Estonian Health Insurance Fund Yearbook 2014

Eesti Haigekassa

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.

Annual Report of the Estonian Health Insurance Fund

Eesti Haigekassa

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End of financial year	31 December 2014
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Statement by the Management Board of the Health Insurance Fund

2014 in Estonian health insurance – a more personal approach and focus on the customer

A comprehensive approach that includes an informed person in the centre of the system and effective cooperation and coordination of activities between all parties of the system based on the person's individual health-related needs is a prerequisite for an effective healthcare system. In order to promote a personal and comprehensive approach to the patient, we have set the following objectives in the Development Plan of the Health Insurance Fund: supporting the development of primary healthcare, ensuring funding of evidence-based and cost-effective pharmaceuticals, medical equipment and healthcare services, and continuous modernisation. We also prioritise contributing to the development of the functioning of information systems and high-quality information exchange, which enables to make decisions taking into consideration the patient's full medical records and to increase the level of integration of the treatment. As an important area of activity, we support the development of treatment quality. All these activities create the prerequisites for primary care, specialised medicine and nursing care forming a whole that supports the best outcome for health. Thereat, being the main financer of the area of healthcare, it is our duty to ensure the stability of the financing of the different levels of healthcare, continuous analysis and development of the efficiency of the existing models of financing and the sustainability of health insurance.

Continuous development of primary care for the benefit of the health of the insured

Development of primary healthcare through increasing the role of the family physician and the family physician's team is an important priority in the Development Plan of the Health Insurance Fund. Since the majority of an individual's health problems are solved on the primary level, sustainable financing and development of strong primary care are vital. Last year, we updated the terms and conditions of primary medical care contracts in cooperation with the Estonian Society of Family Doctors and, as of 2015, we concluded new, more flexible 5-year frame contracts with family physicians, the conditions of which enable us to continue to support the development of an effective healthcare system that is based on the patient's needs. Ensuring quality is also an important feature in these contracts and we will continue to work on these issues in 2015.

For promotion of health, prevention of diseases and for the treatment to be effective, the person in the middle of the system must trust in and feel confident about all parties of healthcare and be aware of the possibilities, responsibilities and their own role in the healthcare system.

> « The EHIF is prepared to support reasonable convergence of family physicians in healthcare centres by reviewing and updating the financing model.

In order to increase the health awareness of the population, we have paid significant attention to informing the population of the role of the family physician and the possibilities of the primary healthcare system. In cooperation with the Estonian Society of Family Doctors, we carried out an extensive social campaign in 2014, within the framework of which we explained in depth the services offered in primary care and the competencies of the family physician and the family nurse in solving health issues.

We will continue to develop the primary care system; among other things, financing of the home nursing service, physiotherapy and obstetric care could also be organised through the family physician in the future. The added services further strengthen the coordinating role of the family physician in the primary healthcare centres, the establishment of which with the support of the Structural Funds of the European Union is one of the important goals of the organisation of national healthcare for the next decade. The EHIF is prepared to support reasonable convergence of family physicians in healthcare centres by reviewing and updating the financing model. In the next few years, we will continue working with family physicians in the name of expanding the family physician's service package and team.

Availability of effective and cost-effective services and pharmaceuticals is a priority

The main task of the Health Insurance Fund is to ensure to the insured persons the availability of the necessary modern and effective services, pharmaceuticals and medical equipment. We believe that it is extremely important to ensure to the people the best modern diagnostics and treatment, while following the legal obligation of the EHIF to use public resources as efficiently as possible. Development of health-related technologies enables development of increasingly efficient pharmaceuticals and safer services that are less invasive for the patient, thus, it is extremely important to regularly update the list of pharmaceuticals, medicinal equipment and healthcare services.

In order to renew the list of healthcare services, 93 applications were accepted for processing in the beginning of last year and, as a result of assessment involving all parties, 50 partially or completely new services have been added to the list as of 2015. In addition to the new possibilities in family and specialised healthcare, several possibilities for the treatment of people with various diseases were added to the list of services as hospital pharmaceuticals, e.g., the possibilities of biological treatment were expanded with biosimilars and new pharmaceuticals to treat cancer were added. The reference prices of independent inpatient nursing care and the home care service were also updated in cooperation with the relevant specialists and service providers. The cooperation will continue in 2015 with an aim to differentiate the prices of inpatient days on the basis of the need for nursing care.

The list of the pharmaceuticals with a discount rate reimbursed by the EHIF was complemented last year by adding several important options. The total of more than 35 new active ingredients have been added to the list of prescription and hospital pharmaceuticals in the last two years.

Last years, for the first time, we also commenced reimbursement of three new pharmaceuticals based on the so-called risk-spreading scheme. This means reimbursement by the EHIF if the pharmaceutical has a positive effect on the patient, i.e.

the outcomes of the treatment agreed in advance are achieved. This way we are able to make rarely needed and very expensive pharmaceuticals available to the patient, in case of which it is uncertain whether or not the hoped results will be achieved.

Continuous analysis of reimbursement of medical equipment (e.g. test strips for measuring the level of blood sugar, etc.) to the inