emphasised that the problem is more prevalent when it comes to outpatient appointments. The waiting times for specialised day care and scheduled inpatient medical care are generally within the limits established by the Supervisory Board of the EHIF. The accessibility of family healthcare, though, is excellent.

Family healthcare meets the expectations of people

When it comes to medical care in Estonia, people are the most satisfied with family healthcare. Both the opinions of the people and the accessibility analysis of the EHIF's services indicate that people generally get an appointment with their family physicians very quickly. According to our inspection of waiting times, patients with acute health issues are 100% guaranteed an appointment with the family physician on the same day and the average waiting time in the case of health issues that are not acute is two working days. According to the expectations of people revealed by earlier surveys, the EHIF and the family physicians have developed family healthcare to make it comply more with the needs of people. For example, financing for family physician appointments outside the working hours (in evenings and at weekends) is prescribed from 2014 to make it easier for working people to get an appointment with a family physician. A recent survey indicated that ca one quarter of the Estonian population have requested this option.

The independent appointments with family nurses also deserve a mention, as they're becoming increasingly more commonplace and people have started trusting them. The big support for the increasing role of family nurses in the health system is also indicated by the fact that 93% of the people who visited their family nurses are satisfied with the service.

Expectations of convenient IT solutions

The development of e-health services and further development of the health information system with the e-Health Foundation are among the priorities of the EHIF in the coming years. This direction is also supported by people's expectations – it is understandable that things are moving from paper to digital in this era of information and technology and people expect information to move quickly and efficiently. A survey of the population revealed that 93% ca two-thirds of the Estonian population who have heard about the launch of the electronic health records consider them necessary. The first thing people hope to see as a result of the efficient implementation of IT opportunities is faster information exchange between doctors of different levels, and convenience in the prescription and purchase of pharmaceuticals. There are also hopes for an improved treatment quality via more detailed documentation and faster movement of data. The option to review one's health records is also considered important and people are also looking forward to the opportunity to check available appointments in a nationwide digital registration system and make appointments when necessary.

In conclusion, let us mention the satisfaction indicators regarding a success story of e-Estonia, which has found recognition by Estonian people as well as at the international level. 97% of Estonian people consider the organisation of prescription and purchasing of pharmaceuticals good. The success of the digital prescription system is clear proof of the fact that well thought through e-services that meet the needs of people make the organisation of the entire system better in the end. ■

Motivated employees are the key to our sustainable development

Anne-Ly Mendel, Head of Human Resources Department

The development of the Estonian Health Insurance Fund has been fast and undoubtedly successful for a public organisation. We have excellent specialists working for us, our staff turnover is low and our performance results are consistently good. The satisfaction of our employees has been high throughout the years, ranging from 89-95%.

Motivated employees and their readiness and will to contribute to the achievement of the organisation's goals have been one of the important development factors of the EHIF.

What have we done to motivate our staff and achieve a good working environment?

We understand that employees make an effort if successful performance brings them satisfaction – after all, we spend 75% of the day at work. In order to motivate our employees, we have relied on the PERMA wellbeing principle, which confirms a simple truth – the better our relationships at work, the more we enjoy our jobs, the better we achieve the goals set for the organisation, the more satisfied our clients and partners are with our work and the more success our employees achieve. Employees need good salaries to be satisfied with their jobs. We keep the salary level of the EHIF competitive, because employees associate their salaries with their value. All elements are connected with each other.

Positive emotions at work. Our managers are visible, accessible and organise their work in such a manner that our employees can regularly confer with them. Supporting employees and recognising them for good performance is the direct obligation of every manager. A healthy and open working environment is important for us – we understand that people need self-confidence, a positive image of themselves, the recognition of their colleagues and the feeling that they're needed and appreciated. We have created good working conditions and supplied excellent work equipment. We organise several events to recognise our employees, tie them to the organisation and give attention to their family members: summer retreats, Christmas parties, children's Christmas parties, receptions by the Management Board, OUR days, etc. We motivate our employees to engage in sports and offer them the chance to participate in public sports events with the

employer's support.

Goals, meaning. We set our goals for a four-year term proceeding from the needs of our clients and we assess the achievement of our goals at the end of every year. In order to guarantee the sustainability of health insurance, the goals we've set ourselves have been high and our development has therefore been extremely fast. Our clients and partners have been satisfied with our activities throughout the years.

Our managers direct and steer the development of our employees in the manner that complies best with our long-term goals and needs as well as the potential and value of our employees. The right person has to work in the right position. In the interests of developing our employees and increasing their motivation, we support their initiative to have a say in the development of the organisation as well as in the entire area of healthcare. We've noticed that we achieve great results by setting big goals. Professional development is very important for the people who work for us. We all want to have meaningful jobs that matter to ourselves and also to others.

The ability to achieve something. We've tried to fill our positions with people whose specialty and/or experience is as closely related to the job on offer as possible, so that the effort made to achieve the goals is in balance with the employee's feeling of wellbeing. We're offering our employees work-related challenges in the form of various development activities to keep them active and creative and to avoid any complacency or dissatisfaction with work, which is one of the biggest sources of stress. We've managed to do it well so far and we've won several innovation and management quality prizes both at home and abroad.

Ties to the team. Teamwork is extremely important for the achievement of the EHIF's goals. We believe that good communication, giving advice to colleagues as well as instructing and supporting them is very important. Any proposals by employees regarding the improvement of the working environment are welcome, because mutual trust is the basis of cooperation. Shared values are extremely important, as a team whose members are considerate to each other is flexible in the performance of various functions. We offer our employees various professional training opportunities and conferences, participation in national and international workgroups and programmes, the opportunity to cooperate with various institutions in Estonia and at the international level. We support post-graduate studies at home and abroad by guaranteeing flexitime. In addition to regular meetings, performance appraisals are also important in the development process of the organisation and the employees, as they enable us to give feedback to employees, discuss their development needs and consider their development requests and opportunities for both vertical and horizontal movement in the organisation or making changes in their tasks.

This day and age, most jobs, incl. the ones in the public sector, demand creativity, analytical skills, the ability to see connections and resolve new situations. An atmosphere of trust in the working environment, feeling good about oneself, motivating goals and adequate autonomy in the performance of tasks are the factors that unleash the creativity of employees and raise their motivation.

We find that the organisation's activities in motivating and supporting its employees are good, but we've also noticed that employees need a more personal approach and we certainly have room for development here. ■

Budget Implementation Report

Table 3. Budget implementation in thousand euros

	2012 actual	2013 budget	2013 actual	Budget implementation	Change compared to 2012
REVENUE OF EHIF					
Health insurance component of social tax	776,919	826,886	829,699	100%	7%
Revenue from contracts for persons considered equal to insured persons	1,318	1,500	1,138	76%	-14%
Recoveries from other persons	607	580	926	160%	53%
Financial income	1,241	645	613	95%	-51%
Other income	3,046	2,632	4,516	172%	48%
Government grants	1,625	1,740	1,744	100%	7%
Other income	1,421	892	2,772	311%	95%
TOTAL BUDGET REVENUE	**783,131**	**832,243**	**836,892**	**101%**	**7%**
HEALTH INSURANCE EXPENSES					
Health service expenses	563,944	604,913	605,257	100%	7%
Disease prevention	6,854	7,626	7,230	95%	5%
Primary medical care	70,212	77,341	76,088	98%	8%
Specialised medical care	450,472	478,747	481,561	101%	7%
Nursing care	17,538	21,013	20,607	98%	17%
Dental care	18,868	20,186	19,771	98%	5%
Health promotion expenses	814	1,000	706	71%	-13%
Expenses of pharmaceuticals reimbursed to insured persons	98,967	108,770	103,391	95%	4%
Expenses of benefits for temporary incapacity for work	84,265	90,300	94,101	104%	12%
Expenses of other financial benefits	9,136	9,767	9,327	95%	2%
Other expenses	16,449	18,334	17,637	96%	7%
Expenses covered by targeted financing from state budget	1,572	1,740	1,465	84%	-7%
Other expenses of health insurance benefits	14,877	16,594	16,172	97%	9%
Total health insurance expenses	**773,575**	**833,084**	**830,419**	**100%**	**7%**
OPERATING EXPENSES OF EHIF					
Personnel and management expenses	4,645	5,044	4,947	98%	7%
Wages and salaries	3,460	3,765	3,695	98%	7%
incl. remuneration of management board members	153	151	172	114%	12%
Unemployment insurance	45	36	35	97%	-22%
Social tax	1,140	1,243	1,217	98%	7%
Administrative expenses	1,012	1,180	1,069	91%	6%
IT expenses	773	1,016	990	97%	28%
Development expenses	151	281	231	82%	53%
Training	86	113	101	89%	17%
Consultations	65	168	130	77%	100%
Other operating expenses	750	823	700	85%	-7%
Supervision over health insurance system	75	125	70	56%	-7%
Public relations/communication	108	109	86	79%	-20%
Other expenses	567	589	544	92%	-4%
Total operating expenses of EHIF	**7,331**	**8,344**	**7,937**	**95%**	**8%**
TOTAL BUDGET EXPENSES	**780,906**	**841,428**	**838,356**	**100%**	**7%**
Profit/loss for budgetary year	2,225	-9,185	-1,464	-	-
RESERVES					
Change in legal reserve	0	0	0	-	-
Change in risk reserve	857	1,079	1,078	-	-
Change in retained earnings	1,368	-10,264	-2,542	-	-
Total change in reserves	**2,225**	**-9,185**	**-1,464**	**-**	**-**

Number of insured persons

The following persons have the right to health insurance: permanent residents of Estonia, persons living in Estonia on the basis of a temporary residence permit or right of residence for whom social tax is paid or who pay social tax on their own behalf. Persons considered equal to the above persons on the basis of the Health Insurance Act or a relevant contract are also insured persons.

For the purposes of health insurance statistics, the persons insured on different basis are divided into five categories:

- **employed insured persons** – persons insured by employers, self-employed persons (incl. their spouses who participate in their activities), members of managing bodies, persons who have entered into contracts under the law of obligations;
- **persons considered equal to insured persons** – old-age pensioners, children, students, pregnant women, persons maintained by their spouses;
- **persons insured by the state** – unemployed persons, persons on parental leave, carers of disabled persons, conscripts;
- **persons insured under international agreements** – pensioners from other European Union Member States who settle in Estonia, employees seconded to Estonia from other EU Member States, Estonian pensioners who settle in another EU Member State, military pensioners of the Russian Federation;
- **persons considered equal to insured persons under voluntary contracts** – persons insured with voluntary contracts.

Statistically, the category of employed insured persons is of primary importance. This means that if a person has several effective insurance covers, these data are not duplicated in health insurance statistics. The data of a person insured as a pensioner who is still working are therefore only recognised in the category of employed insured persons.

Table 4. Number of insured persons

	31.12.2011	31.12.2012	31.12.2013	Change comapred to 2012 (persons)	Change comapred to 2012
Employed insured persons	568,434	575,277	584,094	8,817	2%
Persons considered equal to insured persons	608,708	602,249	594,408	-7,841	-1%
Other insured persons	68,327	59,578	52,701	-6,877	-12%
Persons insured by the state	65,463	57,619	50,391	-7,228	-13%
Persons insured under international agreements	2,600	1,642	1,903	261	16%
Persons considered equal to insured persons under voluntary contracts	264	317	407	90	28%
Total	**1,245,469**	**1,237,104**	**1,231,203**	**-5,901**	**0%**

The changes in the number of insured persons in 2013 is characterised by:

- the increase in the number of employed insured persons;
- the decrease in the number of persons insured by the state due to unemployed persons returning to the labour market;
- the discontinuation of the insurance cover of unemployed persons.

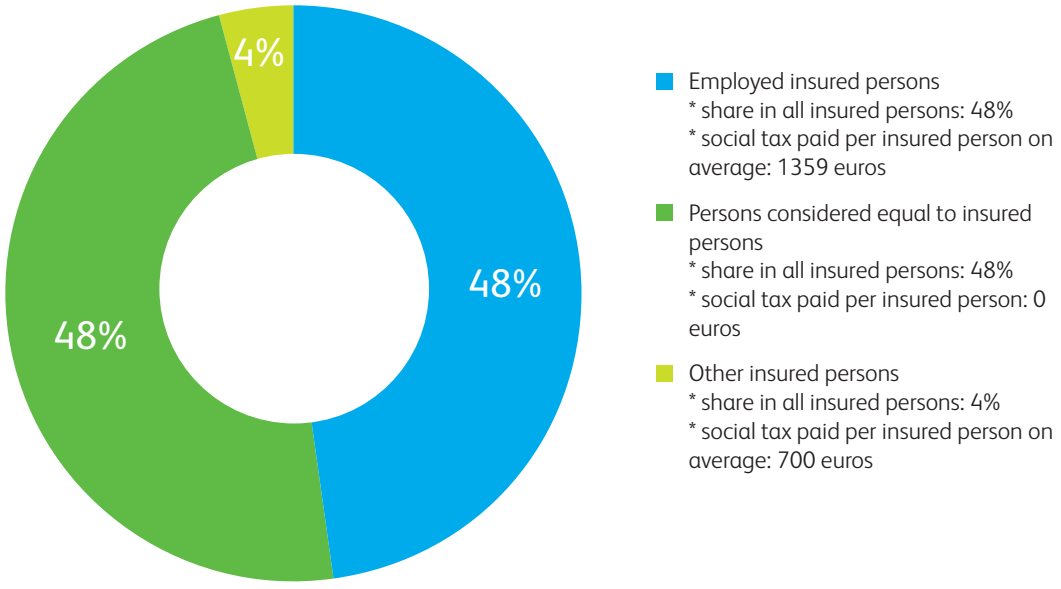


Figure 1. Breakdown of insured persons by category and social tax contribution

The main reasons why the general number of persons covered by health insurance decreased in 2013 are migration to foreign countries and the fact that the number of deaths exceeded the number of births in 2013.

When we analyse the share of insured persons by county (see Figure 2), we see that 99.99% of people in Saare County and 99.59% of people in Hiiu County are insured and that the share of insured persons when compared to other counties is the smallest in Tartu County. The share of employed insured persons is the smallest in Ida-Viru County, which complies with the general employment situation in Estonia.

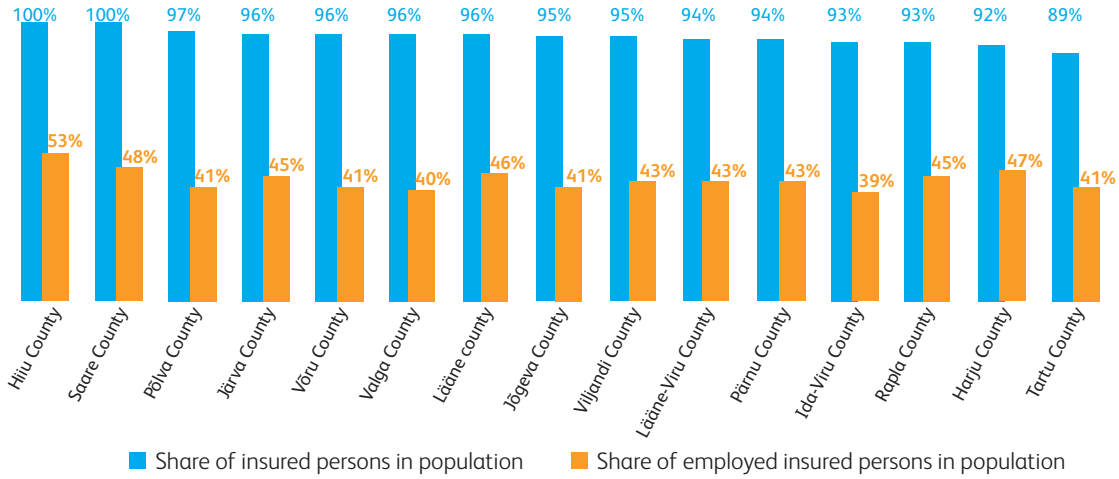


Figure 2. Share of insured persons and employed insured persons in population

The overview of average health insurance expenses per each insured person is given in Table 5.

Table 5. Average expenses per insured person in 2013, euros

Age of insured persons	Number of insured persons as 31.12.2013	Primary medical care	Specialised medical care*	Pharmaceuticals reimbursed to insured persons	Total average expenses
0–9	148,353	66	282	25	373
10–19	124,789	48	247	21	316
20–29	154,651	49	260	36	345
30–39	158,342	51	293	51	395
40–49	155,468	54	297	62	413
50–59	165,194	68	439	102	609
60–69	146,159	71	632	164	867
70–79	113,363	83	893	198	1,174
80–89	57,488	80	930	171	1,181
90–99	7,240	72	796	101	969
100–...	156	67	655	44	766

*Includes specialised medical care, nursing care, dental care and monetary compensation of dental care.

Revenues

An overview of the revenues of the EHIF is given in Table 6.

Table 6. Revenues, thousand euros

	2012 actual	2013 budget	2013 actual	Budget implementation
Health insurance component of social tax	776,919	826,886	829,699	100%
Revenue from contracts for persons considered equal to insured persons	1,318	1,500	1,138	76%
Recoveries from other persons	607	580	926	160%
Financial income	1,241	645	613	95%
Other income, incl.	3,046	2,632	4,516	172%
government grants	1,625	1,740	1,744	100%
other income	1,421	892	2,772	311%
Total	**783,131**	**832,243**	**836,892**	**101%**

The majority of the revenues of the EHIF consist of the **health insurance component of social tax**, which in 2013 comprised 99.1% of the total revenues. Social tax revenues amounted to 829.7 million euros, which exceeded the budget for 2013 (budget implementation 100.3%).

95.7% of the social tax is paid by employers. The remaining 4.3% is paid by the state on behalf of unemployed persons and people on social benefits (see Figure 3).

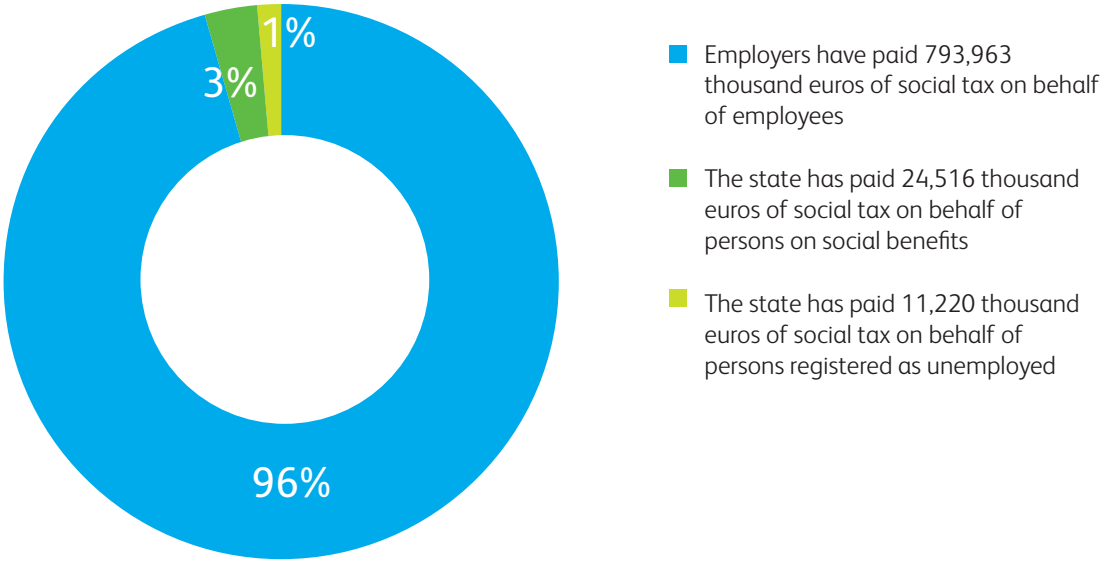


Figure 3. Breakdown of social tax revenues

An overview of the dynamics of revenues from the health insurance component of the social tax is given in Figure 4.

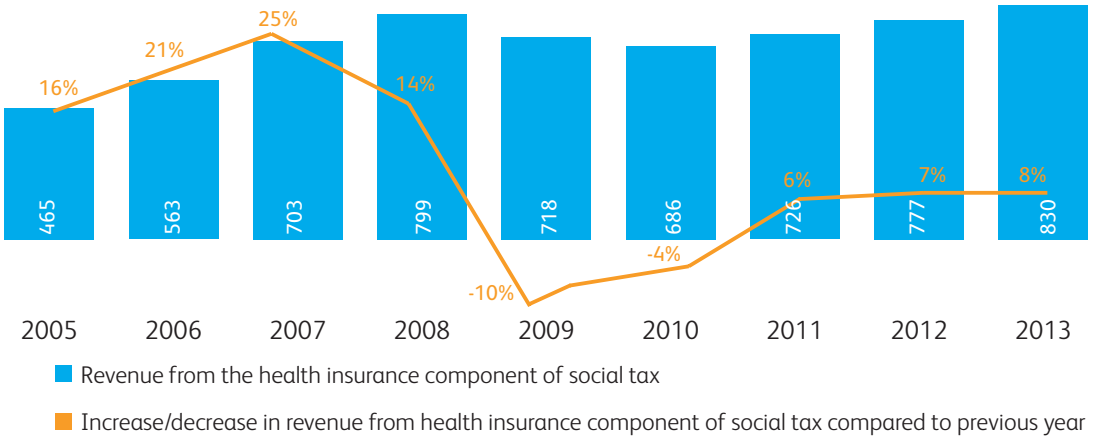


Figure 4. Increase and decrease in revenue from health insurance component of social tax from 2005-2013

Revenue from contracts with **persons considered equal to insured persons** amounted to 1.1 million euros in the period under review, incl. 520 thousand euros in contributions paid under voluntary contracts and 618 thousand euros in contributions for non-working pensioners of the armed forces of the Russian Federation.

The voluntary contracts entered into in 2013 exceeded the ones entered into in 2012 by 140 thousand euros.

Whilst the revenue from voluntary contracts was 520 thousand euros and the number of persons who had such contracts in 2013 was 659, the health insurance benefits used by these persons in 2013 amounted to 402 thousand euros. Health services in the amount of 344 thousand euros comprised the biggest share.

Claims submitted to health service providers, pharmacies, insured persons and other persons as a result of inspections and recoveries of health insurance benefits paid out to insurance companies as a result of traffic damage are recognised as **recoveries from other persons**.

The amount of claims for recoveries in 2013 was 926 thousand euros. Revenue from recoveries increased by 53% compared to 2012 as a result of the increase in the recoveries of the health insurance benefits paid out to insurance companies as a result of motor third party liability insurance. Claims in the amount of 578 thousand euros were filed with insurance companies in 2013 (384 thousand euros in 2012).

Financial income amounted to 613 thousand euros in the financial year. The profitability of 2013 was 0.33%.

The money of the EHIF has been kept in the group account of the State Treasury since 2013. Based on a deposit agreement concluded with the Ministry of Finance the EHIF earns interest on the balance of the money held on the accounts at the rate which equals the profitability of the state cash reserve. The profitability of the year depends on the events that influenced the price movements on the bond market during the year and on short-term deposit interest rates.

In terms of **other income**, the most important type of income consists of government grants from the state budget and income from the medical treatment provided to the insured persons of EU Member States in Estonia.

The EHIF received 1.5 million euros in government grants from the state budget for payment for pharmaceuticals and health services on the basis of the Artificial Insemination and Embryo Protection Act.

The Ministry of Foreign Affairs supported the project related to the development of the health insurance system of Moldova with 7 thousand euros. The National Institute for Health Development allocated 33 thousand euros to the EHIF as cover for the expenses incurred within the scope of the national cancer prevention strategy. The development works of the prescription centre that were transferred free of charge by the Ministry of Social Affairs at their residual value of 239 thousand euros are recognised as targeted financing.

Income for the medical treatment provided to the insured persons of the European Union in Estonia amounted to 2.7 million euros in 2013, which exceeded the planned amount by almost two times. Income from the previous year is also recognised under the revenues of 2013, as the money for the medical treatment provided to the insured persons is received from EU Member States with long delays.

Expenses

The expenses of the EHIF divide into health insurance expenses and operating expenses.

Health insurance expenses

1. Health services

Table 7. Implementation of health services budget, thousand euros

	2012 actual	2013 budget	2013 actual	Budget implementation
Disease prevention	6,854	7,626	7,230	95%
Primary medical care	70,212	77,341	76,088	98%
Specialised medical care	450,472	478,747	481,561	101%
Nursing care	17,538	21,013	20,607	98%
Dental care	18,868	20,186	19,771	98%
Total	**563,944**	**604,913**	**605,257**	**100%**

The budget of health services in 2013 was 604.9 million euros and 100% of the budget was implemented.

The disease prevention budget of 2013 was used to finance school health services, youth reproductive health services, health checks of young athletes, breast and cervical cancer screening, screening new-borns for phenylketonuria and hypothyroidism, new-born hearing screening and perinatal diagnostics for hereditary diseases. 95% of the disease prevention budget was implemented (96% in terms of participants).

98% of the planned primary medical care budget was implemented. The shortfall is primarily related to the underuse of the Fee for Services Fund, but the capitation fee paid to family physicians was also smaller than planned as the number of insured persons in their lists decreased. The budget was exceeded in terms of the additional allowance for a second family nurse – the service proved to be more successful than expected. The use of the advisory line of the family physician was also planned better and increased by 15% compared to the previous year.

The number of persons who used the services of medical specialists increased compared to the previous year. The number of cases increased by 20 thousand in comparison to the previous year, but 1% of the budget remained unimplemented despite the increase. 101% of the budget of specialised medical care was implemented. The budget was over-implemented because of outpatient care – the average cost of an outpatient case increased compared to the planned amount. The price increase of outpatient cases of internal diseases, neurology and rehabilitation had a significant impact on the over-implementation of the budget. Outpatient care was financed by 3.8 million more euros than planned in order to guarantee the accessibility of health services.

The implementation of the nursing care budget was 98%, cases 102%. The under-implementation of the budget was the result of inpatient nursing care where 97% of the budget was implemented. The number of cases increased faster than planned due to the rapid increase in the use of outpatient nursing care services.

The implementation of the dental care budget was 98%, cases 102%. The use of the budget was influenced primarily by the dental care of children, where the implementation of the budget was 97%, cases 102%.

Accessibility of health services

When a person needs help, it is extremely important to ascertain the seriousness of the disease in time and to help people in critical condition as fast as possible. In the remaining cases, people should be guaranteed an appointment with a doctor during the necessary period of time depending on the health problem. The EHIF monitors waiting times for health services in both primary medical care as well as in specialised medical care, dental care and nursing care. The EHIF cooperates with medical institutions to guarantee timely accessibility of medical care to insured persons.

Primary medical care

Patients suffering from acute health disorders must be able to get an appointment with their family physician on the day they contact the doctor, other persons (who are not suffering from acute health disorders) must get an appointment within five working days. An acute health disorder is a condition whereby postponing the administration of primary medical care may cause the patient's condition to deteriorate or the exacerbation of the disease[2].

Accessibility of primary medical care is checked by visiting family health centres. Accessibility checks in 2013 indicated that 100% of patients suffering from acute health disorders were able to get an appointment with their family physician on the same day they contacted the doctor. 98% of the patients with non-acute health disorders were able to get an appointment with the family physician within five working days in the second half of 2013. The average waiting time for an appointment in case of patients with non-acute health disorders was two working days.

Specialised medical care

The maximum permitted waiting time in specialised medical care is six weeks for outpatient care and generally eight months for scheduled hospitalisation. Medical institutions submit reports to the EHIF about the waiting times for specialised medical care, nursing care and dental care – hospitals of the Hospital Network Development Plan[3] (HNDP hospitals) submit monthly reports, other contractual partners submit quarterly reports. The waiting time reports submitted as of 1 January 2014 indicate that adherence with the permitted waiting times is the biggest problem in outpatient care. Long waiting times often occur in medical institutions and specialities where the patients' demand for treatment in the specific medical institution or speciality is big (especially in regional and central hospitals). In terms of types of care as of 1 January 2014, 50% of appointments in outpatient specialised medical care took place within the permitted waiting time. The same indicator in inpatient treatment was 90% and in day care 98% (see Figure 5).

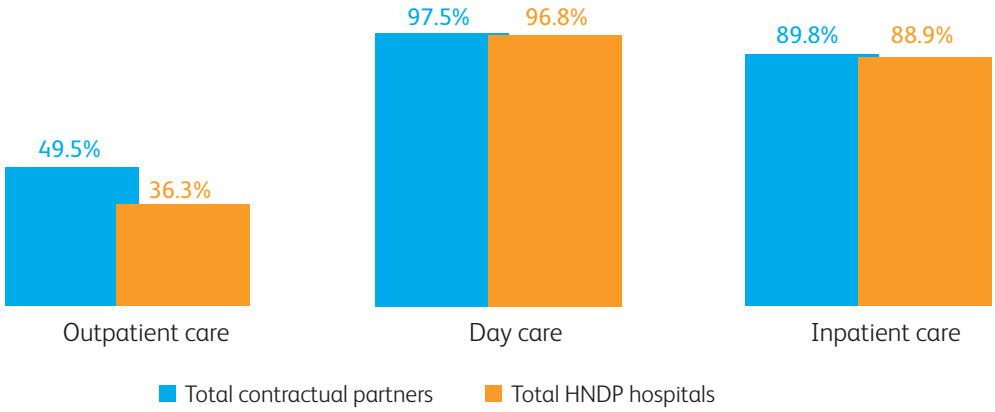


Figure 5. Share of specialised medical care appointments within permitted waiting time based on data from reports submitted as at 1 January 2014

[2] *Regulation of the Minister of Social Affairs No. 2 "Work Instructions of Family Doctors and Health Professionals Working with Them" of 6 January 2010.*

[3] *Regulation of the Government of the Republic No. 105 "Hospital Network Development Plan" of 2 April 2003.*

When the waiting times for appointments are assessed, we must keep in mind that appointments with very short waiting times are not recognised in reports submitted as at the first day of the month, which means that the information on waiting times does not give a comprehensive overview of the actual waiting times. In order to obtain an overview of actual waiting times, the HNDP hospitals also submit a retroactive report on the waiting times for outpatient specialised medical care since 2013. These reports recognise the scheduled appointments of the previous month, incl. the time the patient spent on the waiting list. According to retroactive reports, 74% of the outpatient appointments in HNDP hospitals took place within the permitted waiting time in the fourth quarter of 2013 A significant share of the primary scheduled outpatient appointments in HNDP hospitals took place after a very short waiting time (0-7 calendar days) – the share of such appointments among all appointments in Q4 was 34% (see Figure 6). The very short waiting time may have resulted from the lack of a waiting list in the specific medical institution and the specific speciality as well as from the fact that patients who needed help more urgently were given an appointment with a shorter waiting time than usual (cito referrals, options created for family physicians to make appointments for patients themselves when necessary). The number of appointments that exceeded the permitted waiting time also includes appointments where the long waiting time was the result of circumstances not dependent on the patient (shortage of financial resources and/or capacity of the medical institution) as well as the cases where the patient wanted to make an appointment with a specific doctor – the reason why the waiting time was exceeded is not given in the retroactive report.

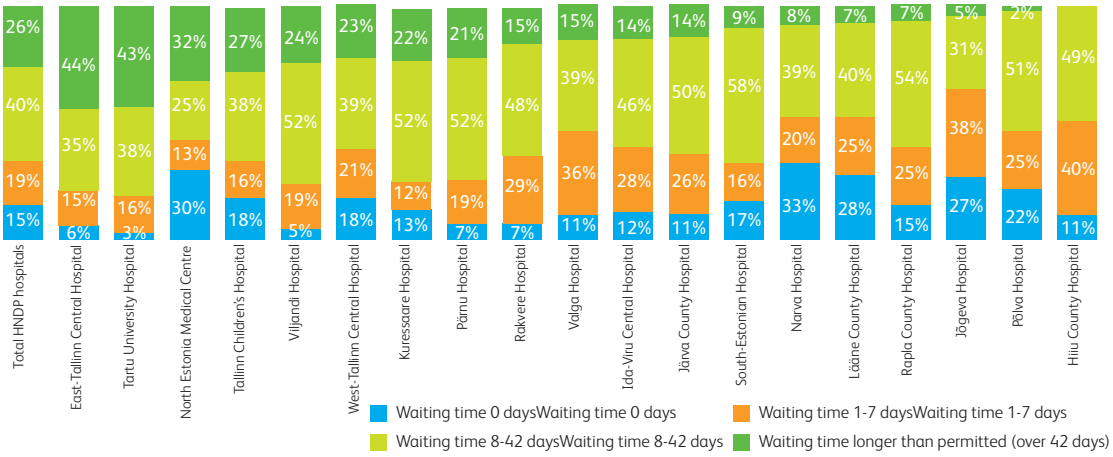


Figure 6. Actual waiting time for specialised outpatient care appointments in HNDP hospitals in Q4 2013

The waiting times by medical institutions and specialties are different and the data in the retroactive reports also indicate that waiting times in the same specialties in different medical institutions are very different. The insured persons have the right to choose the medical institution irrespective of their insurance region or the name of the medical institution written on the referral – if the waiting time in the medical institution preferred by the patient is too long, it may be considerably shorter in another institution.

Nursing care

The maximum permitted waiting time is three months in inpatient nursing care and two months in outpatient nursing care. As at 1 January 2014, 99% of the appointments in nursing care took place during the permitted waiting time.

Dental care

The permitted waiting time in children's dental care is one week in the case of chronic pulpitis, two months in the case of simple caries and chronic periodontitis, and nine months in the case of orthodontic services. 95% of dental care appointments took place within the permitted waiting as at 1 January 2014.

The quarterly reports on the accessibility of specialised medical care, nursing care and dental care are available on the website of the EHIF.

1.1. Disease prevention

The objective of disease prevention is early detection of the disease in order to take measures to avoid illness. 7.2 million euros was invested in disease prevention in 2013, which comprised 95% of the budgeted amount (see Table 8).

Table 8. Implementation of the disease prevention budget in thousand euros and number of participants in projects

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of participants	Amount	Number of participants	Amount	Number of participants	Amount	Number of participants
School health	3,342	148,504	3,797	154,004	3,648	147,297	96%	96%
Youth reproductive health	882	32,680	987	33,300	973	32,345	99%	97%
Breast cancer screening	916	33,079	1,019	35,000	937	34,550	92%	99%
Cervical cancer screening	209	13,518	233	15,000	224	13,910	96%	93%
Phenylketonuria and hypothyroidism screening	180	14,039	198	14,500	191	13,632	96%	94%
Prenatal diagnostics for hereditary diseases	319	1,432	393	1,500	374	1,470	95%	98%
New-born hearing screening	283	13,915	307	14,000	280	13,764	91%	98%
Health checks of young athletesl	563	9,750	692	10,000	603	9,198	87%	92%
Prevention of cardiovascular diseases in risk groups*	120	2,647	0	0	0	0	-	-
Osteoporosis screening*	40	866	0	0	0	0	-	-
Total	**6,854**	**270,430**	**7,626**	**277,304**	**7,230**	**266,166**	**95%**	**96%**

*The activities of the prevention of cardiovascular diseases and osteoporosis screening are integrated in the health system from 2013 and the provision of the services continues by the general procedure.

Disease prevention financing increased by 5% compared to the same period of the last year. The main reason for this is the increase in the reference prices of health services.

School health comprised the majority of the disease prevention budget and the service was provided to 3200 students in special needs schools. The data of the prophylactic checks of students indicate that the main health issues during school age are same as in previous years – the majority of them were vision disorders (31%), posture disorders (21%) and thirdly overweight (11%), which has continued to increase until now.

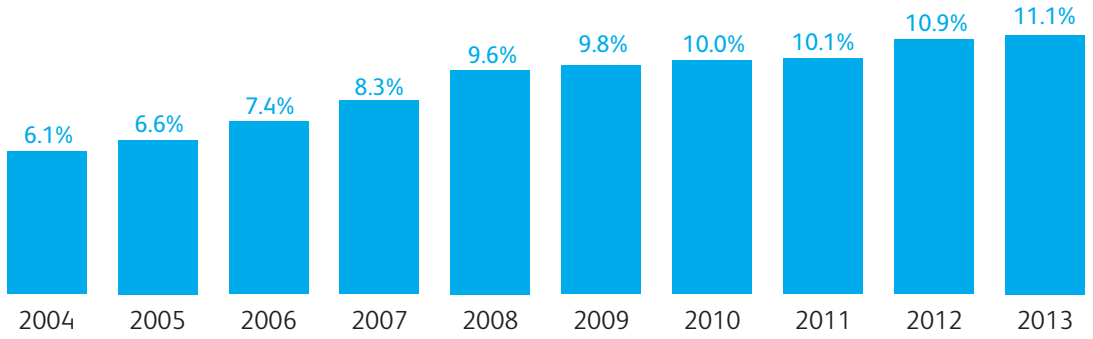


Figure 7. Share of overweight children among children examined during preventive health checks from 2004-2013

Counselling on youth reproductive health and prevention of sexually transmitted diseases was provided in separate youth centres in all counties. 31,907 young people used the counselling services last year. 6% of them were young men (also 6% in the previous year; the share of young men among first-time visitors was 15%). Ca 22% of young people received counselling from a youth centre for the first time this year. Sexually transmitted diseases were detected in 613 cases, five of them were cases of HIV infection. 645 of the girls up to 19 years of age who visited the centres sought pregnancy counselling.

The goal of breast and cervical cancer screening projects was to increase the rate of participation in screening. Women aged 50-62 are invited to have their breasts checked once every two years and women aged 30-55 are invited to cervical cancer screening once every five years. More than one-half of smear tests are done in the course of ordinary health checks.

In January, women were informed of cervical cancer prevention in articles and with posters. In May, information activities focussed on breast cancer screening with the help of posters, TV clips, etc. In autumn, women were once again reminded of the need to take part in screening. 110,000 invitations for screening were sent out during the year. Breast cancer screening services are provided in two mammography buses in the counties (except Harju County, Tartu County, Pärnu County and Ida-Viru County), which has considerably increased the number of participating women in these counties. In previous years the participation rate of women in the counties that the bus did not visit (e.g. Jõgeva and Põlva) was equal to that of large cities.

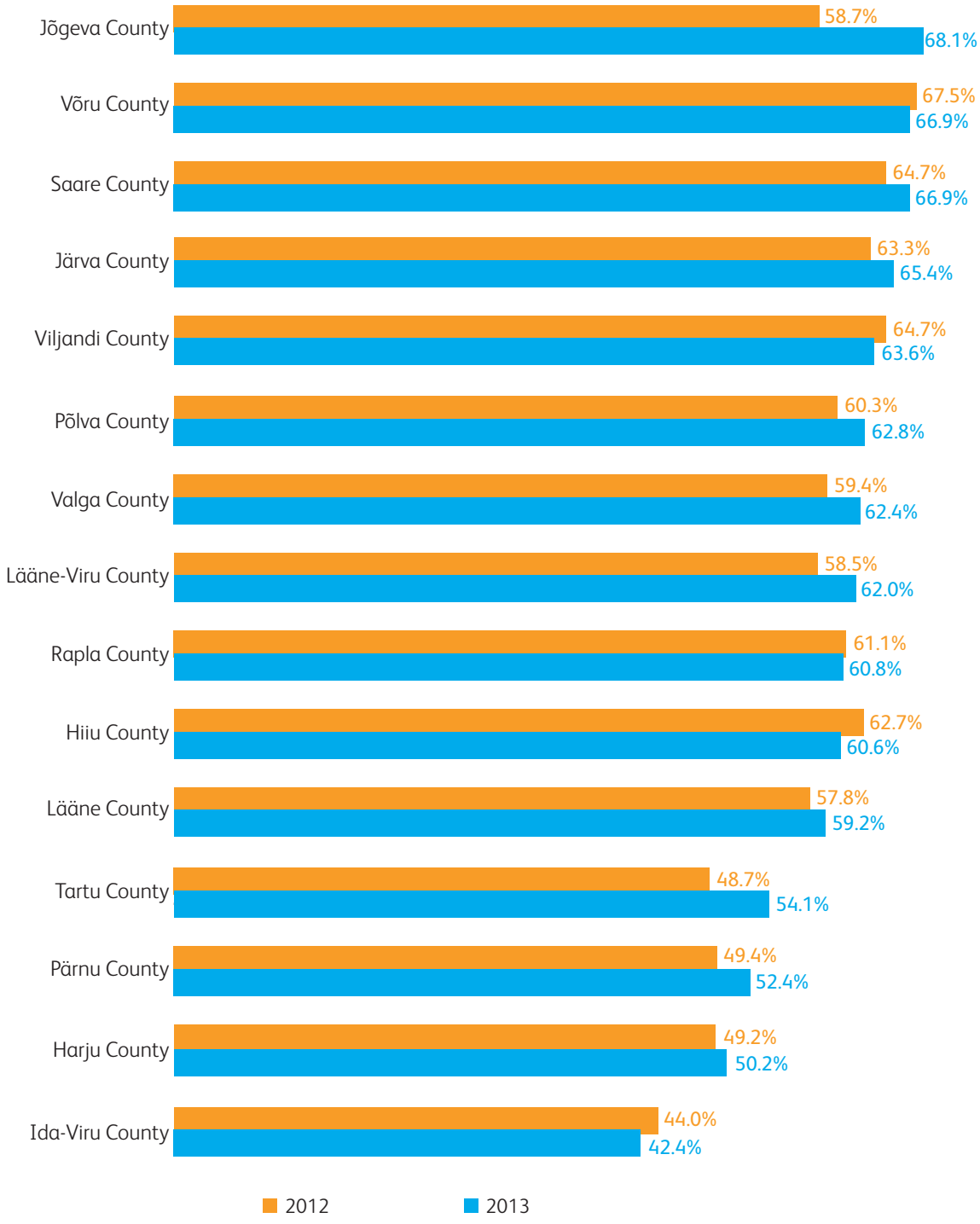


Figure 8. Participation in breast cancer screening by county from 2012-2013

The size of the target groups of **phenylketonuria and hypothyroidism screening and new-born hearing screening** depends on the number of births. Phenylketonuria was detected in five and hypothyroidism in two children. 35 parents refused to have their children tested. Hearing impairment was detected in 28 children (born in 2012 and 2013), in 12 cases the impairment was serious or very serious. The average age at which serious hearing impairment was diagnosed was 6.3 months and five of these children have already received cochlear implants. Fewer additional tests have been required in new-born hearing screening, as the share of false-positive results in medical institutions is smaller than presumed. This can be considered a good indicator.

Pregnant women whose children are at risk of such diseases on the basis of maternal serum screening tests are included in the **project for prenatal diagnostics of hereditary diseases**. Effective screening means that the volume of diagnostics was smaller than planned. Invasive procedures were required in 879 cases. Consultations with a geneticist were sufficient in the remaining cases. Foetal chromosomal anomaly was detected in 65 cases (including 27 cases of Down syndrome). The prenatal diagnostics project will be integrated into the specialised medical care system from 2014, as primary screening before invasive tests has already become a routine part of pregnancy monitoring.

Health checks of young athletes are aimed at young people aged 9-19, who regularly engage in sports for at least six hours a week in addition to the physical education classes at school. In 2013 the number of young people who engaged in sport for more than eight hours a week was higher than planned. The number of tests decreased and was smaller than planned due to the capacity of medical institutions, but the need for the tests has not decreased. East-Tallinn Central Hospital joined the project in 2013 to improve accessibility and an additional selection of contractual partners will be carried out in 2014.

1.2. Primary medical care

The additional allowance for a second family nurse and the implementation of the e-consultation services were the biggest changes in primary medical care financing in 2013. Strengthening the primary level in Estonia is important for the EHIF and as a result of this, several significant changes in financing were developed during the year in order to guarantee well-functioning and sustainable medical care.

The IT and utility expenses of family physicians were updated in 2013. The operations fund and remuneration of appointments outside working hours were added as new services. The reference prices of the advisory line of the family physician were also updated in 2013. The relevant changes in the health services list entered into force on 1 January 2014.

Primary medical care was given financing in the amount of 76.1 million euros in 2013. Compared to 2012, the budget grew mostly on the account of the increase in the share of the Fee for Services Fund and the implementation of the second family nurse allowance.

Table 9. Implementation of primary medical care budget, thousand euros

	2012 actual	2013 budget	2013 actual	Budget implementation
Basic allowance	8,981	9,055	9,037	100%
Distance allowance	492	492	486	99%
Second family nurse allowance	0	1,028	1,830	178%
Total capitation fee	44,878	47,855	47,439	99%
Capitation fee for insured persons of up to 3 years of age	2,674	2,747	2,729	99%
Capitation fee for insured persons 3-6 years of age	2,843	3,101	3,082	99%
Capitation fee for insured persons 7-49 years of age	18,983	20,066	19,893	99%
Capitation fee for insured persons 50-69 years of age	11,927	12,734	12,741	100%
Capitation fee for insured persons over 70 years of age	8,451	9,207	8,994	98%
Fee for Services (FFS) Fund	14,050	16,648	15,336	92%
Family physician's performance pay*	1,192	1,228	1,246	101%
Advisory line of the family physician	619	635	714	112%
Primary medical care reserve**	0	400	0	-
Total	**70,212**	**77,341**	**76,088**	**98%**

* The performance pay is budgeted for and paid out on the basis of the performance of the previous year(s) as a single payment in Q3.
** The funds for monitoring pregnancies and conducting autopsies are budgeted for under the primary medical care reserve.

The primary medical care financing structure is similar to the previous period: capitation fee once again comprised the biggest share (62%). The share of the capitation fee in the total primary medical care financing has decreased by 2% compared to 2012. The share of the Fee for Services Fund in the total budget was 20% and the share of the basic allowance was 12%. Since 2013, family physicians were paid an additional allowance for a second family nurse, which comprised 2% of the total implementation of the primary medical care budget in 2013. The implementation of this service was better than predicted – this is also evidenced by the conservable over-implementation of the budget (see Table 9).

Basic allowance is the monthly allowance paid to family physicians in order to cover the rent of their premises, utilities and transport expenses. The 1% increase in the basic allowance compared to the previous year is the result of the change in the reference price from 1 January 2013. Basic allowance was paid to 56 practice lists at the coefficient of 1.5 to those family physicians, who had several places of appointments. There were 53 practice lists with several places of appointments in 2013.

The 6% increase in the **capitation fee** compared to 2012 arises from the changes in the reference price of the capitation fee in 2013. The reference price of the capitation fee increased as a result of the salary agreement for medical professionals. The number of insured persons remained at the same level as in 2012. The

number of insured persons under three years of age decreased by 3% and the number of insured persons aged 3-6 increased by 3%. The number of insured persons aged over 50 also increased.

The **Fee for Service Fund** is allocated to family physicians for tests and procedures carried out on patients. Financing of the Fee for Services Fund increased by 9% compared to 2012. The share of the capitation fee of the Fee for Services Fund increased from 31% to 32% in 2013. Compared to 2012, the average implementation of the Fee for Services Fund also increased by 2% (91% in 2013 and 89% in 2012). 16% of contractual partners had exceeded the Fee for Services Fund as at year end, but 25% of contractual partners used less than 80% of their Fee for Services Fund. The Fee for Services Fund is used more primarily in group practices. In 2013 invoices with the coefficient of 0.3 were submitted for overtime related to the Fee for Services Funds of family physicians by 16 service providers in the total amount of 44 thousand euros. The e-consultation service, which is budgeted in the primary medical care reserve, is also recognised in the Fee for Services Fund.

Since 2013, family physicians can ask specialists for advice and treatment recommendations with the help of the e-consultation service in order to improve cooperation between specialists and family physicians. The service became available in the specialities of urology and endocrinology in 2013. The use of the e-consultation service in 2013 was considerably more modest than expected. The EHIF financed 122 e-consultations in total and as a result there are plans to pay more attention to the development of the e-consultation as a whole in 2014. Since the beginning of 2014, e-consultations are also offered in the specialities of pulmonology, rheumatology and otorhinolaryngology, and the option should also be extended to paediatrics, neurology, cardiology and haematology in 2015.

The **total number of practice lists** increased by one in 2013 and the number of insured persons on the list increased by four persons per list on average. The number of insured persons on practice lists for whom capitation fee was paid has increased by ca 4600 persons.

The number of small practice lists that serve areas of under 1200 people, which received capitation fees for 1200 people from the EHIF, increased by four compared to the previous year, i.e. 19 practice lists with fewer than 1200 persons were financed in 2013.

As at the end of 2013, 470 service providers had contracts with the EHIF for the provision of primary medical care services.

The total number of practice lists that receive the distance allowance is 190. 134 of them are located 20-40 km from the nearest hospital and 56 are further than 40 km from the nearest hospital. The number of **distance allowance** recipients decreased by five lists compared to the same period the year before.

Implementation of the second family nurse services during family physician appointments has proven to be considerably more successful than expected. The initial plan was to pay the allowance for the second family nurse to ca 100 lists, but the number of lists receiving the allowance as at the end of 2013 was 182.

Table 10. Number of practice lists of family physicians and number of insured persons on the lists

	2012 actual	2013 actual	Change compared to 2012
Number of practice lists			
Number of practice lists	800	801	0%
Number of lists receiving distance allowance	195	190	-3%
Number of lists receiving second family nurse allowance	0	182	-
Average size of practice lists (number of insured persons)	1,559	1,563	0%
Number of persons			
insured persons under 3 years of age (maximum capitation fee 5.53 euros/month)	43,185	41,849	-3%
insured persons 3-6 years of age (maximum capitation fee 4.14 euros/month)	61,219	63,092	3%
insured persons 7-49 years of age (maximum capitation fee 2.57 euros/month)	659,132	656,113	0%
insured persons 50-69 years of age (maximum capitation fee 3.47 euros/month)	305,846	310,961	2%
insured persons over 70 years of age (maximum capitation fee 4.24 euros/month)	177,841	179,795	1%
Total number of persons for whom capitation fee was paid	**1,247,223**	**1,251,810**	**0%**

The successful implementation of the service is certainly an important factor in the improvement of the accessibility and quality of primary medical care.

The number of participants in the quality bonus system (QBS)has increased constantly since 2007, but the participation rate in 2013 remained at the same level as in the year before (97%). The results of the quality bonus system are summarised once a year. Based on the performance in 2012, the maximum performance pay for successful disease prevention and chronic disease monitoring was paid to 328 family physicians. 154 family physicians were paid extra for additional professional competency.

The shares of family physicians who participated in the quality system and those who did or did not earn the performance pay from 2006-2012 are given in Figure 9.

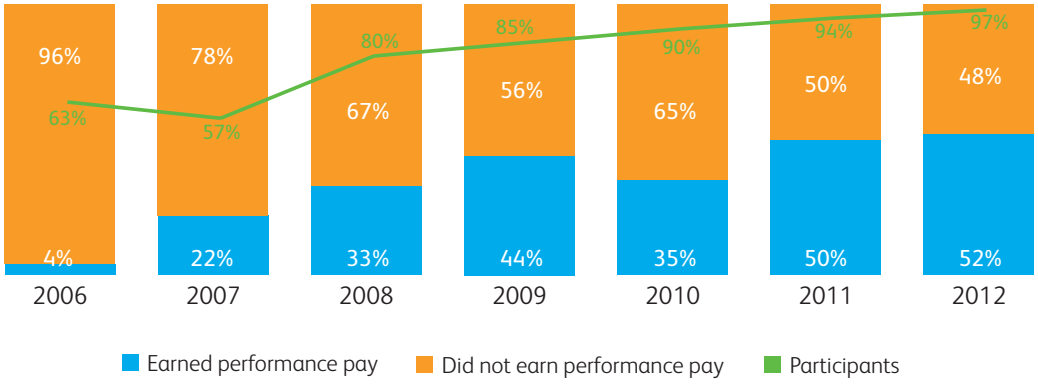


Figure 9. Shares of practice lists that participated in quality system and earned performance pay from 2006-2012

The principles of recording appointments in primary medical care changed in 2013. Instead of the earlier option to code the cases of patient consultations carried out by telephone and documented in the patient's medical records, or carried out by e-mail and documented in the patient's medical records, on the invoice for medical services, it is now possible to code consultation by telephone and e-mail separately for the family physician and the family nurse. Only consultation appointments with nurses were included in the number of appointments with nurses until 2012, but they can now be coded separately as consultation appointments and nursing procedures. The number of appointments with family nurses has more than doubled as a result of the changes and the number of appointments with doctors has decreased by 16%. The number of prophylactic appointments has decreased by 27%. This change is also related to changes in coding appointments. The total number of appointments has decreased by 1% compared to 2012. 3% fewer people visited a doctor in 2013 than in 2012. The number of persons on practice lists has remained the same, but the share of persons who visited family physicians among all the persons on the list decreased by 2% (see Table 11).

Table 11. Number of family physician and family nurse appointments from 2008-2013

	2008	2009	2010	2011	2012	2013
Appointments with family physicians	4,368,668	4,182,361	3,994,334	4,411,214	4,523,318	3,804,813
Appointments with family nurses*	370,853	418,305	480,269	535,240	592,690	1,342,658
Prophylactic appointments	450,309	387,782	394,360	363,182	326,747	238,140
Total appointments	**5,189,830**	**4,988,448**	**4,868,963**	**5,309,636**	**5,442,755**	**5,385,611**
Number of persons who had appointments	983,466	973,129	957,090	981,575	973,882	948,486
Number of persons on practice lists	1,286,597	1,280,795	1,271,082	1,255,971	1,247,223	1,251,810
Share of persons who had appointments with family physicians among persons on practice lists	76%	76%	75%	78%	78%	76%

* Appointments with family nurses and nursing procedures by family nurses, consultations with family physicians and family nurses by telephone and e-mail were separated in 2013.

The average number of appointments per person by county in 2013 is given in Figure 10. The average number of appointments per person per year in Estonia is four. The number of appointments with family physicians in 2013 was the highest in Rapla County and the smallest in Lääne County. The average number of doctor's appointments per one nurse's appointment in Estonia is three.

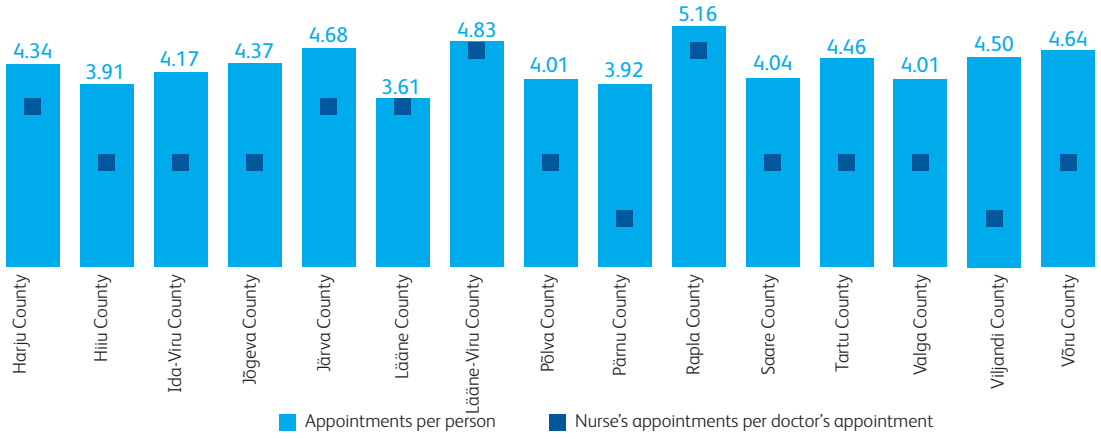


Figure 10. Appointments per person and number of nurse's appointments per one doctor's appointment in 2013 by county

The services of the nationwide Family physician Advise Line 1220 are available in Estonia 24 hours a day so that people can quickly receive advice in the case of health concerns. It is also possible to request information about the organisation of health care. The selection of the new provider of the nationwide advisory line service for the new contract period was declared in 2013 and the components of financing the advisory line were also reviewed. The changes to the list of health services entered into force in 2014.

The use of the advisory line of the family physician grew by 15% compared to the previous year. The total number of calls answered by doctors and nurses in 2013 was 236,674. The average number of calls per day is 648 (222,287 calls were answered in 2012 and the average number of calls per day was 609). The over-implementation of the budget was caused by the number of calls being higher than expected due to the virus outbreak in the beginning of the year. The average number of calls per day from 2005-2013 is shown in Figure 11.

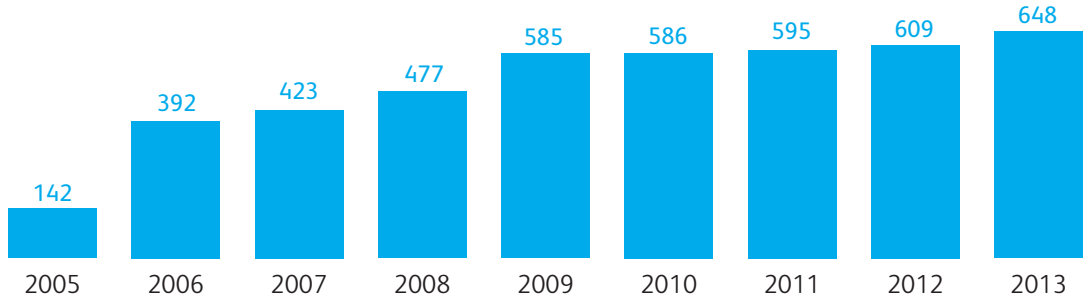


Figure 11. Average number of calls answered per day from 2005-2013

1.3. Specialised medical care

The financing allocated to specialised medical care in 2013 amounted to 481.6 million euros, which was 31.1 million euros more than in 2012. These funds divided between outpatient care, day care (health service whereby the patient needs monitoring in a bed for a couple of hours due to a treatment or test, and can go home for the night), inpatient care (health service the provision of which requires that the patient be hospitalised) and centrally contracted health services. Services the regional planning of which is not reasonable were regarded as centrally contracted health services in 2013 – these services are usually considerably more expensive that the average and that are relatively infrequently required.

The increase in financing compared to the previous year was 7%, incl. 10% in outpatient specialised medical care, 9% in day care, 5% in inpatient specialised medical care and 13% in centrally contracted health services. The main factors that caused the increase were updating the list of health services (incl. the price increase in health services resulting from the salary agreement of medical professionals) and changes in the use of treatments.

Below, the implementation of the specialised medical care budget is assessed in two categories:

- specialised medical care without centrally contracted health services;
- centrally contracted health services

1.3.1. Specialised medical care, except centrally contracted health services

The implementation of the budget was 101%, cases 99%. Budget implementation by type of care is given in the table below.

Table 12. Implementation of specialised medical care budget, except centrally contracted health services, in thousand euros and cases by type of care

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of case	Amount	Number of case	Amount	Number of case	Amount	Number of case
Total specialised medical care	436,696	3,162,267	464,121	3,211,993	466,739	3,182,139	101%	99%
Total outpatient care	148,291	2,865,870	159,207	2,916,150	162,975	2,882,795	102%	99%
Total day care	28,322	65,092	30,870	67,789	30,878	67,740	100%	100%
Total inpatient care	260,083	231,305	274,044	228,054	272,886	231,604	100%	102%
Preparedness fee	9,250	382	9,694	380	9 694	380	100%	100%
Total	**445,946**	**3,162,649**	**473,815**	**3,212,373**	**476,433**	**3,182,519**	**101%**	**99%**

Services related to the specialties of orthopaedics, rehabilitation and radiation therapy were recognised in the list of health services in 2013. The component of the salaries of medical professionals was changed in the reference prices of health services and the working hours of medical professionals in outpatient appointments of medical specialists and bed days were increased. Several new services were added to the list of health services. The impact of the updates made to the list of health services on the budget for 2013 was an estimated 31 million euros. Services in the specialties of cardiac surgery, neurology, neurosurgery and psychiatry were updated in the EHIF's list of health services in 2013. The relevant changes in the health services list entered into force on 1 January 2014.

The new updated DRG[4] grouping version, which streamlined the DRG grouping logic, was introduced in DRG-

[4] *"DRG" (diagnosis related groups) is the case-based financing system used in Estonia where patients with the same clinical diagnosis and need for resources are classified in the same group.*

based financing in 2013.

The increase in the financing of specialised medical care in 2013 was also influenced by the volume inflation of cases (change in the services provided within the scope of a case estimated in comparable prices). The total volume inflation of a case in specialised medical care was 1.8%, incl. 4.3% in outpatient care, 1.4% in day care and 0.5% in inpatient care.

The Government of the Republic established the list of hospitals of the Hospital Network Development Plan (HNDP) in order to guarantee an even access to health services. The EHIF enters into treatment financing contracts for at least five years with the hospitals on the list. The HNDP hospitals are also paid for services provided in excess of the agreed volume – the EHIF pays for these services at a coefficient of 0.3. The cases in the HNDP hospitals that exceeded the agreed volume totalled 3.2 million euros (i.e. 0.7% of the total specialised medical care budget). The additional number of cases paid for was 9700 (incl. 3000 inpatient, 400 day care and 6300 inpatient cases). The impact of overtime was the biggest in inpatient care where the invoices paid at the coefficient of 0.3 comprised 1.1% of budget implementation and 2.7% of the budgeted cases.

Key indicators of specialised medical care

An overview of the key indicators of specialised medical care from 2009-2013 is given in Table 13.

Table 13. Key indicators of inpatient and outpatient specialised medical care

						Change			
	2009 actual	2010 actual	2011 actual	2012 actual	2013 actual	2010/ 2009	2011/ 2010	2012/ 2011	2013/ 2012
Average cost per case in euros	128	122	123	138	147	-5%	1%	12%	7%
in outpatient care	44	43	45	52	57	-2%	5%	16%	10%
in day care	449	404	371	435	456	-10%	-8%	17%	5%
in inpatient care	1,011	982	1,008	1,124	1,178	-3%	3%	12%	5%
Number of inpatient days	1,449,960	1,458,555	1,436,100	1,412,328	1,385,260	1%	-2%	-2%	-2%
Average length of inpatient stay (days)	6.1	6.1	6.0	6.1	6.0	0%	-2%	2%	-2%
Number of outpatient appointments	3,647,303	3,671,655	3,801,950	3,785,111	3,796,893	1%	4%	0%	0%
in outpatient care	3,573,286	3,609,613	3,732,239	3,714,476	3,724,438	1%	3%	0%	0%
in day care	74,017	62,042	69,711	70,635	72,455	-16%	12%	1%	3%
Outpatient appointments per case	1.32	1.18	1.28	1.29	1.29	-11%	8%	1%	0%
in outpatient care	1.31	1.29	1.29	1.30	1.29	-2%	0%	1%	-1%
in day care	1.34	1.07	1.07	1.09	1.07	-20%	0%	1%	-1%
Number of persons who used specialised medical care services	800,578	797,048	807,875	795,581	796,698	0%	1%	-2%	0%
in outpatient care	777,144	774,589	786,099	774,661	775,566	0%	1%	-1%	0%
in day care	44,474	47,063	52,230	51,549	52,554	6%	11%	-1%	2%
in inpatient care	163,911	162,514	161,550	1,55,653	155,982	-1%	-1%	-4%	0%
Number of cases per person:	3.76	3.89	3.97	3.97	3.99	3%	2%	0%	1%
in outpatient care	3.50	3.62	3.69	3.70	3.72	3%	2%	0%	1%
in day care	1.24	1.23	1.24	1.26	1.29	-1%	1%	2%	2%
in inpatient care	1.47	1.48	1.48	1.49	1.48	1%	0%	1%	-1%
Emergency care as a percentage of medical expenses									
in outpatient care	17	18	18	17	17	1%	0%	-1%	0%
in day care	9	9	7	8	8	0%	-2%	1%	0%
in inpatient care	67	67	64	66	64	0%	-3%	2%	-2%
Emergency care as a percentage of cases									
in outpatient care	17	17	17	17	17	0%	0%	0%	0%
in day care	15	12	9	10	10	-3%	-3%	1%	0%
in inpatient care	61	62	62	64	63	1%	0%	2%	-1%
Number of surgeries	155,010	160,403	163,718	154,969	155,289	3%	2%	-5%	0%
in outpatient care	20,302	21,154	19,808	18,345	17,719	4%	-6%	-7%	-3%
in day care	42,620	46,911	52,507	50,479	51,609	10%	12%	-4%	2%
in inpatient care	92,088	92,338	91,403	86,145	85,961	0%	-1%	-6%	0%

Compared to the previous year, the number of insured persons who used specialised medical care services has increased in outpatient and inpatient care as well as in day care. The total number of insured persons decreased at the same time. The increase in the average cost of a case is related to the changes in the list of health services (incl. the price increase resulting from the salary agreement of medical professionals) as well as the changes in the use of health services (increase in the number of tests and procedures).

The number of persons who received care as well as the number of cases per person has increased in **outpatient care**. The general number of appointments increased primarily on the account of the independent appointments with nurses and midwives (an increase of *ca* 27 appointments compared to the previous year). The decrease in the number of outpatient surgeries is related to the updates made in the surgery chapter of the EHIF's list of health services (various surgical procedures that were previously noted on invoices as surgeries can now be noted on invoices as procedures).

The number of persons who received inpatient care is at an absolute level similar to that of the previous year. The average number of days in **inpatient care** has decreased – the share of short-term inpatient cases, whereby the patient is hospitalised for a short time for tests and procedures, has increased.

The number of persons who received care, the number of surgeries as well as the number of cases per person has increased in **day care**. The number of cases per person is increasing, because non-surgical activities keep moving into the category of day care – systematic treatment, e.g. infusion therapy, etc.

Volume inflation cases of specialised medical care

The number of high-cost cases has increased in comparison to the previous year and the financing of high-cost cases exceeded the previous year's amount by 248 thousand euros.

Table 14. High-cost cases by specialties in thousand euros and by cases

	2012 actual		2013 actual		Change compared to 2012	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Surgery	1,099	10	978	11	-11%	10%
Neurology			111	1		
Oncology	213	3				
Orthopaedics	94	1				
Paediatrics	493	5	1,272	12	158%	140%
Pulmonology			266	3		
Internal diseases	1,029	11	549	6	-47%	-45%
Centrally contracted services			70	1		
Total	**2,928**	**30**	**3,176**	**33**	**8%**	**10%**

Budget implementation and cases by specialties

The main specialties in the contracts entered into between the EHIF and medical institutions for the financing of specialised medical care in 2013 were dermatovenerology, primary follow-up care, infectious diseases, surgery, neurology, ophthalmology, oncology, orthopaedics, otorhinolaryngology, paediatrics, psychiatry, pulmonology, internal diseases, obstetric care, gynaecology and rehabilitation. Below is an overview of the budget implementation in specialised medical care, except centrally contracted services, by main specialties.

Dermatovenerology

Table 15. Implementation of dermatovenerology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Dermatovenerology	5,311	161,152	6,101	171,632	6,155	163,639	101%	95%
outpatient	4,187	159,058	4,849	169,531	4,766	161,359	98%	95%
day care	371	698	444	743	615	944	139%	127%
inpatient	753	1,396	808	1,358	774	1,336	96%	98%

The implementation of the dermatovenerology budget was 101%, cases 95%. The under-implementation of cases is primarily related to the volume of the inpatient care provided in the Harju region being smaller than expected. The waiting times for appointments in dermatovenerology in the Harju region are often longer than permitted – according to the reports of 1 January 2014, the waiting times were longer than permitted in both the North Estonia Medical Centre and the East-Tallinn Central Hospital. The reason why waiting times in these two medical institutions were longer than permitted is their lack of capacity – increasing the number of appointments is impossible. The provision of inpatient care and the average cost of an inpatient case have decreased faster than forecast, allowing for the provision of more financing to day care and outpatient services, The increase in the average cost of an outpatient and day care case is mostly related to the share of biological treatment being higher than planned.

Primary follow-up care

Table 16. Implementation of primary follow-up care budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Primary follow-up care	1,541	2,208	1,685	2,162	1,770	2,232	105%	103%
inpatient	1,541	2,208	1,685	2,162	1,770	2,232	105%	103%

The implementation of the primary follow-up care budget was 105%, cases 103%. Primary follow-up care services are provided mostly by general hospitals and selected partners as a separate contractual specialty. The East-Tallinn Central Hospital is the only one among central and regional hospitals that provides primary follow-up care services as a separate contractual specialty. The average cost of a case is higher than planned, which indicates that cases have been more complicated and lasted longer. The reason given for the increase in the number of cases is treatment of patients in acute conditions in higher-stage hospitals. Once active treatment is completed, the patient is generally referred to the general hospital of their place of residence for inpatient follow-up care (primary follow-up care is provided separately in the East-Tallinn Central Hospital).

Infectious diseases

Table 17. Implementation of infectious disease budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Infectious diseases	6,705	37,545	7,283	37,235	7,371	38,814	101%	104%
outpatient	2,486	27,364	2,754	26,766	2,652	27,588	96%	103%
day care	0	1	0	0	0	0	-	-
inpatient	4,219	10,180	4,529	10,469	4,719	11,226	104%	107%

The implementation of the infectious disease budget was 101%, cases 104%. The number of both outpatient and inpatient cases was higher than planned. The average cost of a case was lower than planned in both types of care. The treatment of infectious diseases is relatively difficult to forecast due to possible outbreaks and the deviation by regions and medical institutions exceeds the planned indicators more than in the case of aggregate data. There was an outbreak of the ROTA virus in the Harju region in 2013 and the number of the resulting cases of lower average cost was bigger than planned. The number of cases in the Tartu region was increased by the outbreak of viral meningitis among children that was treated in the Tartu University Hospital.

Surgery

Table 18. Implementation of dental care budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Surgery	77,269	381,425	81,065	388,198	81,070	392,303	100%	101%
outpatient	15,425	327,704	16,673	334,511	17,259	337,918	104%	101%
day care	3,380	11,448	3,754	11,994	3,749	11,990	100%	100%
inpatient	58,464	42,273	60,638	41,693	60,062	42,395	99%	102%

The sub-specialties of surgery in 2013 were cardiac surgery, paediatric surgery neurosurgery, maxillofacial surgery, thoracic surgery, urology, vascular surgery and general surgery. The surgery budget was implemented as planned.

The average cost of a case was smaller than planned. The cost of the average case decreased as a result of inpatient care where the average cost of a case was lower than budgeted for. The number of cases in inpatient care has increased. The decrease in the average cost of a case and the increase in the number of cases in inpatient care are primarily related to general surgery. The cost of an outpatient case increased due to the increase in the number of tests and procedures, and the movement of simpler cases from day care to outpatient care, and the number of appointments per case has also increased.

In terms of the sub-specialties of surgery, the use of services in general surgery and urology was bigger than planned. The budget in terms of the number of cases as well as the amount of money was under-implemented in cardiac surgery, neurosurgery, maxillofacial surgery, vascular surgery and organ transplants. The budget of thoracic surgery was exceeded as a result of two high-cost cases, but the number of cases in thoracic surgery was smaller than planned.

Available data indicate that waiting times in inpatient surgical care and day care, as well as in outpatient cases in cardiac surgery, paediatric surgery, maxillofacial surgery, thoracic surgery and general surgery were within the permitted limits. Waiting times are longer than permitted in the outpatient cases of neurosurgery,

vascular surgery and urology. The main reason why waiting times are longer that permitted is the shortage of capacity (medical staff).

Cardiac surgeries, urinary sphincter surgeries and organ transplants were highlighted as separately monitored services in the budget and in contracts in 2013. 817 cardiac surgeries were carried out in 2013; the total number of cardiac surgeries in 2012 was 866. The budget of cardiac surgeries was under-implemented and use has also decreased in comparison to the previous year. Cardiac surgeries are performed in the North Estonia Medical Centre, Tartu University Hospital and Tallinn Children's Hospital. The number of cardiac surgeries in the North Estonia Medical Centre was smaller than planned. One of the reasons for this was the renovation works carried out in the hospital.

The organ transplant budget was under-implemented. The under-implementation of the budget was primarily influenced by the number of kidney transplants being smaller than planned. The number of kidney transplants depends on the suitability of the donor organ for the patient awaiting the transplant. The number of persons on haemodialysis who make it to the transplant waiting list is also an important factor. In Estonia, ca 10% of patients on haemodialysis receive transplants, but the same indicator is higher elsewhere in the world (for example, 70-75% of patients in Norway are referred for transplants in the same year when they started haemodialysis). In 2013, there were 47 kidney transplants (61 in 2102), 7 liver transplants (11 in 2012), 3 lung transplants (2 in 2012) and 1 combined liver and kidney transplant. The following number of patients were on the waiting list as at 1 January 2014: kidney transplant – 37 patients (incl. 25 on the active waiting list); liver transplant – 4 patients; lung transplant – 2 patients.

Neurology

Table 19. Implementation of neurology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Neurology	15,697	140,730	16,591	142,390	17,732	139,314	107%	98%
outpatient	7,248	132,645	7,771	134,626	8,196	131,358	105%	98%
day care	43	190	51	209	51	162	100%	78%
inpatient	8,406	7,895	8,769	7,555	9,485	7,794	108%	103%

The implementation of the neurology budget was 107%, cases 98%. The average cost of a case is considerably higher than planned in all types of care, especially due to the increased use of tests and pharmaceuticals (incl. biological treatment). The number of cases in 2013 was on a similar absolute level to that of 2012 – the forecast increase in cases did not occur. According to the reports of 1 January 2014, the waiting time for outpatient neurology appointments exceeded the permitted length in all Tallinn hospitals. The reason for this is the lack of capacity in medical institutions – it is impossible to increase the number of appointments with the present number of doctors.

Ophthalmology

Table 20. Implementation of ophthalmology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Ophthalmology	17,466	373,837	18,695	379,426	18,615	370,600	100%	98%
outpatient	8,740	357,854	9,817	363,555	9,539	354,242	97%	97%
day care	7,132	14,296	7,358	14,293	7,426	14,593	101%	102%
inpatient	1,594	1,687	1,520	1,578	1,650	1,765	109%	112%

The implementation of the ophthalmology budget was 100%, cases 98%. Ophthalmology is a predominantly outpatient specialty and cataract surgeries comprise a significant part of the volume of day care (93% of cases and 97% of the amount). The volume of inpatient care was bigger than planned as a result of the number of emergency cases. In inpatient care, the budget remained under-implemented both in terms of cases and the amount, whilst the waiting times for outpatient care by most contractual partners are longer than permitted. The lack of capacity is usually the reason why the waiting times are longer than permitted, but financial reasons have also been mentioned in reports (the East-Tallinn Central Hospital, where demand exceeds supply and even the medical institution itself finds that increasing the contractual volume would not shorten the actual waiting time).

Ophthalmology is a specialty where the specialist can be contacted directly – a family physician's referral is not required and ophthalmologists are at least partly dealing with problems that could be treated by family physicians or optometrists.

Cataract surgeries were highlighted as special cases in the specialty of ophthalmology in the budget and in contracts in 2013. Cataract surgeries are generally scheduled. The number of cataract surgeries has remained the same compared to the previous year – the EHIF financed 13,652 cataract surgeries in 2012 and 13,691 surgeries in 2013. The waiting times for cataract surgery in all contractual partner institutions were within the permitted limit (1.5 years).

Oncology

Table 21. Implementation of oncology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Oncology	44,606	110,914	46,980	111,625	47,083	114,419	100%	103%
outpatient	23,838	97,169	24,595	97,604	25,321	99,833	103%	102%
day care	1,506	2,880	1,740	3,189	1,852	3,224	106%	101%
inpatient	19,262	10,865	20,645	10,832	19,910	11,362	96%	105%

The speciality of oncology is characterised by a stable increase in the number of cases and in the average cost of cases. Despite the number of planned cases being exceeded slightly, the increase in the number of cases is still only half the increase in 2012 (ca 6%). The number of cases increased ca 3% in 2013 in comparison to the previous year. The implementation of the oncology budget was 100%, cases 103%. The waiting times in oncology were within the permitted limits in all medical institutions. The number of cases increased faster than planned in all types of care and the average cost of a case was lower than planned in inpatient care and higher than planned in outpatient care and day care. Some of the services have been transferred from inpatient care to day care and some cases of chemotherapy have moved from day care to outpatient care. The movement of treatment from inpatient care to day care and from day care to outpatient care makes it possible to offer necessary services to the insured persons in a speciality where demand is growing. The number of persons who received oncological treatment has increased faster than the average of specialised care in recent years. The reasons for this are the aging of the population, but also the accessibility of new methods of diagnosis and treatment.

Brachytherapy – a form of radiotherapy where a small quantity of radioactive material is introduced into the body close to the tumour – was highlighted as a separate service in the specialty of oncology in both the budget and contracts in 2013. The number of brachytherapy cases was 30 instead of the planned 32 and the launch of the treatment in the Tartu University Hospital was slower than planned.

Orthopaedics

Table 22. Implementation of orthopaedics budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Orthopaedics	35,336	260,898	37,576	266,962	36,836	262,562	98%	98%
outpatient	8,200	243,293	9,031	249,040	9,103	244,643	101%	98%
day care	1,965	4,354	2,172	4,541	2,201	4,482	101%	99%
inpatient	25,171	13,251	26,373	13,381	25,532	13,437	97%	100%

An increase in all types of care in 2013 was budgeted for in orthopaedics. The actual increase was smaller – the number of cases increased by 1700 in comparison to the previous year. The average cost of a case was lower than planned in inpatient treatment – the average cost of the endoprosthetic replacement included in the total amount of inpatient treatment as well as the cost of other inpatient orthopaedic treatment (mainly treatment of traumas) was lower than planned.

Endoprosthetic replacements were highlighted as special cases in the specialty of orthopaedics in the budget and in contracts in 2013. The implementation of the endoprosthetic replacements budget was 97%, cases 99%. The waiting times for endoprosthetic replacements by all contractual partners were within the permitted limit (1.5 years). The North Estonia Medical Centre, Tartu University Hospital and Kuressaare Hospital did not achieve the contracted volume.

Otorhinolaryngology

Table 23. Implementation of otorhinolaryngology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Otorhinolaryngology	10,915	192,647	11,810	195,097	11,967	192,744	101%	99%
outpatient	5,168	176,131	5,727	178,523	5,956	176,027	104%	99%
day care	1,816	6,298	2,014	6,582	1,930	6,233	96%	95%
inpatient	3,931	10,218	4,069	9,992	4,081	10,484	100%	105%

The implementation of the otorhinolaryngology budget was 101%, cases 99%. The number of cases has basically not changed in comparison to the previous year and the average cost of a case has increased primarily in outpatient care. The number of appointments per case has increased in inpatient care (a case lasts longer) and the use of x-rays and computer scans has also increased. The waiting times in HNDP hospitals according to the reports of 1 January 2014 are generally within the permitted limits. The under-implementation of day care cases is mainly the result of the over-implementation of inpatient cases in the Tartu University Hospital. The quantity of inpatient otorhinolaryngology services provided in the Tartu University Hospital is relatively high compared to other hospitals - 44% of inpatient cases in otorhinolaryngology were treated in the Tartu University Hospital.

Installation of cochlear implants was highlighted as a special case in otorhinolaryngology in the budget and contracts in 2013. 20 cochlear implants were installed in 2013 and the use of the budget complies with the planned use.

Paediatrics

Table 24. Implementation of paediatrics budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Paediatrics	18,362	149,714	19,381	147,811	20,465	154,984	106%	105%
outpatient	5,696	119,730	6,212	118,754	6,379	125,081	103%	105%
day care	844	2,268	926	2,331	979	2,502	106%	107%
inpatient	11,822	27,716	12,243	26,726	13,107	27,401	107%	103%

The implementation of the paediatrics budget was 106%, cases 105%. The number of outpatient cases was increased primarily by the increase in the number of appointments in the Emergency Medicine Department (EMD) in the Harju region (Tallinn Children's Hospital). The cost of appointments in the EMD is lower than the average and the cases they treat often tend to fall into the competency of family physicians. The decrease in the number of inpatient cases compared to the previous year was slower than planned. High-cost cases had a significant influence in inpatient care. In 2013 there were 12 paediatric cases that cost more than 65 thousand euros and these cases in total comprised 1.3 million euros. Without the inclusion of the high-cost cases, the average cost of a case was lower than planned.

Psychiatry

Table 25. Implementation of psychiatry budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Psychiatry	19,848	236,438	21,565	238,392	21,616	237,558	100%	100%
outpatient	5,582	225,452	6,046	227,604	6,082	226,824	101%	100%
day care	203	484	265	498	241	479	91%	96%
inpatient	14,063	10,502	15,254	10,290	15,293	10,255	100%	100%

An increase compared to the previous year was planned in the specialty of psychiatry and the budget was implemented as planned. The number of outpatient cases increased in comparison to the previous year whilst the number of inpatient cases decreased somewhat. The number of day care cases basically remained the same. The waiting times for psychiatric treatment are generally within the permitted limits.

Pulmonology

Table 26. Implementation of pulmonology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Pulmonology	14,005	73,794	15,236	74,887	15,821	75,840	104%	101%
outpatient	6,749	69,809	7,305	71,049	7,474	71,878	102%	101%
day care	28	45	41	72	104	115	254%	160%
inpatient	7,228	3,940	7,890	3,766	8,243	3,847	104%	102%

The implementation of the pulmonology budget was 104%, cases 101%. An increase in the number of outpatient and day care cases was planned in the budget and the actual increase was even higher than expected. The data in the reports submitted on 1 January 2014 indicate that waiting times in pulmonology are not longer than permitted in any of the medical institutions that provide services in the speciality – the services are accessible. The introduction of home respiratory therapy that reduced the need for inpatient care had an impact on the increase in the number of outpatient cases. The number of inpatient cases decreased slower than anticipated and the higher than average increase in the cost of a case is the result of the expensive cases where emergency care was required.

Internal diseases

Table 27. Implementation of internal disease budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Internal diseases	117,817	440,398	123,938	448,466	124,678	440,739	101%	98%
outpatient	29,329	382,300	31,164	390,832	32,644	383,232	105%	98%
day care	8,699	5,895	9,421	6,199	9,120	6,427	97%	104%
inpatient	79,789	52,203	83,353	51,435	82,914	51,080	99%	99%

The sub-specialties in the specialty of internal diseases in 2013 were endocrinology, gastroenterology, haematology, cardiology, occupational diseases, nephrology, rheumatology and internal diseases. Dialyses and bone marrow transplants were highlighted as separately financed services in the budget and contracts.

The implementation of the internal disease budget was 101%, cases 98%. Inpatient care has decreased faster than planned, moving to day care and then to outpatient care. The increase in the number of outpatient cases was lower than planned. However, the average cost of an outpatient case was considerably higher than planned. The number of outpatient cases is also limited by the small capacity of medical institutions, which does not allow them to increase the number of outpatient appointments in many sub-specialities of internal diseases. The average cost of an outpatient case has grown the most in rheumatology when compared to the planned amount; in terms of services, the cost of an outpatient case has increased primarily due to the increase in the volume of pharmaceuticals (incl. biological treatment), tests and procedures.

The implementation of the dialysis budget was 96%, cases 99%. There were more bone marrow transplants than planned. Inpatient services related to bone marrow transplants were provided to 84 people in 2013 (the relevant number in 2012 was 69).

Obstetric care and gynaecology

Table 28. Implementation of obstetric care and gynaecology budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Obstetric care and gynaecology	41,694	523,624	44,989	528,893	44,172	521,452	98%	99%
outpatient	20,589	477,043	22,182	481,446	22,231	475,064	100%	99%
day care	2,335	16,235	2,684	17,138	2,610	16,589	97%	97%
inpatient	18,770	30,346	20,123	30,309	19,331	29,799	96%	98%

The implementation of the obstetric care and gynaecology budget was 98%, cases 99%. There were fewer cases than planned in all types of care. In terms of inpatient cases, this was mainly the result of the number of births being lower than anticipated. Waiting times for gynaecological appointments in all HNDP hospitals are within the permitted limits – the under-implementation of the budget is the result of the demand being lower than planned.

Births and in vitro fertilisation (IVF) were highlighted as special cases of obstetric care and gynaecology in the budget and contracts in 2013. The number of births in 2013 was 4% lower than planned – instead of the planned increase, the number of births decreased also in 2013 compared to the previous year. The rather numerous generation of the Singing Revolution has reached child-bearing age and we've therefore budgeted for an increase in the number of births in 2014 despite the decrease trend of the previous years.

The number of IVF cases (2455) was considerably higher than planned (2177 cases). However, the amount of the EHIF's finances that were used was lower than expected – the reason for this was that the volume of the service compensated by the Ministry of Social Affairs was larger than anticipated (the procedures are financed from the state budget from the fourth time onwards). The age of the women who have received IVF treatment as well as the number of treatments per woman have both increased.

Rehabilitation

Table 29. Implementation of rehabilitation budget in thousand euros and cases

	2012 actual		2013 eelarve		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Rehabilitation	10,124	76,943	11,226	78,817	11,388	74,939	101%	95%
outpatient	5,054	70,318	5,081	72,309	5,373	67,748	106%	94%
inpatient	5,070	6,625	6,145	6,508	6,015	7,191	98%	110%

The implementation of the rehabilitation budget was 101%, cases 95%. The implementation of the number of outpatient cases was 94%. Compared to the year before, the number of outpatient cases increased but at a slower speed than anticipated. The average cost of an outpatient case was considerably higher than planned – group therapy was not implemented as much as expected. The number of inpatient rehabilitation cases has increased compared to the previous year and one of the reasons for this is the addition of indications to the EHIF's list of health services in the case of which patients are referred to inpatient rehabilitation. The average cost of a case was lower than planned. The implementation of the inpatient care budget was 98%, cases 110%. Based on the reports submitted on 1 January 2014, the waiting times for outpatient rehabilitation in the HNDP hospitals is generally within the permitted limits.

Performance of specialised medical care contracts of hospitals of the Hospital Network Development Plan

In 2013 the EHIF paid the HNDP hospitals 439.5 million euros for the 2.6 million cases of specialised medical care they treated. The cases treated in the HNDP hospitals comprised 80% and the amount paid to them comprised 92% of the specialised medical care budget implementation. The data of the performance of the specialised medical care contracts of the HNDP hospitals in 2013 is given in the table below.

Table 30. Performance of specialised medical care contracts of HNDP hospitals in thousand euros

	2012 actual		2013 contract		2013 actual		Contract performance	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
North Estonia Medical Centre	**108,840**	**335,860**	**114,135**	**337,388**	**115,162**	**336,981**	**101%**	**100%**
outpatient	30,362	294,504	32,512	295,954	33,820	296,058	104%	100%
day care	4,396	6,779	4,664	6,926	4,651	6,862	100%	99%
inpatient	74,082	34,577	76,959	34,508	76,691	34,061	100%	99%
Tartu University Hospital	**103,593**	**457,586**	**110,179**	**466,683**	**110,772**	**470,323**	**101%**	**101%**
outpatient	29,927	401,762	32,345	409,908	33,021	413,169	102%	101%
day care	4,601	11,545	5,210	12,073	5,264	12,133	101%	100%
inpatient	69,065	44,279	72,624	44,702	72,487	45,021	100%	101%
East-Tallinn Central Hospital	**56,351**	**444,463**	**59,330**	**449,935**	**60,024**	**452,281**	**101%**	**101%**
outpatient	20,678	403,823	22,224	409,202	22,492	410,489	101%	100%
day care	5,183	12,484	5,639	12,870	5,727	13,003	102%	101%
inpatient	30,490	28,156	31,467	27,863	31,805	28,789	101%	103%
West-Tallinn Central Hospital	**31,145**	**301,939**	**33,367**	**308,846**	**33,634**	**310,401**	**101%**	**101%**
outpatient	11,924	276,287	13,258	283,091	13,266	284,232	100%	100%
day care	2,695	4,644	2,793	4,955	2,759	4,977	99%	100%
inpatient	16,526	21,008	17,316	20,800	17,609	21,192	102%	102%
SA Ida-Viru Keskhaigla	**20,362**	**154,993**	**21,459**	**152,454**	**21,439**	**148,775**	**100%**	**98%**
outpatient	6,013	138, 950	6,465	136,045	6,467	132,484	100%	97%
day care	1,750	3,561	1,822	3,587	1,808	3,579	99%	100%
inpatient	12,599	12,482	13,172	12,822	13,164	12,712	100%	99%
Pärnu Hospital	**19,446**	**168,208**	**21,015**	**175,697**	**21,173**	**176,060**	**101%**	**100%**
outpatient	6,218	150,468	6 857	157,158	6,897	157 421	101%	100%
day care	936	3,988	1,150	4,730	1,129	4 776	98%	101%
inpatient	12,292	13,752	13,008	13,809	13,147	13 863	101%	100%
Tallinn Children's Hospital	**16,226**	**170,820**	**17,780**	**171,781**	**18,039**	**175,281**	**101%**	**102%**
outpatient	5,526	149,509	6,241	152,736	6,198	154,001	99%	101%
day care	1,069	3,143	1,182	3,210	1,214	3,485	103%	109%
inpatient	9,631	18,168	10,357	15,835	10,627	17,795	103%	112%
Narva Hospital	**11,233**	**106,579**	**11,749**	**101,852**	**11,763**	**102,250**	**100%**	**100%**
outpatient	3,534	92,830	3,688	88,385	3,677	88,733	100%	100%
day care	397	1,144	434	1,129	434	1,115	100%	99%
inpatient	7,302	12,605	7,627	12,338	7,652	12,402	100%	101%

Continues on p. 62 ↓

Table 30. Performance of specialised medical care contracts of HNDP hospitals in thousand euros

	2012 actual		2013 contract		2013 actual		Contract performance	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Viljandi Hospital	**8,453**	**63,834**	**8,886**	**63,315**	**8,956**	**63,575**	**101%**	**100%**
outpatient	2,147	56,289	2,357	56,159	2,358	56,159	100%	100%
day care	229	955	263	972	266	1,002	101%	103%
inpatient	6,077	6,590	6,266	6,184	6,332	6,414	101%	104%
Rakvere Hospital	**6,058**	**40,152**	**6,613**	**41,980**	**6,608**	**41,768**	**100%**	**99%**
outpatient	1,644	33,408	1,830	34,862	1,844	34,617	101%	99%
day care	234	1,120	272	1,219	271	1,209	100%	99%
inpatient	4,180	5,624	4,511	5,899	4,493	5,942	100%	101%
Kuressaare Hospital	**5,375**	**45,771**	**5,773**	**47,985**	**5,727**	**47,168**	**99%**	**98%**
outpatient	1,488	40,735	1,700	42,974	1,709	42,032	101%	98%
day care	300	582	325	618	301	577	93%	93%
inpatient	3,587	4,454	3,748	4,393	3,717	4,559	99%	104%
South-Estonian Hospital	**4,815**	**40,556**	**5,036**	**38,901**	**5,158**	**39,440**	**102%**	**101%**
outpatient	1,374	34,813	1,482	33,542	1,482	33,682	100%	100%
day care	350	1,320	382	1,235	384	1,277	101%	103%
inpatient	3,091	4,423	3,172	4,124	3,292	4,481	104%	109%
Järvamaa Haigla AS	**4,161**	**41,619**	**4,443**	**42,214**	**4,449**	**42,432**	**100%**	**101%**
outpatient	1,809	37,793	1,971	38,381	1,989	38,676	101%	101%
day care	216	771	241	811	229	811	95%	100%
inpatient	2,136	3,055	2,231	3,022	2,231	2,945	100%	97%
Põlva Hospital	**3,185**	**29,217**	**3,385**	**29,205**	**3,385**	**29,245**	**100%**	**100%**
outpatient	971	25,263	1,028	25,246	1,028	25,308	100%	100%
day care	192	1,055	220	1,082	220	1,072	100%	99%
inpatient	2,022	2,899	2,137	2,877	2,137	2,865	100%	100%
Läänemaa Haigla SA	**3,203**	**32,862**	**3,364**	**32,990**	**3,328**	**32,017**	**99%**	**97%**
outpatient	947	29,458	1,073	29,670	1,083	28,976	101%	98%
day care	84	444	112	530	108	522	96%	98%
inpatient	2,172	2,960	2,179	2,790	2,137	2,519	98%	90%
Rapla County Hospital	**3,009**	**30,876**	**3,249**	**31,834**	**3,259**	**30,411**	**100%**	**96%**
outpatient	1,075	27,577	1,219	28,827	1,234	27,381	101%	95%
day care	135	623	222	597	216	565	97%	95%
inpatient	1,799	2,676	1,808	2,410	1,809	2,465	100%	102%
Valga Hospital	**3,041**	**32,662**	**3,186**	**31,762**	**3,187**	**31,831**	**100%**	**100%**
outpatient	1,013	29,100	1,087	28,510	1,093	28,511	101%	100%
päevaravi	267	975	257	831	252	840	98%	101%
inpatient	1,761	2,587	1,842	2,421	1,842	2,480	100%	102%
Jõgeva Hospital	**2,102**	**17,876**	**2,217**	**17,797**	**2,215**	**16,827**	**100%**	**95%**
outpatient	666	15,764	695	15,726	695	14,772	100%	94%
day care	59	237	65	237	62	220	95%	93%
inpatient	1,377	1,875	1,457	1,834	1,458	1,835	100%	100%
Hiiumaa Hospital	**1,141**	**11,994**	**1,269**	**12,107**	**1,270**	**11,511**	**100%**	**95%**
outpatient	320	10,750	396	10,848	380	10,311	96%	95%
day care	52	281	59	307	42	238	71%	78%
inpatient	769	963	814	952	848	962	104%	101%
Total	**411,739**	**2,527,867**	**436,435**	**2,554,726**	**439,548**	**2,558,577**	**101%**	**100%**

Provision of services as day surgery or outpatient services

The EHIF has been giving the HNDP hospitals feedback about their activities on the basis of medical invoices since 2012. The objective of the report is to give hospitals the opportunity to compare their activities with those of other hospitals and to learn from the experience of others if necessary. The report consists of various indicators, which describe the different aspects of the activities of hospitals in the treatment of various medical conditions[5]. The data of the indicator that measures the provision of services as day surgery and outpatient services are presented in this annual report.

The data of special medical care usage indicate that the share of surgeries in day care and outpatient care has increased from 41% in 2009 to 45% in 2013. The movement of services from inpatient care to other types of care complies with the EHIF's objective, which is to finance services from the viewpoint of an efficient use of resources and, if possible, in day care.

Below is an example of the change in the percentage of cases related to herniotomy (the surgical treatment of inguinal hernia) depending on the type of care from 2011-2013.

The share of herniotomies carried out without hospitalisation in the last three years has increased and it comprised 34% of all herniotomies in 2013. The primary reason for the change is the increase in the number of non-laparoscopic procedures.

The share of laparoscopic herniotomies carried out as day surgery in Estonia from 2011-2013 was 13%, 16% and 7%, respectively, whilst the indicator in the OECD countries where the share of such surgeries is the highest is as follows: 82% in Canada (in 2010), 78% in the Netherlands (in 2010) and 71% in Sweden (in 2011).

These percentages differ by hospital type and the trend towards day surgery is more dominant in regional and central hospitals. At the same time, all services have been provided as day surgery in other hospitals in the last three years (see Figure 12).

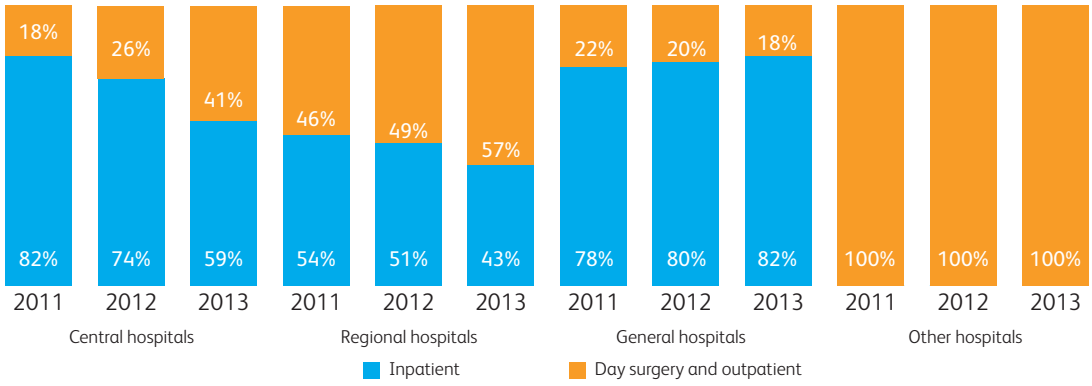


Figure 12. Herniotomies by hospital type from 2011-2013

The data of the OECD suggest that in developed countries, these services are increasingly more often provided as day surgery. As indicated above, a similar trend is also present in Estonia, but the potential for the development of day surgery is still great compared to other countries.

[5] *The feedback report to HNDP hospitals can be viewed online at http://www.haigekassa.ee/raviasutusele/ kvaliteet/tagasiside.*

1.3.2. Centrally contracted health services

The implementation of the centrally contracted health services budget was 104%, cases 80%.

Table 31. Implementation of the budget of centrally contracted health services in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of case	Amount	Number of case	Amount	Number of case	Amount	Number of case
Emergency transportation of insured persons (plane, helicopter)	173	103	221	127	235	128	106%	101%
Haematological treatment cycles	2,519	381	2,043	384	2,279	385	112%	100%
Pathoanatomical autopsies	76	532	81	545	45	327	56%	60%
Centrally contracted pharmaceuticals	1,758	972	2,587	1,344	2,569	1,081	99%	80%
Total	**4,526**	**1,988**	**4,932**	**2,400**	**5,128**	**1,921**	**104%**	**80%**

The use of emergency air transport services was expected to increase in 2013 and the actual speed of the increase was faster than planned.

The budget of haematological treatment cycles was exceeded by 236 thousand euros – the budget was exceeded in Q1. The reason of the over-implementation is that the high-cost coagulation factor replacement therapy given to a child was supposed to end in 2012, but instead continued in Q1 2013. The budget of haematological treatment cycles was used according to the plan in Q2-Q4.

56% of the budget of pathoanatomical autopsies was implemented. The budget was planned in consideration of the high usage in 2012.

The implementation of the centrally contracted pharmaceuticals budget was 99%, cases 80%. Centrally contracted pharmaceuticals cover the biological treatment of the Gaucher disease, Fabry disease and multiple sclerosis as well as depot antipsychotics.

1.4. Nursing care

Many changes were developed in relation to nursing care in 2013, which included changing its Estonian name from 'hooldusravi' to 'iseseisev õendusabi' in 2014. The regulation of the Minister of Social Affairs "List of nursing care services permitted to be independently provided in nursing hospitals, the activities they include and requirements for the staff, premises, equipment, apparatuses and tools necessary for the independent provision of nursing care", which stipulates the conditions required for the provision of the service, was adopted. The price of inpatient nursing care was also updated due to the change in legislation and the changes made to the list of health services entered into force on 1 January 2014.

In 2013, the Health Insurance Fund spent 17% more on nursing care provided to insured persons than in 2012 (see Table 32). The costs for outpatient and inpatient nursing care grew by 13% and 19%, respectively. The increase was the biggest in home nursing (14%), The number of cases increased by 11% in comparison to 2012 in both inpatient and outpatient nursing care. The numbers of cases also increased the most in home nursing.

The reason for planning a fast budgetary increase was the emergence of new contemporary nursing care opportunities after the renovation and construction of new nursing care facilities with the support of the European structural funds. The planned budget of inpatient nursing care was under-implemented already in the first half of the year. The main reason for this is the under-implementation of inpatient nursing care in some general hospitals. The number of cases was bigger than planned because of the rapid growth of home nursing.

Table 32. Implementation of nursing care budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Inpatient nursing care	13,796	16,848	16,817	19,146	16,362	18,647	97%	97%
Outpatient nursing care, incl.	3,742	32,146	4,196	33,742	4,245	35,540	101%	105%
home nursing	3,258	26,470	3,689	27,953	3,711	29,542	101%	106%
home care for patients	397	4,249	410	4,302	441	4,559	108%	106%
geriatric assessment	87	1,427	97	1,487	93	1,439	96%	97%
Total	**17,538**	**48,994**	**21,013**	**52,888**	**20,607**	**54,187**	**98%**	**102%**

The higher number of home nursing visits and of people who were provided such care is also proof of better accessibility to outpatient nursing care (see table 33). The average number of home nursing appointments is 30 per each person who used the service. The number of home care appointments for cancer patients has increased, but the number of persons who used the service has decreased by 4%. The average number of appointments per person has increased by one appointment. The number of outpatient nursing care appointments per person aged 65 or over in 2013 was 27.8 (26.5 in 2012). The number of inpatient nursing care bed days per person aged 65 or over in 2013 was 35.2 (32.7 in 2012). In comparison to 2012, the number of outpatient appointments as well as bed days per person has increased among persons aged 65 and over. This is an increasing trend as the population of Estonia is aging, and the EHIF takes this into consideration when planning its nursing care resources.

Table 33. Outpatient nursing care appointments

	2012 actual		2013 actual		Change compared to 2012	
	Number of appointments	Number of persons	Number of appointments	Number of persons	Number of appointments	Number of persons
Home nursing	197,707	6,497	214,387	7,063	8%	9%
Home-based supportive therapy for cancer patients	17,337	1019	17,562	976	1%	-4%

Performance of nursing care contracts

In 2013 the EHIF paid medical institutions 20.6 million euros for 54 thousand cases. The data of the performance of the specialised medical care contracts in 2013 is given in the table below.

Table 34. Performance of nursing care contracts in thousand euros

	2012 actual		2013 contract		2013 actual		Contract performance	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Aili Roots	7	108	8	116	8	128	100%	110%
Abja Hospital	141	332	137	314	137	317	100%	101%
Aidelia OÜ	10	99	17	159	15	166	90%	104%
Alba Nursing Services	6	117	12	218	12	181	98%	83%
Almeda Nursing Hospital	155	217	169	225	169	240	100%	107%
Alutaguse Nursing Centre	73	213	104	258	104	240	100%	93%
Anne-Ly Varuson	11	70	14	86	14	86	100%	100%
Ascoli SA	51	492	57	519	57	519	100%	100%
Azeltor OÜ	34	320	32	288	32	278	100%	97%
Avahoole OÜ	38	312	40	311	40	463	99%	149%
Carrara SA	9	124	9	124	9	124	100%	100%
Corrigo OÜ	16	179	18	193	18	202	100%	105%
Depoo OÜ	296	2,874	299	2,752	299	2,832	100%	103%
Tallinn Diaconics Hospital of the Estonian Evangelical Lutheran Church	532	1,689	536	1,663	536	1,702	100%	102%
Elva Hospital	278	820	441	1,077	441	1,078	100%	100%
Finkre OÜ	10	73	10	75	10	79	99%	105%
Hiiu Care Centre	385	450	797	876	797	942	100%	108%
Hiiumaa Hospital	89	108	99	116	99	106	100%	91%
East-Tallinn Central Hospital	1,929	3,750	2,096	3,899	2,101	3,820	100%	98%
Ida-Viru Central Hospital	204	891	221	922	220	960	100%	104%
Jõgeva Hospital	226	498	236	552	224	458	95%	83%
Jõhvi Hospital	252	419	265	419	265	414	100%	99%
Jõhvi Care Centre	79	110	88	116	88	116	100%	100%
Järva County Hospital	344	876	384	931	388	973	101%	105%
Kadrina Health Centre	6	100	2	26	2	26	100%	100%
Kallavere Hospital	967	846	748	670	748	650	100%	97%
Kilingi-Nõmme Health and Care Centre	216	224	225	215	225	216	100%	100%
Kiviõli Health Centre	285	363	300	363	300	376	100%	104%
Koduõde OÜ	552	3,779	629	4,073	629	4,054	100%	100%
Koduõendus OÜ	70	787	79	849	79	689	99%	81%
Koeru Care Centre	129	215	136	216	129	202	95%	94%
Kuressaare Hospital	474	962	546	1,064	546	1,210	100%	114%
Käru Hooldusravi AS	10	109	12	115	12	99	101%	86%
Lagle Everest	9	59	1	8	1	8	100%	100%
Loksa Hospital	8	15	0	0	0	0	-	-
Lõhavere Care and Nursing Centre	156	299	145	273	145	273	100%	100%
South-Estonian Hospital	590	1 427	678	1,600	678	1,581	100%	99%
South-Lääne County Healthcare and Social Welfare Centre	169	157	171	154	164	147	96%	95%
Lääne County Hospital	150	392	356	591	346	675	97%	114%
West-Tallinn Central Hospital	504	922	1,327	1,809	1,332	1, 460	100%	81%

Continues on p. 67 →

Table 34. Performance of nursing care contracts in thousand euros

	2012 actual		2013 contract		2013 actual		Contract performance	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Maire Adler	13	94	13	92	13	101	100%	110%
Medendi OÜ	139	1,143	165	1,287	165	1,330	100%	103%
Mustvee Health	152	292	153	294	144	265	95%	90%
Märjamaa Hospital	246	241	255	234	255	228	100%	97%
Märjamaa Family Health Centre	0	0	12	84	10	81	85%	96%
Narva Hospital	511	937	731	1,257	731	1,225	100%	97%
Otepää Health Centre	105	210	105	216	105	217	100%	100%
Peipsiveere Nursing Care Centre	167	264	158	220	158	256	100%	116%
Pille Lemats	12	110	13	114	13	120	100%	105%
PJV Nursing Care	792	836	640	702	640	702	100%	100%
North Estonia Medical Centre	367	467	393	446	396	444	101%	100%
Põltsamaa Health	109	302	96	191	96	192	99%	101%
Põlva Hospital	283	630	381	787	381	763	100%	97%
Pärnu Hospital	759	1,210	988	1,387	988	1,486	100%	107%
Pärnu-Jaagupi Nursing Home	73	69	131	120	131	135	100%	113%
Rada Koduõendus OÜ	19	206	22	222	22	222	100%	100%
Rakvere Hospital	303	1,327	417	1,843	417	1,884	100%	102%
Rapla County Hospital	159	218	275	324	276	322	100%	99%
Riina Sinisoo	9	105	10	114	10	114	93%	100%
Rõngu Nursing Care Centre	108	164	100	142	100	146	100%	103%
Räpina Hospital	263	490	277	509	277	512	100%	101%
Sillamäe Hospital	145	312	157	326	157	326	100%	100%
Sillamäe Harbour Hospital	14	115	16	125	16	125	100%	100%
Sõmeru Tervisekeskus OÜ	53	951	63	1,068	63	997	100%	93%
Tapa Hospital	326	443	316	406	311	373	98%	92%
Tartu Kesklinna Koduõendus OÜ	82	462	87	530	87	529	100%	100%
Tartu Mental Health Care Centre	17	68	18	68	18	80	100%	118%
Tartu University Hospital	864	1,781	943	1,919	916	1,877	97%	98%
Tervisekeskus Ljumam OÜ	118	673	135	726	135	726	100%	100%
TNP Konsultatsioonid OÜ	284	2,840	323	3,060	323	2,999	100%	98%
Tõrva Hospital	73	105	75	103	75	103	100%	100%
Tõrva Tervisekeskus OÜ	13	104	16	119	16	119	100%	100%
Valga Hospital	331	771	409	866	382	873	93%	101%
Viljandi Hospital	601	1,521	618	1,554	618	1,905	100%	123%
Võnnu Hospital	102	114	93	100	93	103	100%	103%
Supportive Cancer Treatment Foundation	301	3,312	355	3,768	355	3,769	100%	100%
Vändra Health Centre	138	145	266	268	265	241	100%	90%
Õendusabiteenus OÜ	0	0	7	45	7	45	99%	100%
Õendusteenused OÜ	21	165	22	165	22	162	100%	98%
Total	**17,538**	**48,994**	**20,703**	**54,036**	**20,607**	**54,187**	**100%**	**100%**

1.5. Dental care

Dental care of children up to 19 years of age comprises the biggest percentage of the dental care services financed by the EHIF. In the case of adults, the EHIF takes over the obligation to pay for dental treatments only in the event of emergency care. Financial benefits for dental care (for dentures, dental care) are regarded separately from other dental care services in the EHIF's budget. An overview of financial benefits is given in Chapter 5 of this report.

The implementation of the dental care budget was 98%, cases 102%.

Table 35. Implementation of dental care budget in thousand euros and cases

	2012 actual		2013 budget		2013 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Children's dental care	14,402	301,247	15,426	302,099	15,032	309,240	97%	102%
Orthodontics	3,393	44,864	3,626	46,635	3,560	46,267	98%	99%
Prevention of dental disease in children	292	19,778	327	21,030	294	18,986	90%	90%
Emergency dental care for adults	781	19,252	807	19,025	885	20,160	110%	106%
Total	**18,868**	**385,141**	**20,186**	**388,789**	**19,771**	**394,653**	**98%**	**102%**

The implementation of the children's dental care budget was 97%, cases 102%. At the same time, 90% of the budget for prevention of dental diseases in children was implemented in both regards. Prevention is partially carried out in the course of children's dental care – over-implementation of cases of children's dental care compensates for the under-implementation of dental disease prevention. An increase in the use of orthodontics was planned for 2013, but the actual speed of the increase was somewhat lower than anticipated. The use of emergency dental care for adults was bigger than planned – instead of the anticipated decrease, the use of the service increased compared to the previous year.

The times of medical checks for the prevention of dental diseases are set forth in the regulation of the Minister of Social Affairs and the financing contract defines four birth cohorts which are financed from the prevention budget line designated for this purpose.

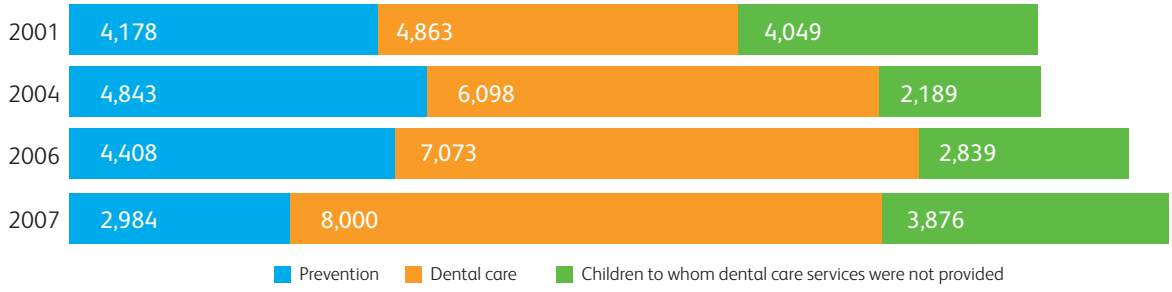


Figure 13. Participation of children up for preventive medical checks in 2013 according to their year of birth under treatment contracts in preventive examinations or receipt of dental care services by these children in absolute figures and as a percentage of all children of the same year of birth

Family nurses and school nurses are the ones obliged to recommend (refer to) preventive dental care appointments – this is regulated in the work instructions of family doctors and the health professionals who

work with them as well as in the regulation of the work of school nurses. The use of the service was the lowest among 6-year-olds, which means that the referral system is more efficient in terms of school-age children. The cooperation between family nurses, school nurses and dentists must be improved.

The DMFT index is also documented as a part of preventive appointments – the index shows how many of a child's second teeth are missing, filled or decayed. Dental diseases were detected in 14% of the children who went for preventive checks. The goal should be to increase the percentage children whose teeth are healthy at the age of 12.

2. Health promotion

The EHIF finances health promotion on the basis of the Development Plan of the Health Insurance Fund in order to achieve the goals of the Public Health Development Plan. 706 thousand euros or 71% of the health promotion budget has been used. The under-implementation is the result of the postponement of certain activities to 2014 (harmonisation of patient guidelines with the updated principles for the preparation of clinical guidelines) as a result of the changes made in operating principles. The implementation of the budget is also influenced by the best-priced tenders made in public procurement.

Table 36. Health promotion expenses in thousand euros

	2012 actual	2013 budget	2013 actual	Budget implementation
Health promotion activities for children	220	165	157	95%
Prevention of home and leisure time injuries and poisoning (incl. prevention of alcohol consumption)	284	250	243	97%
Activities aimed at patient awareness (incl. prevention of cardiac diseases and malignant tumours)	310	585	306	52%
Total	**814**	**1,000**	**706**	**71%**

649 education and health workers and specialists from 229 institutions were trained within the scope of the children's health promotion programme "Health Promotion in Schools and Nursery Schools". Local coordinators gave 268 nursery schools and schools advice on health promotion. Helping diabetic children and the staff who work with them adapt in educational institutions is a part of the project. Support networks for diabetic children were created in 31 institutions (10 pre-school institutions, 21 general education schools) and the satisfaction indicator of the support persons of the children with the activities was 84%.

Information events for stakeholders (family nurses, teachers, health promoters, etc.) were held as part of the children's dental health project. 188 family nurses and health promotion nurses, and 360 education professionals participated in the training. The website www.kiku.hambaarst.ee was updated in order to carry out prevention activities for younger schoolchildren and guidelines for teachers "Oral Health in School" were also prepared. 68 consultations were carried out in 50 children's institutions and advice was given to 1757 children and 204 parents.

1419 persons were given advice on 2978 occasions within the scope of the pregnancy crisis counselling project after being referred for counselling by midwives, gynaecologists or family doctors. Counselling takes place in 10 counties and 12 institutions.

Scheduled events for raising public awareness were held within the scope of a county-based injury project to guarantee safety at home and in the community. Specialists were also given training to improve their competencies. Safety camps for 6th form students were also held as part of the projects.

Giving information about cervical and breast cancer screening was supported with the Estonian Cancer Society in January, February and May in order to increase the awareness of people. Special health sections were published in six dailies and weeklies during the year to introduce topics related to health and the health system. The campaign of reasonable use of pharmaceuticals was repeated in autumn and the campaign's noticeability was 90%. The campaign about the role of primary care and making informed choices in the use of health services was prepared for 2014. The Estonian Society of Family Physicians was an important partner in this.

The nationwide conference Supporting Informed Choices was held in June for the promotion of the health system and it focussed on evidence-based medicine health literacy, nutrition, mental health and prevention of drug abuse. There were more than 300 participants. A course about evidence-based medicine for the

preparation of clinical guidelines was held in July and it was attended by more than 50 specialists. A healthcare quality seminar about data and clinical indicators was held in August and it was attended by ca 30 experts of different specialties.

The process of preparing patient guidelines about the nature of diseases, prevention of complications and treatment options was updated. The guidelines are available online at www.ravijuhend.ee. Materials for families with diabetic children were completed and preparation of the patient guideline to the clinical guideline Treatment of Adult Hypertension at Primary Level was initiated.

3. Pharmaceuticals reimbursed to insured persons

The pharmaceuticals reimbursed by the EHIF, which the patients can use independently, are dispensed from pharmacies on the basis of prescriptions issued by health professionals. Some of the cost of the prescription is paid by the EHIF and the relevant amount is subtracted in the pharmacy. This means that the patient can immediately buy pharmaceuticals at a discount and don't have to apply for reimbursement afterwards. The pharmacies in their turn submit invoices to the EHIF at certain intervals. Different discount rates are applied to different diseases and pharmaceuticals. These rates are established with the regulations of the Government of the Republic and the Ministry of Social Affairs, which in their turn are based on the Health Insurance Act.

Reimbursement of pharmaceuticals for outpatient use to insured persons is an open commitment for the EHIF. This means that the EHIF has the obligation to reimburse the needs-based costs to the extent prescribed by law and cannot refuse payment on the grounds of lack of funds. Neither is the implementation of the budget entirely under the control of the EHIF, as it also depends on the inclusion of new pharmaceuticals into the list of pharmaceuticals subject to reimbursement, changes in prices, etc. The Ministry of Social Affairs and the Government of the Republic develop and impose measures for managing the costs. Pharmaceuticals were reimbursed to the insured persons in the total amount of 103.4 million euros in 2013. 95% of the budget was implemented (see Table 37).

Table 37. Implementation of the budget of pharmaceuticals reimbursed to insured persons

	2012 actual	2013 budget	2013 actual	Budget implementation
Pharmaceuticals reimbursed 100%	49,358	54,542	50,919	93%
Pharmaceuticals reimbursed 90%	29,259	30,721	30,231	98%
Pharmaceuticals reimbursed 75%	5,609	6,134	5,738	94%
Pharmaceuticals reimbursed 50%	14,741	17,373	16,503	95%
Total	**98,967**	**108,770**	**103,391**	**95%**

The financing required for reimbursement of pharmaceuticals increased by 4% compared to 2012. The increase was caused by the increase in the number of reimbursed prescriptions as well as the average amount to be reimbursed per one prescription. The number of reimbursed prescriptions has increased by 3%, which is a reflection of the increase in the use of pharmaceuticals with 50% discount rate and expensive pharmaceuticals with 100% discount rate. The cost of the average reimbursed prescription for the EHIF has increased by 2%. The cost of pharmaceuticals with 75%, 90% and 100% discount rates has increased by just 1%, which is a sign that price control has been effective (good price agreements, reference prices, etc.). The average cost of prescriptions with 50% discount rate has increased by 9%, which is the result of the abolishment of the maximum reimbursement amount per one prescription in Q4 2012 and the larger shift of the related expenses from the patients to the EHIF (see Table 38).

Table 38. Number and average cost of reimbursed prescriptions

	2012 actual		2013 actual		Change compared to 2012	
	Number of prescriptions	Cost to EHIF	Number of prescriptions	Average cost of reimbursed prescription for EHIF	Number of prescriptions	Average cost of reimbursed prescription for EHIF
Pharmaceuticals reimbursed 100%	824,298	59.88	845,903	60.19	3%	1%
Pharmaceuticals reimbursed 90%	2,710,094	10.80	2 774,212	10.90	2%	1%
Pharmaceuticals reimbursed 75%	553,561	10.13	558,438	10.28	1%	1%
Pharmaceuticals reimbursed 50%	3,350,717	4.40	3,446,582	4.79	3%	9%
Total	**7,438,670**	**13.30**	**7,625,135**	**13.56**	**3%**	**2%**

All in all, the EHIF financed reimbursed prescriptions in the amount of 84 euros on average per patient in 2013 and this amount increased by 5% compared to the previous year.

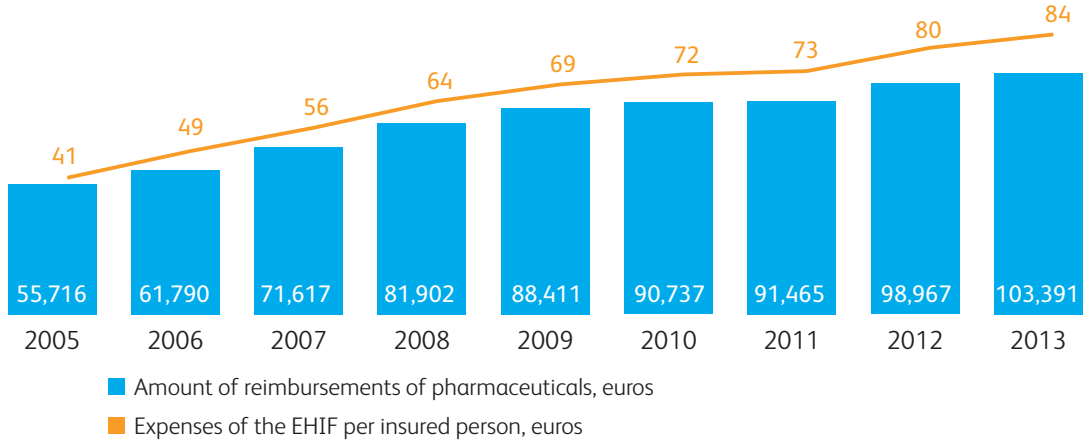


Figure 14. Total cost of reimbursed pharmaceuticals and cost per one insured person

The out-of-pocket expenses of insured persons when purchasing prescription pharmaceuticals have decreased from 33% to 32.1%. The main reason of the decrease is the abolition of the maximum limit when 50% of the cost of pharmaceuticals is reimbursed. The out-of-pocket expenses of patients decreased to the extent of 1.5 million euros per year as a result of this. Out-of-pocket expenses remained stable in terms of other reimbursement rates (see Table 39).

Table 39. Out-of-pocket expenses by insured person, %

	2012 actual	2013 actual	Change compared to 2012
Prescriptions with 100% discount rate	2.8	3.2	0.4%
Prescriptions with 90% discount rate	29.7	29.8	0.1%
Prescriptions with 75% discount rate	39.3	39.5	0.2%
Prescriptions with 50% discount rate	68.0	65.0	-3.0%
Average own funding by insured person	33.0	32.1	-0.9%
incl. prescriptions with 75%, 90% and 100% discount rate	17.2	17.3	0.1%

The practice of prescribing pharmaceuticals has improved considerably as a result of the consistent activities of the Health Board and the EHIF. 80% of the prescriptions issued by doctors in the second half of 2013 were based on the active ingredient. This means that any further decrease in out-of-pocket expenses can occur as a result of the informed decisions patients made with the help of pharmacists. In 2013, the EHIF paid 13.6 euros and the patient paid 6.4 euros for the average reimbursed prescription. This is 20% less than in 2009 when the out-of-pocket expenses of patients were 8 euros per average reimbursed prescription.

Diabetes has secured its place as the number one diagnosis that requires the biggest percentage of the budget (see Table 40 on p. 74). Compared to the previous leader, hypertension, the need for diabetes treatment has increased rapidly and the tendency is likely to continue in the future. The financing required for the treatment of viral hepatitis C has decreased, but as the EHIF started reimbursing new pharmaceuticals (boceprevir and telaprevir), we can forecast a rapid increase in 2014.

The reimbursement of five new active ingredients started in 2013, expanding the selection of pharmaceuticals for the treatment of chronic obstructive pulmonary disease, type 2 diabetes and atrial fibrillation. A new active ingredient was added for the prophylactics and treatment of the fungal infections associated with serious

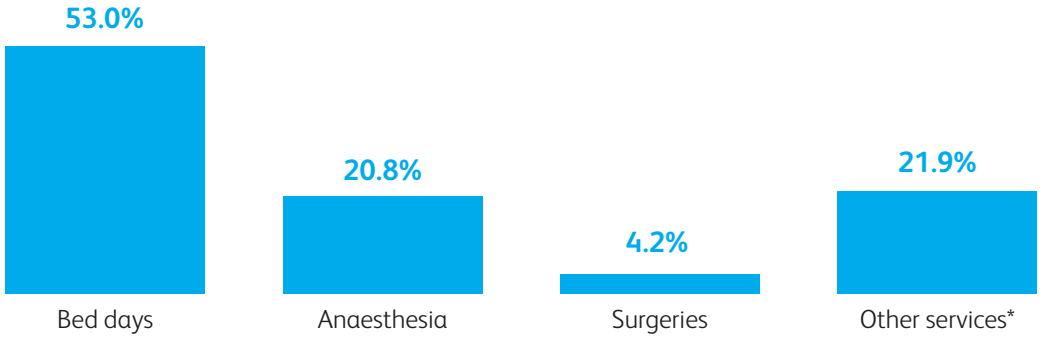
haematological diseases and special food is now reimbursed to patients suffering from rare fatty acid oxidation disorders. 100% of the cost of antipsychotics and antiepileptic drugs used to treat bipolar disorder and epilepsy will be reimbursed in the future.

Table 40. Diagnoses with the biggest reimbursement of pharmaceuticals in thousand euros

	2012 actual		2013 actual	
Diagnosis	**Reimbursed by the EHIF**	**% of total reimbursed cost**	**Reimbursed by the EHIF**	**% of total reimbursed cost**
Total diabetes, incl.	14,478	15	16,099	16
insulin	9,995	10	10,986	11
orally administered preparations	4,483	5	5,113	5
Hypertension	14,295	14	14,675	14
Cancer	11,722	12	13,187	13
Bronchial asthma	5,919	6	6,149	6
Glaucoma	4,011	4	3,875	4
Chronic hepatitis C	2,205	2	1,964	2
Mental disorders	2,878	3	2,792	3
Hypercholesterolemia	2,757	3	2,370	2
Total	**58,265**	**59**	**61,111**	**59**

Reimbursement of hospital pharmaceuticals from health services budget

In addition to the reimbursement of outpatient pharmaceuticals, health insurance money is also used to pay for the pharmaceuticals used in hospitals. In 2013 the pharmaceutical component of health services amounted to 16.5 million euros, which is 1% less than in the year before. This was caused by the decrease in the volume of inpatient care. The costs of pharmaceuticals are included in the cost of a bed day, but also in the reference prices of surgical procedures and anaesthesia (see Figure 15).



* Other services are haemodialysis or peritoneal dialysis (ca 70%), services related to bone marrow transplants, various endoscopic procedures, certain dental care services for children, etc.

Figure 15. Division of pharmaceuticals in health care services

The EHIF also assumes the obligation to pay for the so-called pharmaceutical services (R-code services) separately named in the list of services. These mainly include chemotherapy in oncology and haematology, biological treatment in rheumatology and the use of other expensive specific pharmaceuticals (e.g. antibiotics used for treating sepsis or pharmaceuticals used when transplanting organs) (see figure 16).

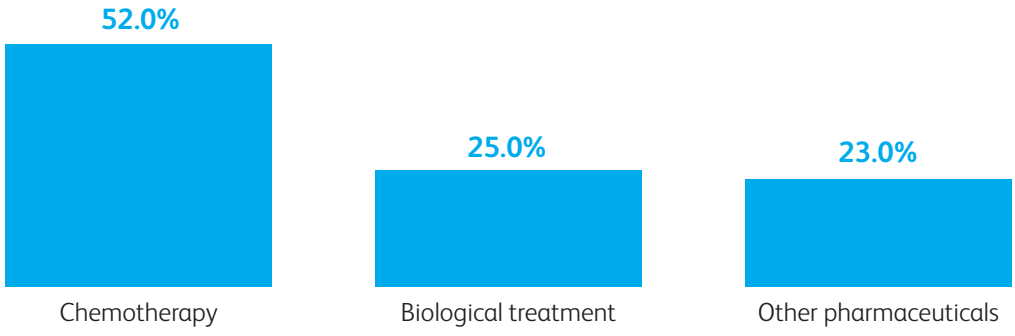


Figure 16. Share of pharmaceuticals reimbursed via the list of health services

The share of the pharmaceutical services in the list of health services was 39.8 million euros in 2013, which indicates an increase of 9% compared to the previous year.

159.8 million euros in total was allocated by the EHIF as financing for pharmaceuticals from the health services budget, the budget for reimbursement of outpatient pharmaceuticals and the budget for supplementary pharmaceutical benefits, which comprises 19.7% of the total health insurance budget (see table 41).

Table 41. Financing of pharmaceuticals in thousand euros

	2012 actual	2013 actual	Change compared to 2012
Prescription pharmaceuticals reimbursed to insured persons	98.967	103.391	4%
Separate pharmaceutical services in the list of health services	36.534	39.760	9%
Pharmaceuticals as part of health services	16.697	16.483	-1%
Supplementary benefit for pharmaceuticals	421	187	-56%
Total	**152.619**	**159.821**	**5%**

4. Benefits for temporary incapacity for work

The benefit for temporary incapacity for work is monetary compensation paid to insured persons on the basis of a certificate of incapacity for work, if the person foregoes social-taxed income due to a temporary exemption from work.

Benefits for temporary incapacity for work totalled 94.1 million euros in 2013, i.e. 9.8 million euros more than the previous year.

Table 42. Execution of the budget for benefits for temporary incapacity for work, € '000

	2012 actual	2013 budget	2013 actual	Execution of budget
Sickness benefits	37,546	39,438	42,421	108%
Care benefits	12,214	13,236	15,192	115%
Maternity benefits	32,168	35,073	33,736	96%
Occupational accident benefits	2,337	2,553	2,752	108%
Total	**84,265**	**90,300**	**94,101**	**104%**

The EHIF calculates benefits for temporary incapacity for work on the basis of the person's social-taxed income for the previous calendar year and the employer calculates sickness benefits based on the employee's previous six months' average salary. Benefits are paid on the basis of relevant certificates: certificates for sick leave, care leave, maternity leave and adoption leave.

The procedure for payment of benefits for temporary incapacity for work depends on the type of certificate of incapacity for work and the cause of the incapacity (see the Health Insurance Fund's website).

Figure 17 shows that sickness benefits continued to account for the largest share of all benefits in 2013, i.e. 45%. Compared to the previous year, the share of maternity benefits decreased 2% while care benefits increased.

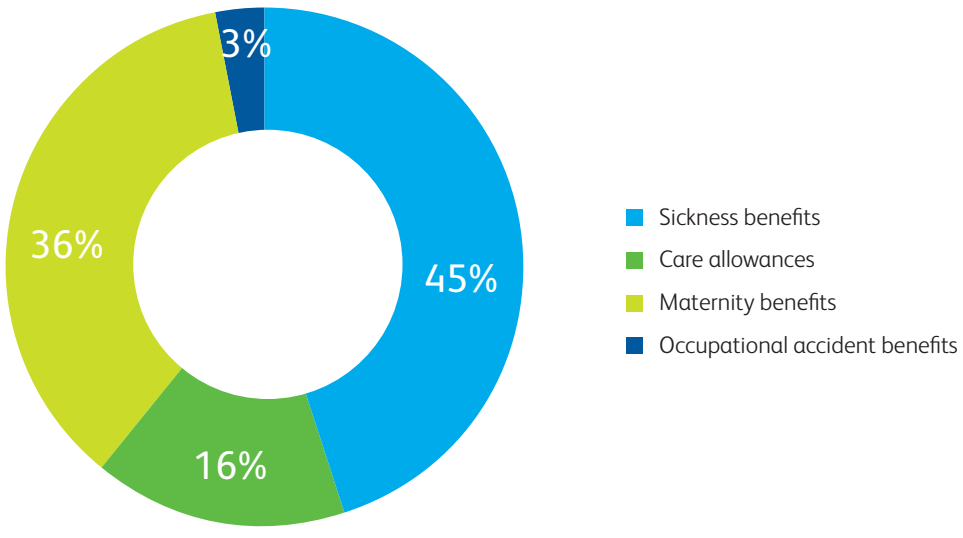


Figure 17. Distribution of benefits for temporary incapacity for work by type of benefit in 2013

Benefits for temporary incapacity for work increased 12% compared to the year 2012 and exceeded the budget by 4%. Part of the growth was due to a 6% increase of gross salaries last year and part of it owed to an unusual spread of viral diseases in the first half of the year. It is impossible to exactly predict the occurrence of upper respiratory infections and influenza over the years. For example, the occurrence of these illnesses decreased 21% in the first half of 2012 compared to 2011, while the occurrence of viral diseases increased 92% in January and February 2013, according to the Health Board.

As regards the breakdown of different types of benefits, care benefits have increased the most, i.e. 24% compared to 2012. The increase in the number of certificates for care leave is partly explained by the joint effect of the increase in the number of employed insured persons and greater spread of viral diseases. While the number of sickness days per employed insured person increased 7%, the number of care leave days increased 15% (see Table 43).

Table 43. Number of insured persons and take-up of days of incapacity for work

	2012 actual	2013 actual	Change from 2012
Number of employed insured persons (average for the period)	576,687	584,492	1%
Number of sickness days	4,313,698	4,647,481	8%
Sickness days per employed insured person	7.5	8.0	7%
Number of children under 12*	160,031	161,455	1%
Care leave days	763,376	871,261	14%
Care leave days per employed insured person	1.3	1.5	15%

* Based on Statistical Office data

Table 44 shows that the number of certificates of incapacity for work increased 11% in 2013, while the number of days paid for by the EHIF increased 6%. This indicates a shortening of the average duration of leave, which in turn indicates a greater share of shorter-term leaves characteristic of viral infection periods.

Table 44. Comparison of benefits for incapacity for work

	2012 actual	2013 actual	Change from 2012
Sickness benefit			
Certificates paid for by the EHIF	201,753	220,929	10%
Total number of certificates issued to insured persons*	293,675	325,335	11%
Days paid for by the EHIF	2,742,257	2,915,972	6%
Total number of sickness days*	4,313,698	4,647,481	8%
Total average duration of paid leave*	14.7	14.3	-3%
Total benefits paid by the EHIF (€ '000)	37,546	42,421	13%
Average benefit per day (€)	13.7	14.5	6%
Care benefit			
Number of certificates	91,145	104,019	14%
Days paid for by the EHIF	740,609	846,660	14%
Total benefits (€ '000)	12,214	15,192	24%
Average benefit per day (€)	16.5	17.9	8%
Average duration of paid leave	8.1	8.1	0%
Maternity benefit			
Number of certificates	9,770	9,677	-1%
Days paid for by the EHIF	1,364,348	1,347,845	-1%
Total benefits (€ '000)	32,168	33,736	5%
Average benefit per day (€)	23.6	25.0	6%
Average duration of paid leave	139.6	139.3	0%
Occupational accident benefits			
Number of certificates	5,026	5,469	9%
Days paid for by the EHIF	107,547	118,109	10%
Total benefits (€ '000)	2,337	2,752	18%
Average benefit per day (€)	21.7	23.3	7%
Average duration of paid leave	21.4	21.6	1%
Total benefits			
Certificates paid for by the EHIF	307,694	340,094	11%
Days paid for by the EHIF	4,954,761	5,228,586	6%
Total benefits paid by the EHIF (€ '000)	84,265	94,101	12%
Average benefit per day (€)	17.0	18.0	6%

* Including all certificates and days of incapacity for work (including the financial contributions of insured persons, their employers and the EHIF).

Sickness benefits

The main causes of sick leave in 2013 were illnesses and domestic injuries (83% and 11% respectively, see Figure 18). Changes in the breakdown of causes were marginal compared to 2012.

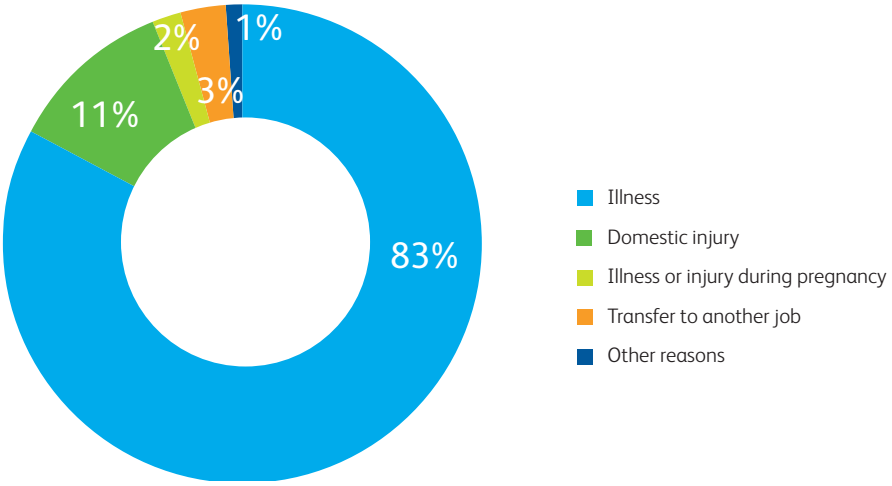


Figure 18. Breakdown of sick leave certificates by cause of leave

As regards different types of treatment regimes, outpatient treatment, inpatient treatment and medical rehabilitation were used in 89%, 10% and 1% of the cases, respectively.

An analysis of the take-up of sickness days by age group shows that the take-up of sickness days has increased in all age groups (see Table 45).

Table 45. Number of employed insured persons and take-up of sickness days across age groups*

Age group	Number of employed insured persons as of 31 December 2013	Number of sickness days per employed insured person	Number of employed insured persons as of 31 December 2013	Number of sickness days per employed insured person	Change in number of employed persons	Change in number of sickness days
...–29	112,483	5.8	112,041	6.1	0%	5%
30–39	130,963	5.2	132,827	5.3	1%	2%
40–49	134,346	6.4	135,324	6.7	1%	5%
50–59	129,521	9.0	131,323	9.8	1%	9%
60–...	67,964	8.5	72,579	9.1	7%	7%

* Includes sickness days for all causes of sick leave (including occupational accidents).

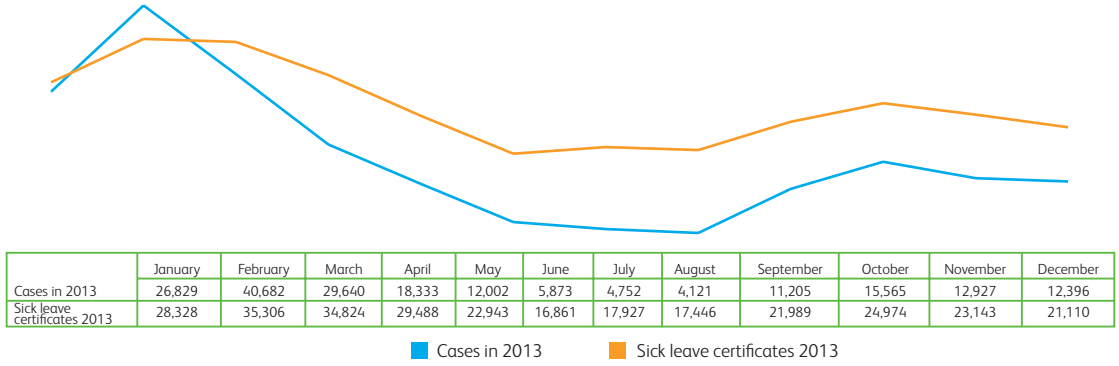
The number of sickness days paid for by the EHIF increased 6% in 2013 compared to 2012. The numbers of sickness days with the insured person's financial contribution (days 1–3) and the employer's financial contribution (days 4–8) increased equally by 10% (see Table 46). The main reason for the increased number of sickness days in 2013 was a much greater occurrence of viral infections and influenza compared to the previous period.

Table 46. Numbers of sick leave certificates and sickness days*

	2012 actual	2013 actual	Change from 2012
Number of certificates			
1–8 day certificates with financial contributions from the insured person and the employer	91,922	104,406	14%
Certificates paid for by the EHIF	201,753	220,929	10%
Total certificates	293,675	325,335	11%
Päevade arv			
Days 1–3 (with financial contribution of insured persons)	663,911	733,151	10%
Days 4-8 (with financial contribution of employers)	907,530	998,358	10%
Days paid for by EHIF	2,742,257	2,915,972	6%
Total days	4,313,698	4,647,481	8%
Average duration of leave	14.7	14.3	-3%

* Includes initial sick leave certificates issued on the basis of illness, traffic accident or domestic injury.

Figure 19 shows that the number of sick leave certificates increases during the months when the occurrence of acute upper respiratory infections and influenza is the greatest. The numbers of illness cases and certificates were the largest in 2013 in February and March and, as usual, the smallest during the summer months.



	January	February	March	April	May	June	July	August	September	October	November	December
Cases in 2013	26,829	40,682	29,640	18,333	12,002	5,873	4,752	4,121	11,205	15,565	12,927	12,396
Sick leave certificates 2013	28,328	35,306	34,824	29,488	22,943	16,861	17,927	17,446	21,989	24,974	23,143	21,110

Figure 19. Acute upper respiratory infections, influenza[6] and number of sick leave certificates[7]

Care benefits

Certificates for care leave for nursing a child under 12 years of age make up 98% of all care leave certificates. The use of certificates for care leave across the causes of leave has not changed since 2012. However, there has been a change in the use of certificates for care leave across the carers. While in 2012, 24% of such certificates were issued to men and 76% to women, then in 2013 the distribution was 25% and 75%, respectively. As regards the breakdown of certificates for care leave used for nursing a child under 12, the age distribution of the children being nursed has changed a few per cent compared to the previous period, as shown in Figure 20. This may be due to changes in age groups caused by the birth rate trends of various years that are expressed in the use of certificates for care leave.

[6] *Infectious disease statistics www.terviseamet.ee*
[7] *Covers sick leaves with illness as the cause of leave*

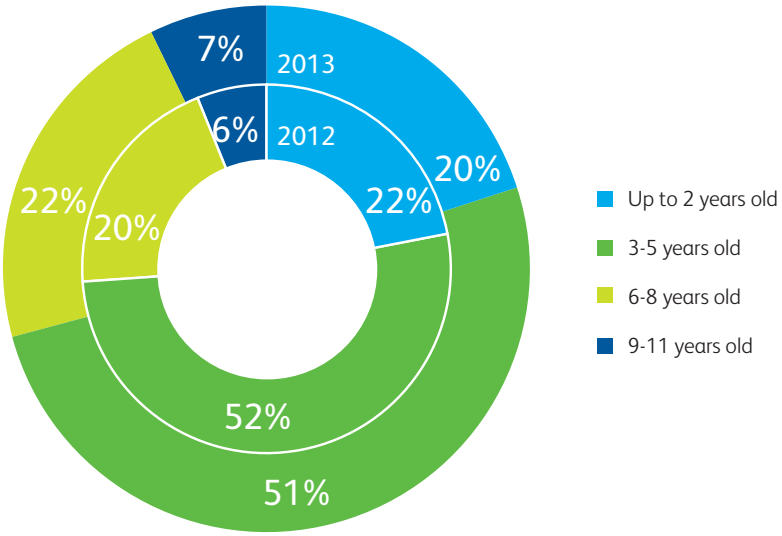


Figure 20. Certificates for care leave for nursing a child under 12 by age of child

Maternity benefits

As the average duration of leave and the average daily benefit are the largest for maternity leaves among all the benefits for incapacity for work, the share of maternity benefits in the total benefits was 36% in 2013. The average benefit per maternity leave certificate was 3,500 euros in 2013. As in the previous year, the largest share of maternity leave beneficiaries, i.e. 49%, were in the age group 20–29. Maternity leave benefits increased 5% in 2013 because of the 6% increase in average daily benefit due to increased salaries.

Occupational accident benefits

Sick leaves for occupational accidents broke down across causes of leave as follows: occupational accidents 95%, complications resulting from occupational accidents 3%, and occupational accidents which occurred in traffic 2%. The number of days of incapacity for work due to occupational accidents increased 10% in 2013 compared to 2012. The increase may have resulted from increasing employment, which is likely to raise the number of occupational accidents. According to the Labour Inspectorate,[8] one-third of serious occupational accidents occur during the first year of work for a new employer.

Benefits paid on the basis of certificates from foreign physicians

The EHIF also pays benefits for temporary incapacity for work to insured persons based on certificates issued by physicians in foreign countries. In 2013, foreign physicians issued 557 initial leave certificates to Estonian insured persons, which is 30% more than during the previous period. The total amount of benefits was 6% higher than in 2012 (see Table 47).

Table 47. Benefits paid on the basis of certificates from foreign physicians

	2012 actual	2013 actual	Change from 2012
Cases of incapacity for work occurring in foreign countries	428	557	30%
Days of incapacity for work	9,795	12,508	28%
Total benefits paid by the EHIF (€)	147,125	155,881	6%

[8] *http://www.ti.ee/public/files/Puudulik_juhendamine.pdf*

Sickness benefits, care benefits, maternity benefits and occupational accident benefits were claimed in 87%, 7%, 2% and 4% of the cases, respectively. Figure 21 shows that 60% of the leave certificates were issued to persons aged 30–49. Compared to other age groups the 30–49 age group stands out for a large share of occupational accident leaves: 18 certificates out of 23.

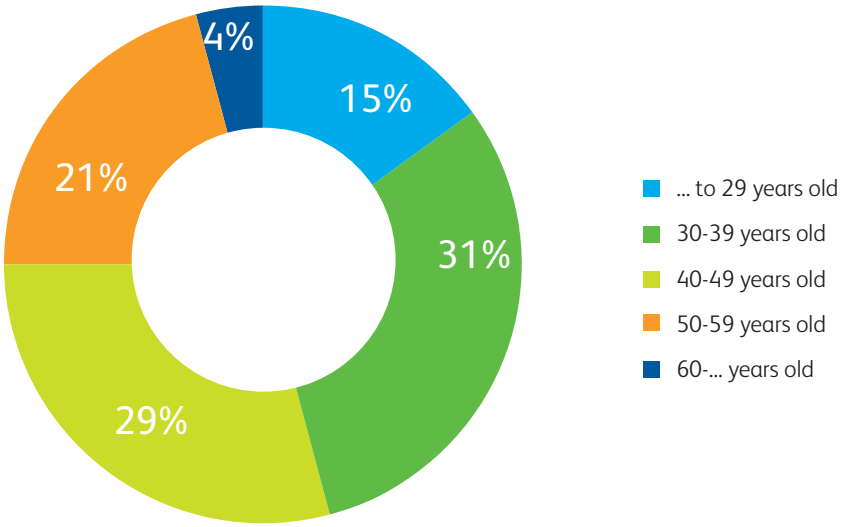


Figure 21. Foreign physicians' certificates across age groups

Across countries, the largest numbers of foreign physicians' certificates were issued in Latvia (31%), Ukraine (24%) and Finland (13%). Compared to 2012, the shares of certificates issued in Latvia and Ukraine have increased 5% and 2%, respectively, while the share of certificates from Finland has decreased 2%.

5. Other financial benefits

Other financial benefits cover

- financial benefits for dental care services;
- supplementary benefits for pharmaceuticals.

Table 48. Execution of the budget for other financial benefits, € '000

	2012 actual	2013 budget	2013 actual	Execution of budget
Financial benefits for dental care services	8,715	9,300	9,140	98%
Supplementary benefits for pharmaceuticals	421	467	187	40%
Total	**9,136**	**9,767**	**9,327**	**95%**

5.1. Financial benefits for dental care services

The benefit for dental care services is a financial compensation paid to the target groups specified by a regulation of the Minister of Social Affairs in order to improve the availability of dental care services.

Financial benefits for dental care services are divided into two:

- denture benefits;
- dental care benefits.

Financial benefits for dental care services totalled 9.1 million euros in 2013, i.e. 425 thousand euros more than the previous year (see Table 49).

Table 49. Execution of the budget for benefits for dental care services, € '000, and number of applications

	2012 actual		2013 budget		2013 actual		Execution of budget	
	Amount	Number of Applications	Amount	Number of Applications	Amount	Number of Applications	Amount	Number of Applications
Denture benefits	6,848	42,327	7,304	47,062	7,228	39,181	99%	83%
Dental care benefits	1,867	94,390	1,996	105,051	1,912	96,095	96%	91%
Total	**8,715**	**136,717**	**9,300**	**152,113**	**9,140**	**135,276**	**98%**	**89%**

The EHIF reimburses the cost of dental care services to insured persons every year as follows:

- to pregnant women, to persons with an increased need for dental care and to mothers of children under one year of age 28.77 euros;
- to insured persons from 63 years of age and to persons eligible for a pension for incapacity for work or an old-age pension pursuant to the State Pension Insurance Act 19.18 euros.

Persons eligible for a pension for incapacity for work, or an old-age pension pursuant to the State Pension Insurance Act Insured, and insured persons over 63 years of age are reimbursed up to 255.65 euros for

dentures within a three-year period.

In order to receive a benefit for dental care services, an insured person has to submit an application and a document proving payment for the services to the EHIF.

An application for denture benefits can be submitted to the EHIF after receiving the service. However, an application can be submitted directly to the dentist, so that the service would be cheaper by the amount of the benefit. In such case, the insured person would only pay for the dentures the amount exceeding the benefit and the EHIF would cover the difference. In 2013 the share of those who applied for the benefit through the service provider remained unchanged at 77%. Pensioners prefer this option, since they are saved the journey to the EHIF and their dentistry bill is smaller by the amount of the benefit.

Statistics of the applications submitted for benefits for dental care services show that persons eligible for a pension for incapacity for work or an old-age pension submitted 92% of all the applications for denture and dental care benefits. In the 19–39 age group, 70% of the applications for dental care and denture benefits were submitted by pregnant women and mothers of children under one year of age, and 30% by persons eligible for a pension for incapacity for work. In the 40–49 and 50–59 age groups, applications from persons eligible for a pension for incapacity for work accounted for 92% and 97%, respectively.

As regards dental care benefits, applications from the 19–39 age group accounted for 10% and those from the 40–59 age group 14%.

Compared to the breakdown of benefit types in 2012, the number of applications from pregnant women and mothers of children under one year of age has decreased. This is probably due to the lower birth rate[9]. Persons with an increased need for dental care used 21% more benefits than in 2012 (see Table 50). An analysis of the use of benefits by type of insurance shows that 81% of the persons with an increased need for dental care are persons entitled to a pension for incapacity for work.

Table 50. Applications for benefits for dental care services by type of benefit

	2012 actual	2013 actual	Change from 2012
Pregnant women	5,386	5,027	-7%
Mothers of children under one year of age	6,165	5,807	-6%
Persons with an increased need for dental care	107	129	21%
Persons entitled to a pension for incapacity for work or an old-age pension	82,732	85,132	3%
Kokku	**94,390**	**96,095**	**2%**

As regards the breakdown of denture benefits across amounts of payments, the share of applications where the bulk of the permitted amount of benefit was used up at one go has increased 2% since 2012 (see Figure 22, page 86). This shows that the amount of the benefit does usually not cover the whole cost of the dentures. Also, the average cost of dentures has increased. It was 162 euros in 2012 and 184.5 euros in 2013.

[9] *According to the Statistical Office, 2% fewer children were born in 2013 than in 2012 http://www.stat.ee/34270*

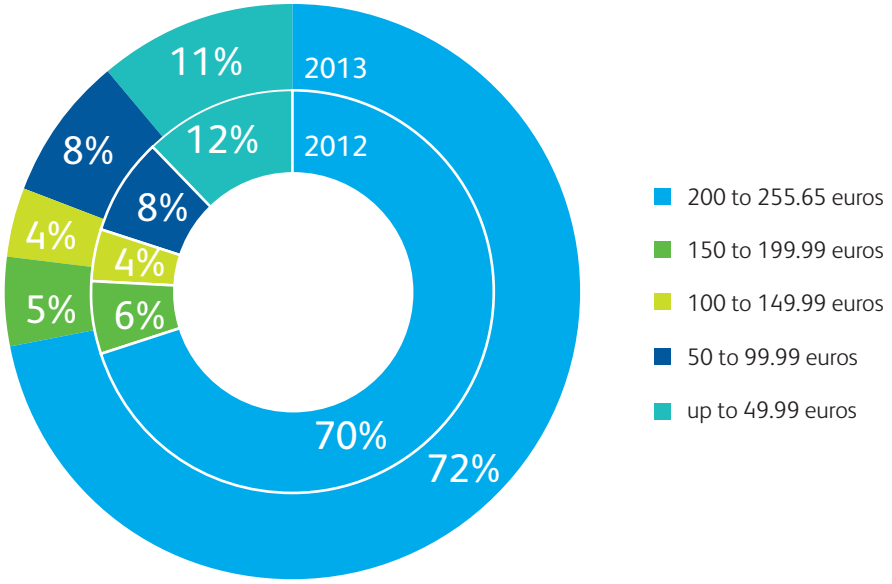


Figure 22. Percentage of denture benefit applications by amount of payment

There were 3% more beginnings of three-year denture benefit periods in 2013 compared to 2012. Table 49, however, shows that the total amount of denture benefit applications has decreased. This is because pensioners have already spent all or a greater part of the benefit in the first year.

5.2. Supplementary benefits for pharmaceuticals

An insured person is eligible to a supplementary benefit for pharmaceuticals if his or her expenses on listed pharmaceuticals exceed 384 euros in a calendar year (the patient's financial contribution or prescription fee and any amounts exceeding the reference price are not taken into account). The number of insured persons receiving this benefit, as well as the average payment, decreased in 2013. This is because of abolishment of the maximum amount paid per one prescription reimbursed by 50% and the resulting decrease in patients' financial contributions. The need for supplementary benefits for pharmaceuticals decreased accordingly. Furthermore, the discount rate was increased for certain pharmaceuticals, which also reduced patients' expenditure (such as the medicines for bipolar disorder).

Table 51. Supplementary benefits for pharmaceuticals

	2012 actual	2013 budget	2013 actual	Execution of budget
Amount of benefit (€ '000)	421	467	187	40%
Number of beneficiaries	1,734	1,710	1,357	79%
Average payment per beneficiary (€)	243	273	138	51%

6. Other expenses

Other expenses include

- planned treatment abroad;
- benefits arising from EU legislation;
- benefits for medical devices;
- expenses covered by government grants.

Table 52. Execution of the budget for other expenses, € '000

	2012 actual	2013 budget	2013 actual	Execution of budget
Planned treatment abroad	2,035	1,760	2,168	123%
Benefits arising from EU legislation	5,158	5,440	5,679	104%
Benefits for medical devices	7,684	9,394	8,325	89%
Government grants	1,572	1,740	1,465	84%
Total	**16,449**	**18,334**	**17,637**	**96%**

6.1. Planned treatment abroad

The EU legislation and the agreement between the Estonian EHIF and the Finnish Red Cross for finding unrelated bone marrow donors regulate the free movement of insured persons within the European Union.

An insured person can be referred for planned treatment or tests abroad if the health care service sought for is neither provided in Estonia, nor are there any alternatives to that service available in Estonia. The health care service must be indicated for the insured person, its medical effectiveness must be confirmed by evidence and the average probability of achieving the desired outcome must be at least 50%. A council of at least two medical specialists must assess the case for compliance with these criteria.

In 2013 the EHIF received 274 applications for referral for treatment abroad. Of these, 93% were granted. Of the referrals 54 patients were to receive treatment abroad, 182 were to undergo examinations and 20 were seeking unrelated bone marrow donors via the Finnish Red Cross. The largest numbers of patients were referred for treatment to Finland and Germany. Most of the gene tests were carried out in The Netherlands and Belgium (see Table 53, page 88).

Table 53. Countries where insured persons received treatment or underwent tests in 2013*

Countries	Total	Treatment	Tests
Germany	65	18	47
Belgium	56	0	56
Netherlands	48	0	48
Finland	28	21	7
UK	17	2	15
Sweden	16	9	7
Austria	3	1	2
Russia	2	2	0
Spain	1	0	1
Israel	1	0	1
Italy	1	1	0
Canada	1	0	1
France	1	0	1
Switzerland	1	0	1
Total	**241**	**54**	**187**

* The number of affirmative decisions taken during the year is not compatible with the number of countries, as five decisions covered treatment/tests in two different countries.

The invoices for treatment are not always issued during the same year that the application was made, since the treatment or test could take place later. This is why the number of invoices, that of applications and decisions of the EHIF concerning the applications does not coincide fully in any one year.

In 2013, treatment invoices were received from other countries for 252 persons. Of these, 63 were treated and 161 were tested abroad and 28 persons' invoices concerned searches for bone marrow donors. In 2012, treatment invoices were received from other countries for 205 persons. In comparison with 2012 the number of planned cases has seen an increase, while the average cost per case has dropped slightly. It was 8,604 euros in 2013 and 9,927 euros in 2012. In 2013 planned treatment and tests abroad cost 2.2 million euros, exceeding the amount of 2012 by nearly 7% (see Table 54).

Planned treatment abroad has been utilised increasingly over the past five years. While in 2008, planned treatment abroad cost about 1.5 million euros, it was nearly 45% more in 2013.

Table 54. Execution of the budget for planned treatment abroad, € '000

	2010 actual	2011 actual	2012 actual	2013 budget	2013 actual	Execution of budget
Planned treatment abroad	971	1,745	2,035	1,760	2,168	123%

6.2. Benefits arising from EU legislation

The provision of and payment for health care services are governed by a regulation of the European Parliament and of the Council coordinating the social insurance systems of EU countries, the health care service benefits arising from which are an open commitment for the EHIF.

Persons insured with the EHIF are entitled to:

- receive the necessary health care while staying temporarily in another member state;
- any type of health care when they reside in another member state. Insured persons of other EU member states are entitled to:
- receive the necessary health care during their temporary stay in Estonia;
- any type of health care when they reside in Estonia.

The costs of medical care given to persons insured in other EU member states are first reimbursed by the EHIF, but eventually the insuring country pays for those costs.

According to the patients' rights directive 2011/24/EU (hereinafter Directive), insured persons have an additional option as from 25 October 2013 – they may go to another Member State, receive treatment there, and afterwards apply to their national health insurance fund for a financial benefit for the services they are entitled to at the latter's expense also in Estonia according to the prices specified in the list of health care services. From 25 October to 31 December 2013 the EHIF received 5 such reimbursement applications. As it takes three months to process applications, no reimbursements were made in 2013.

Financing of cross-border health care is an open commitment for the EHIF. A sum of 5.4 million euros was planned for this purpose in the 2013 budget. The actual expenditure was somewhat higher at 5.7 million euros. The use of these benefits has increased 10% compared to the previous year (see Table 55).

Table 55. Execution of the budget for health care services under the Directive and Regulation of the European Parliament and the Council, € '000

	2010 actual	2011 actual	2012 actual	2013 budget	2013 actual	Execution of budget
Expenses of Estonian insured persons abroad	2,060	5,266	3,930	4,320	4,480	104%
Expenses of other member states' insured persons in Estonia	779	1,199	1,228	1,000	1,199	120%
Directive costs	0	0	0	120	0	0%
Total	**2,839**	**6,465**	**5,158**	**5,440**	**5,679**	**104%**

Providers were paid 1.1 million euros for services provided in Estonia to patients from other EU member states and pharmacies were paid 93 thousand euros for pharmaceuticals sold to such patients at a discount.

The EHIF paid 4.5 million euros to other member states for health care services provided to persons temporarily staying in other member states and employees seconded to and retired persons living in other member states. Of this, 686 thousand euros was capitation fee paid on behalf of the persons who receive a pension from Estonia. Health care services provided to persons living or staying in other countries were financed for 3.7 million euros. 75 thousand euros was reimbursed to people. Reimbursements were given to persons who for some reason did not have their European health insurance card on them during their stay in another member state and had to pay themselves for the health care services received.

6.3. Benefits for medical devices

The EHIF reimburses medical devices required by insured persons in order to treat illnesses or injuries and prevent aggravation of the illness. The exact list of such medical devices and the conditions for receiving benefits are approved by a regulation of the Minister of Social Affairs.

Benefits for medical devices are an open commitment for the EHIF similar to the benefits paid to insured persons for pharmaceuticals. The EHIF reimburses medical devices for all insured persons to whom a physician has prescribed such devices, subject to the conditions prescribed in the list of medical devices.

Benefits for medical devices have increased since 2012. This could be expected, as a new category was added to the list of medical devices in 2013, while other categories were complemented with new articles and the conditions of reimbursement were revised.

Table 56. Execution of the budget for benefits for medical devices, € '000, and number of persons

	2012 actual		2013 budget		2013 actual		Execution of budget	
	Amount	Number of persons	Amount	Number of persons	Amount	Number of persons	Amount	Number of persons
Primary prostheses and orthoses	1,502	11,217	1,657	12,748	1,710	12,877	103%	101%
Glucometer test strips	4,337	35,043	4,614	37,889	4,216	38,528	91%	102%
Stoma appliances	956	1,693	1,326	1,590	1,145	1,756	86%	110%
Insulin pumps	408	204	451	267	441	248	98%	93%
Wound dressings and patches	22	537	45	1,458	52	1,128	116%	77%
Other medical devices	39	167	43	259	40	248	93%	96%
Continuous positive airway pressure devices and masks	420	809	422	1,200	504	1,176	119%	98%
Disposable needles for insulin injection devices	0	0	836	14,710	217	7,569	26%	51%
Total	**7,684**	**49,670**	**9,394**	**70,121**	**8,325**	**63,530**	**89%**	**91%**

The actual use of medical devices fell short of the budget. The difference between actual benefits and the budget was especially large for **disposable needles for insulin injection devices**. As this is a new category of medical devices that was added to the list in 2013, it will take some time before the information reaches doctors and insured persons.

Compared to the previous year and the budget, expenditure has increased the most for **wound dressings and patches**. As the number of beneficiaries was, however, smaller than expected, compensation has increased especially for patients with more serious and multiple wounds.

Benefits for **automatic and continuous positive airway pressure devices and masks**

have increased more than expected. This is mainly because the devices themselves have been reimbursed during the year to a greater extent than planned.

Compared to 2012 and the budget, benefits for **glucometer test strips**

have decreased. The number of users has increased as expected. Therefore, the average cost of a case has decreased. This result can be explained by increased use of new, cheaper glucometer test strips that were added to the list, which is a positive development.

Changes in benefits for other medical devices have met the expectations.

In 2013, 57 proposals were submitted for additions to or amendments in the EHIF's list of medical devices, of which 46 were granted. A total of nearly 160 new articles of medical devices were added to the list. This is why the list gave various new opportunities from 2014. In connection with a considerable broadening of the range of similar products, a reference price system was applied to the calculation of the EHIF's benefits in the insulin needles, lancets and wound dressings categories from 1 January 2014 and in the glucometer test strips category from 1 July 2014. The objective of the reference price system is to reduce patients' expenditure on medical devices. The additional resources thus obtained for the health insurance budget will allow for a further broadening of the range of devices reimbursed to insured persons and for increasing the quantities to be reimbursed.

6.4. Expenses covered by government grants

Government grants are paid for pharmaceuticals and health care services under the Artificial Insemination and Embryo Protection Act Insured women of up to 40 years of age (incl.) can apply for assisted reproduction services and the corresponding benefits for pharmaceuticals, if there is a medical indication for in vitro fertilisation and/or embryo transfer.

In 2013, a total of 3,809 infertility treatment procedures were provided for 1,471 women and pharmaceuticals were reimbursed to 1,254 women. Government grants amounted to 1.5 million euros, of which 660 thousand euros was spent on pharmaceuticals and 805 thousand euros on services. In 2012, infertility treatment procedures were provided for 1,442 women and 1,264 women received benefits for pharmaceuticals. In 2012, government grants amounted to 1.6 million euros, including 903 thousand euros for pharmaceuticals and 669 thousand euros for services.

Income from government grants is recorded under other income (see the chapter on Income).

Operating expenses of EHIF

The EHIF's operating expenses on the administration of health insurance benefits totalled 7.9 million euros in 2013. As the budget was used economically, there was a surplus of 5% on operating expenses at the end of the year.

The EHIF's operating expenses account for 0.95% of its total budget. In 2004 and 2005 operating expenses formed nearly 1.3% of the budget and decreased to 1.08% in 2006; from 2007 the EHIF's operating expenses have not exceeded 1% of its budget.

Table 57. Execution of the budget for EHIF's operating expenses, € '000

	2012 actual	2013 budget	2013 actual	Execution of budget
Personnel and management expenses	**4,645**	**5,044**	**4,947**	**98%**
Wages and salaries	3,460	3,765	3,695	98%
Incl. remuneration of management board members	153	151	172	114%
Unemployment insurance contributions	45	36	35	97%
Social tax	1,140	1,243	1,217	98%
Administrative expenses	**1,012**	**1,180**	**1,069**	**91%**
IT costs	**773**	**1,016**	**990**	**97%**
Development expenses	**151**	**281**	**231**	**82%**
Training	86	113	101	89%
Consultation	65	168	130	77%
Other operating expenses	**750**	**823**	**700**	**85%**
Supervision over health insurance system	75	125	70	56%
Public relations/communication	108	109	86	79%
Other expenses	567	589	544	92%
Total EHIF operating expenses	**7,331**	**8,344**	**7,937**	**95%**

The EHIF plans its activities and operating expenses based on the development plan approved by the supervisory board and the scorecard objectives for the current year. The EHIF applies activity-based planning, which includes a review of the work processes/functions required to achieve the organisation's goals and planning of the resources needed to perform these functions.

During budgeting for 2013, the activity-based resource needs were estimated to be 216 positions, of which 211 were filled as of 31 December. Therefore, the personnel budget was under-used.

The IT budget line covers hosting of the Prescription Centre's information system, maintenance of SAP licences and appreciation of IT non-current assets.

Transfer of the hosting of the Prescription Centre to the EHIF's infrastructure was a significant event for the Fund in 2013. The transfer had been thoroughly planned for a length of time and improved the performance of the Prescription Centre, which is of uttermost importance to us.

The EHIF also actively piloted e-certificates of incapacity for work for employers in 2013. This required 95% of the certificates to be prepared electronically by health care workers. About 200 employers around Estonia have joined the piloting stage by now. Further development of the application has also continued throughout the period. After final implementation of the application (2014–2015), the processing of certificates of incapacity for work as well as payments to insured persons will be much simpler and quicker.

The development expenses budget includes resources for training of the EHIF's employees and for legal and

business consultations. Business consultations include those concerning the preparation of clinical guidelines.

The budget for other operating expenses covers supervision, public relations and communication, and other activities. The supervision budget covers clinical audits, assessment of prevention and promotion projects, as well as financial audit.

The public relations and communication budget line is for resources allocated to the preparation of printed and information materials and conducting various surveys. In order to raise the awareness of insured persons, the EHIF published the Haigekassa Teataja (Health Insurance Fund Journal) in both the Estonian and Russian languages in the first half of the year and distributed nearly 200,000 copies.

We continue to be interested in our partners' satisfaction with the EHIF's services. A partners' satisfaction survey was conducted in the first half of the year in cooperation with AS Emor. It covered nearly 700 providers of health care services and pharmacies across Estonia. 98% of the respondents assessed their cooperation with the EHIF to be good or very good and one-third gave maximum points for the cooperation.

Other expenses include an allowance for doubtful receivables, taxes on fringe benefits, insurance payments, including the management board's liability insurance, and VAT.

Legal reserve

Article 38 of the Estonian EHIF Act regulates the formation of the legal reserve as follows:

- The legal reserve of the EHIF means the reserve formed of the budgetary funds of the EHIF for the reduction of the risk which macro-economic changes may cause to the health insurance system.
- The legal reserve shall amount to 6% of the budget.
- 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 EHIF.

As of 31 December 2013 the legal reserve of the EHIF was 51.1 million euros. Against the size of the 2014 budget, the required legal reserve has to amount to 54.4 million euros. In order to reach the amount required by law, the legal reserve has to be increased by 3.3 million euros in 2014.

Risk reserve

Article 39[1] of the Estonian Health Insurance Fund Act regulates the formation of the risk reserve 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 per cent 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.

At the end of 2012, the EHIF's risk reserve amounted to 15.6 million euros. According to § 39[1] of the Estonian Health Insurance Fund Act, the risk reserve was required in 2013 to reach 16.7 million euros. In order to reach the amount required by law, the risk reserve was increased by 1.1 million euros in 2013.

In 2014 the required size of the risk reserve is 18.0 million euros. In order to reach the amount required by law, the risk reserve has to be increased by 1.3 million euros in 2014.

Retained earnings

The EHIF's retained earnings amounted to 164.8 million euros at the beginning of 2013.

A sum of 1.1 million euros was transferred from retained earnings to the risk reserve in 2013 in order to reach the amount of reserve required by law.

The net loss of the EHIF for 2013 was initially estimated to be 9.2 million euros. As the EHIF's income exceeded the budget by 4.6 million euros and budget resources were used to a lesser extent than planned, the year's eventual outcome was a loss of 1.5 million euros.

As of 31 December 2013 the retained earnings of the EHIF were 162.2 million euros.

The EHIF's management board proposes the supervisory board to transfer 3.3 million euros of retained earnings to the legal reserve and 1.3 million euros to the risk reserve in order to meet the requirements imposed on these reserves by law.

Annual Financial Statements

Balance sheet

Assets

€ '000	31/12/2013	31/12/2012	Note
Current assets			
Cash and cash equivalents	199,641	204,300	2
Receivables and prepayments	83,740	79,929	3
Inventories	3	3	4
Total current assets	**283,384**	**284,232**	
Non-current assets			
Long-term receivables	450	656	5
Property, plant and equipment	509	575	6
Intangible assets	199	0	6
Total non-current assets	**1,158**	**1,231**	
Total assets	**284,542**	**285,463**	

Liabilities and net assets

€ '000	31/12/2013	31/12/2012	Note
Liabilities			
Current liabilities			
Payables and deferred income	54,503	53,960	8
Total current liabilities	54,503	53,960	
Total liabilities	**54,503**	**53,960**	
Net assets			
Reserves	67,808	66,730	9
Accumulated surpluses for prior years	163,695	162,548	
Surplus for the year	-1,464	2,225	
Total net assets	**230,039**	**231,503**	
Total liabilities and net assets	**284,542**	**285,463**	

Statement of financial performance

€ '000	2013	2012	Note
Health insurance component of social security tax and recoveries from other persons	830,625	777,526	10
Income from government grants	1,744	1,625	17
Expenses related to government grants	-1,472	-1,595	17
Expenses related to health insurance	-828,954	-772,003	13
Gross surplus	**1,943**	**5,553**	
Administrative expenses	-7,237	-6,581	14
Other operating income	3,910	2,739	11
Other operating expenses	-693	-727	15
Operating surplus	**-2,077**	**984**	
Interest and other finance income	613	1,241	12
Surplus for the year	**-1,464**	**2,225**	

Statement of cash flows

€ '000	2013	2012	Note
Cash flows from operating activities			
Social security tax received	826,632	772,090	
Cash paid to suppliers	-832,572	-771,949	
Cash paid to employees	-3,648	-3,471	
Taxes paid on personnel expenses	-1,237	-1,189	
Other receipts	6,337	5,418	
Net cash from operating activities	**-4,488**	**899**	
Cash flows from investing activities			
Paid for non-current assets	-171	-176	
Net cash used in/from investing activities	**-171**	**-176**	
Net change in cash and cash equivalents	**-4,659**	**723**	
Cash and cash equivalents at beginning of year	204,300	203,577	2
Increase in cash and cash equivalents	-4,659	723	
Cash and cash equivalents at end of year	199,641	204,300	2

Statement of changes in net assets

€ '000	2013	2012	Note
Reserves			
Reserves at beginning of year	**66,730**	**65,873**	
Transfer to the risk reserve	1,078	857	
Reserves at end of year	**67,808**	**66,730**	**9**
Accumulated surpluses for prior years			
At beginning of year	**164,773**	**163,405**	
Transfer to the risk reserve	-1,078	-857	
Surplus for the year	-1,464	2 225	
At end of year	**162,231**	**164,773**	
Net assets at beginning of year	**231,503**	**229,278**	
Net assets at end of year	**230,039**	**231,503**	

Notes to the annual financial statements

Note 1. Significant accounting policies

The annual financial statements of the Estonian Health Insurance Fund (hereafter also the EHIF) for 2013 have been prepared in accordance with accounting principles generally accepted in Estonia (the Estonian GAAP). The Estonian GAAP is based on internationally recognised accounting and reporting principles and its basic requirements are set out in the Estonian Accounting Act and the guidelines issued by the Estonian Accounting Standards Board. The annual financial statements have been prepared considering also the Estonian general accounting rules for state and public sector entities.

The financial year began on 1 January 2013 and ended on 31 December 2013. The numeric data in the financial statements are presented in thousands of euros.

For the first time the EHIF used in the preparation of its annual financial statements the new guidelines of the Estonian Accounting Standards Board, which are mandatory for application to accounting periods beginning on 1 January 2013 or later. The amendments to the guidelines did not have a significant effect on the accounting principles applied by the EHIF so far.

Financial statement formats

The statement of financial performance is prepared based on income statement format 2 set out in the Accounting Act. The structure of entries has been adjusted to the nature of the EHIF's activities.

Financial assets and liabilities

Financial assets comprise cash, trade receivables and other short- and long-term receivables. Financial liabilities comprise trade and other payables, accrued items and short- and long-term loans and borrowings.

Financial assets and liabilities are initially recognised at cost, which is equal to the fair value of the consideration given or received for them. The initial cost of a financial asset or liability comprises all expenses directly attributable to its acquisition.

Purchases and sales of financial assets are consistently recognised at the settlement date, i.e. at the date the assets are transferred to or by the EHIF.

In the balance sheet, financial liabilities are measured at amortised cost.

A financial asset is derecognised when the EHIF's contractual rights to the cash flows from the financial asset expire or it transfers the rights to receive the cash flows of the financial asset and most of the risks and rewards of ownership of the financial asset. A financial liability is removed from the balance sheet when it is discharged or cancelled or expires.

Cash and cash equivalents

Cash and cash equivalents comprise cash at bank. The statement of cash flows has been prepared using the direct method.

Foreign currency transactions

Transactions in foreign currencies are recorded by applying the European Central Bank exchange rates quoted at the dates of the transactions. Monetary financial assets and liabilities and non-monetary financial assets and liabilities denominated in a foreign currency that are measured at fair value are retranslated to euros as at the balance sheet date using the European Central Bank exchange rates quoted at that date. Exchange gains and losses are recognised in the statement of financial performance as income and expenses respectively in the period in which they arise.

Receivables

Trade receivables comprise receivables for goods sold, services provided, and recoveries of health insurance benefits that fall due in the following financial year. Receivables falling due within more than a year, including deferred tax receivables from the Tax and Customs Board, are recorded as long-term receivables.

Receivables for goods sold and services provided comprise receivables for prescription forms sold to medical institutions and family physicians, receivables from the Ministry of Social Affairs for the service of processing health care invoices, and receivables for health services provided in Estonia to patients from other EU Member States from the competent authorities of such persons' insuring countries.

The recoverability of receivables is assessed at least once a year as at the reporting date. Receivables are measured on an individual basis. Under the concept of prudence, only recoverable amounts are recognised in the balance sheet. Doubtful items are recognised as an expense in the period in which they arise. Recovery of previously expensed doubtful receivables is recognised as a reduction of expenses from doubtful receivables.

Items whose collection is impossible or economically impractical are considered irrecoverable and written off the balance sheet.

Inventories

Inventories are initially recognised at cost and expensed using the FIFO formula. After initial recognition inventories are measured at the lower of cost and net realisable value.

Property, plant and equipment

Assets are classified as items of property, plant and equipment when their estimated useful life extends beyond one year and cost exceeds 2,000 euros. Assets with a shorter estimated useful life or lower cost are expensed as acquisitions.

Items of property, plant and equipment are initially recognised at cost and depreciated under the straight-line method over their expected useful lives. Land is not depreciated.

The following depreciation periods (in years) are applied:

- Buildings and structures 10-20
- Fixtures and fittings 2-4
- Plant and equipment 3-5

Expenditure on items of property, plant and equipment incurred after acquisition is generally recognised as an expense as incurred. Subsequent expenditure is added to the cost of a tangible asset when it is probable that future economic benefits generated by the expenditure will exceed the originally assessed benefits and the expense can be measured reliably and attributed to the asset.

Intangible assets

Intangible assets are identifiable items without physical substance that are used in the EHIF's activities, whose estimated useful life extends beyond one year and whose cost exceeds 2,000 euros.

Intangible assets are initially recognised at cost and amortised under the straight-line method over 2 to 5 years.

Expenditure on intangible assets incurred after acquisition is generally recognised as an expense as incurred. Subsequent expenditure is added to the cost of an intangible asset when it is probable that future economic benefits generated by the expenditure will exceed the originally assessed benefits and the expense can be measured reliably and attributed to the asset.

Government grants

A government grant is assistance given and received under certain conditions for a designated purpose where the provider of the grant checks whether or not the assistance is used as designated. Grants are not recognised as income and expenses until the conditions attaching to them have been met.

Grants are recognised as income when they become recoverable.

Revenue and expenses

Revenue and expenses are recognised on an accrual basis. Interest income is recognised as it accrues.

The EHIF's revenue comprises mostly of the health insurance component of social security tax and recoveries from other persons. The health insurance component of social security tax is received from the Estonian Tax and Customs Board through weekly transfers. Once a month, the Estonian Tax and Customs Board sends the EHIF a statement of transfer of tax balances which serves as a basis for recording as revenue in the accounts. Recoveries from other persons are recognised when a claim is submitted against a legal entity based on the law or a contract for compensation of damage caused to the EHIF. Claims against natural persons are recorded upon receipt of payment.

Operating and finance leases

A lease that transfers substantially all the risks and rewards incidental to ownership of an asset to the lessee is recognised as a finance lease. Other leases are classified as operating leases. On classifying leases as operating or finance leases, public sector entities also consider the requirements of paragraph 15 of IPSAS 13 Leases and regard the cases where the leased assets cannot easily be replaced by another asset as meeting the criteria of finance leases.

Assets acquired under finance leases are carried as assets and liabilities at amounts equal to the fair value of the leased property. Lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is recognised over the lease term.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

Provisions and contingent liabilities

Provisions are recognised for liabilities of uncertain timing or amount. The amount and timing of provisions is determined on the basis of estimates made by management or relevant experts.

A provision is recognised when the EHIF has incurred a legal or constructive obligation prior to the balance sheet date, it is probable (over 50%) that an outflow of resources embodying economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Risk reserve

Article 39[1] of the Estonian Health Insurance Fund Act regulates the formation of the risk reserve 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 per cent 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 had the obligation to create the risk reserve since 1 October 2002 when the Health Insurance Act entered into force. The Act amended the Estonian Health Insurance Fund Act by adding section 39[1].

A transfer to the risk reserve is made based on the decision of the supervisory board after the audited annual report has been approved.

Legal reserve

Article 38 of the Estonian Health Insurance Fund Act regulates the formation of the legal reserve as follows:

- The legal reserve of the Health Insurance Fund means the reserve formed of the budgetary funds of the Health Insurance Fund for the reduction of the risk which macro-economic changes may cause to the health insurance system.
- The legal reserve shall amount to 6% of the budget. Each year, at least one-fiftieth of the total budget of the health insurance fund and revenue from social tax revenue prescribed for the payment of health insurance benefits, which is higher than prescribed in the state budget, is 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.

A transfer to the legal reserve is made based on the decision of the supervisory board after the audited annual report has been approved.

Subsequent events

The annual financial statements reflect all significant events affecting the valuation of assets and liabilities that became evident between the balance sheet date (31 December 2013) and the date on which the financial statements were authorised for issue but are related to transactions of the reporting or prior periods.

Subsequent events that are indicative of conditions that arose after the balance sheet date but which will have a significant effect on the result of the next financial year, are disclosed in the notes to the annual financial statements.

Note 2. Cash and cash equivalents

€ '000	31/12/2013	31/12/2012
Cash at bank	199,641	204,300

The funds of the EHIF are kept in current accounts that are part of the group account of the State Treasury of the Ministry of Finance. According to the deposit agreement between the EHIF and the Republic of Estonia, the EHIF has unlimited access to the money on the group account at one week's notice. The Republic of Estonia can apply a usage limit on the deposited amount, but has not done so as of 31 December 2013.

Note 3. Receivables and prepayments

€ '000	31/12/2013	31/12/2012
Trade receivables	2,997	2,365
Allowance for doubtful receivables	-45	-42
Government grant receivable*	60	44
Operating expense recoveries receivable	1	1
Contractual receivables from insured persons	23	17
Interest receivable	32	65
Social tax receivable**	80,395	77,125
Prepaid expenses	277	354
Total	**83,740**	**79,929**

* The government grant receivable comprises a receivable from the Ministry of Social Affairs for funding artificial insemination treatment.
** Social tax receivable of 80,395 thousand euros comprises short-term receivables from the Tax and Customs Board for the health insurance component of social security tax.

Note 4. Inventories

As at 31.12.2013, the EHIF's inventories consisted of unused prescription forms of 3 thousand euros (31.12.2012: 3 thousand euros).

Note 5. Long-term receivables

Miscellaneous long-term receivables

€ '000	31/12/2013	31/12/2012
Long-term deferred tax receivable from the Tax and Customs Board	100	303
Non-current portion of amount paid to the National Social Insurance Board for renovation of the premises of Pärnu department and Rapla office	350	353
Total	**450**	**656**

Note 6. Non-current assets

6.1. Property, plant and equipment

€ '000			
Cost	**Land and buildings**	**Other fixtures and fittings**	**Property, plant and equipment**
31/12/2011	**384**	**1,823**	**2,207**
Acquisitions	38	7	45
Write-off	-10	-3	-13
31/12/2012	**412**	**1,827**	**2,239**
Acquisitions	0	182	182
Write-off	0	-363	-363
31/12/2013	**412**	**1,646**	**2,058**
Accumulated depreciation			
31/12/2011	**238**	**1,163**	**1,401**
Depreciation charge	21	251	272
Write-off	-6	-3	-9
31/12/2012	**253**	**1,411**	**1,664**
Depreciation charge	22	226	248
Write-off	0	-363	-363
31/12/2013	**275**	**1,274**	**1,549**
Carrying amount			
31/12/2012	**159**	**416**	**575**
31/12/2013	**137**	**372**	**509**

6.2. Intangible assets

€ '000	
Cost	**Licences purchased**
31/12/2011	**377**
Acquisitions	0
Write-off	0
31/12/2012	**377**
Acquisitions*	239
Write-off	0
31/12/2013	**616**
Accumulated depreciation	
31/12/2011	**376**
Depreciation charge	1
Write-off	0
31/12/2012	**377**
Depreciation charge	40
Write-off	0
31/12/2013	**417**
Carrying amount	
31/12/2012	**0**
31/12/2013	**199**

* Under Decree No. 92 of the Minister of Social Affairs of 15 July 2013 "Transfer of state assets free of charge", in line with § 10 (3) and § 11 (1) of the State Assets Act, the Ministry of Social Affairs transferred the Prescription Centre to the EHIF as of 1 July 2013, with a residual value of 239 thousand euros.

The EHIF will depreciate the Prescription Centre over the course of three years.

Income from the transfer of state assets free of charge is recorded as a government grant, see Note 17.

Note 7. Leases

Operating leases

Reporting entity as a lessee

The statement of financial performance for 2013 recognises operating lease payments totalling 318 thousand euros. Of this, 24 thousand euros was expensed as lease payments for vehicles and 294 thousand euros was expensed under lease contracts on premises.

In 2012, operating lease payments totalled 322 thousand euros. Of this, 25 thousand euros was expensed as lease payments for vehicles and 297 thousand euros was expensed under lease contracts on premises.

There are no contingent liabilities arising from lease payments. Lease contracts on premises can be terminated by giving 2 months' to 1.5 years' notice depending on the contract.

Operating lease expenses are covered by Note 14.

Note 8. Payables and deferred income

8.1. Trade payables

€ '000	31/12/2013	31/12/2012
Payable to medical institutions for services	42,426	39,256
Payable to pharmacies for medicines distributed at a discount	5,965	5,916
Other payables for health insurance benefits	3,340	5,811
Other trade payables	204	608
Total	**51,935**	**51,591**

Trade payables include related party transactions of 2,595 thousand euros (5,107 thousand euros as of 31. December 2012), see Note 16.

8.2. Taxes payable

€ '000	31/12/2013	31/12/2012
Personal income tax	1,599	1,581
Social tax	268	233
Income tax on fringe benefits	3	4
Unemployment insurance contributions	13	14
Statutory pension insurance contribution	4	4
VAT	6	0
Total	**1,893**	**1,836**

Personal income tax liability includes personal income tax of 1,540 thousand euros (31.12.2012: 1,533 thousand euros) withheld from incapacity benefits paid by the EHIF to insured persons.

Social security tax liability includes social security tax of 52 thousand euros (31/12/2012: 48 thousand euros) accrued on the holiday pay liability.

8.3. Other payables

€ '000	31/12/2013	31/12/2012
Payables to employees	515	416
Other payables	133	92
Advances received	27	25
Total	**675**	**533**

Advances received comprise the balance of an advance payment for the Moldova project funded by the Ministry of Foreign Affairs.

Note 9. Reserves

€ '000	31/12/2013	31/12/2012
Legal reserve	51,147	51,147
Risk reserve	16,661	15,583
Total reserves	**67,808**	**66,730**

At the end of 2012, the EHIF's risk reserve amounted to 15,583 thousand euros. According to § 39[1] of the Estonian Health Insurance Fund Act, the risk reserve was required in 2013 to reach 16,661 thousand euros. In order to reach the amount required by law, the risk reserve was increased by 1,078 thousand euros in 2013.

Note 10. Revenue from operating activities

€ '000	2013	2012
Health insurance component of social security tax	829,699	776,919
Recoveries from other persons	926	607
Total	**830,625**	**777,526**

Recoveries from other persons include related party transactions of 3 thousand euros (14 thousand euros as in 2012), see Note 16.

Note 11. Other operating income

€ '000	2013	2012
Voluntary insurance agreements	520	386
Insurance agreements with other countries	618	932
Services provided to European Union citizens	2,714	1,371
Fees for processing health care invoices	44	47
Foreign exchange gains	14	3
Total other operating income	**3,910**	**2,739**

Note 12. Interest and other finance income

€ '000	2013	2012
Interest on cash balance	613	1,233
Deposit interest	0	8
Total interest and other finance income	**613**	**1,241**

The Ministry of Finance calculates for the EHIF an interest on the balance of the moneys held on the accounts, at the rate which equals the profitability of the state cash reserve, see Note 2.

Note 13. Expenses related to health insurance

€ '000	2013	2012
Health service benefits	605,257	563,944
Of which: disease prevention	7,230	6,854
primary medical care	76,088	70,212
specialised medical care	481,561	450,472
nursing care	20,607	17,538
dental care	19,771	18,868
Health promotion expenses	706	814
Expenses related to benefits for medicines	103,391	98,967
Expenses related to temporary incapacity benefits	94,101	84,265
Other financial benefits	9,327	9,136
Other expenses related to health insurance benefits*	16,172	14,877
Of which: health service benefits arising from international agreements	7,847	7,190
benefits for medical devices	8,325	7,687
Total expenses related to health insurance	**828,954**	**772,003**

* Expenses for 2013 differ from the corresponding figure in the budget execution report since in the budget government grants of 1,465 thousand euros allocated from the state budget have also been recorded as expenses (difference in 2012: 1,572 thousand euros).

Health insurance expenditure includes related party transactions of 34,574 thousand euros (82,374 thousand euros as in 2012), see Note 16.

Note 14. Administrative expenses

€ '000	2013	2012
Personnel and management expenses	4,947	4,645
Wages and salaries	3,695	3,460
Incl. remuneration of management board members	172	153
Unemployment insurance contributions	35	45
Social tax	1,217	1,140
Administrative expenses	1,069	1,012
including operating lease payments*	318	322
IT costs	990	773
Development expenses	231	151
Total administrative expenses	**7,237**	**6,581**

* See Note 7.

Administrative expenses include related party transactions of 35 thousand euros (23 thousand euros as in 2012), see Note 16.

The remuneration of the members of the management board for 2013 includes 22 thousand euros for performance pay, the payment of which will be decided by the supervisory board after approval of the annual report.

Number of employees	2013	2012
Management board members	3	2
Managers	17	18
Senior specialists	39	33
Mid-level specialists	147	152
Support staff	5	5
Total number of employees	**211**	**210**

Note 15. Other operating expenses

€ '000	2013	2012
Supervision over health insurance system	70	74
Public relations/communication	86	108
Management board's liability insurance	5	6
Foreign exchange loss	14	21
Expensed receivables	42	35
Internal communication and information days	15	6
Fringe benefits and taxes	110	113
VAT on operating expenses	351	364
Total other operating expenses	**693**	**727**

Note 16. Related party transactions

Related parties include members of the management and supervisory boards, as well as companies and providers of health care services related to the EHIF via the members of its management and supervisory boards. Health care services are purchased from related parties under the same conditions as from other providers.

Transactions with related parties in 2013

€ '000	Amount	Note
Purchase of services	34,609	13.14
Sale of services	3	10
Payable at 31.12.2013	2,595	8
Receivable at 31.12.2013	0	

No write-downs of receivables from related parties were made in 2013.

Transactions with related parties in 2012

€ '000	Amount	Note
Purchase of services	82,397	13.14
Sale of services	14	10
Payable at 31.12.2012	5,107	8
Receivable at 31.12.2012	0	

Upon expiry of the term of their contract of service, members of the management board are entitled to benefits equal to their three months' remuneration.

For the remuneration of the members of the management board, see note 14.

Note 17. Government grants

Medicine costs related to in-vitro fertilisation that are eligible to compensation under section 351(5) of the Artificial Insemination and Embryo Protection Act are compensated and providers of health care services are paid for infertility treatment provided to insured persons based on a contract funded by the Ministry of Social Affairs through a government grant.

On the basis of section 25(8) of Government of the Republic Regulation No 8 of 21 January 2010 "Conditions and procedure for the provision of development assistance and humanitarian aid", the Ministry of Foreign Affairs has concluded a contract with the EHIF for supporting the development of the health insurance system of Moldova.

Expenses related to government grants

€ '000	2013	2012
Compensation to insured persons for medicine costs incurred on artificial insemination	660	903
Compensation of expenses incurred on infertility treatment based on health services provided	805	669
Moldova project	7	23
Total	**1,472**	**1,595**

Expenses related to government grants for funding the national cancer prevention strategy are recognised within disease prevention expenses and expenses related to the Moldova project are recognised within the EHIF's operating expenses.

Income from government grants

€ '000	2013	2012
Compensation to insured persons for medicine costs incurred on artificial insemination	660	903
Compensation of expenses incurred on infertility treatment based on health services provided	805	669
National cancer prevention strategy funds	33	30
Moldova project	7	23
Prescription Centre	239	0
Total	**1,744**	**1,625**

Non-current assets received free of charge are recorded under Prescription Centre income. Registration of non-current assets is described in Note 6.

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the 2013 annual report.

The annual report is comprised of the management report and the annual financial statements accounts, to which the independent auditor's report has been appended.

The Management Board
22.04.2014

Tanel Ross
Chairman of the Management Board

Mari Mathiesen
Member of the Management Board

Kuldar Kuremaa
Member of the Management Board

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Independent Auditors' Report

(Translation from the Estonian original)

To the Supervisory Board of Eesti Haigekassa

We have audited the accompanying financial statements of Eesti Haigekassa, which comprise the balance sheet as at 31 December 2013, the statements of financial performance, changes in net assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information, as set out on pages 96 to 111.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in Estonia, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing (Estonia). Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects the financial position of the Company as at 31 December 2013, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 22.04.2014

/signed/

Taivo Epner
Authorized Public Accountant No 169

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Estonian Health Insurance Fund Yearbook 2013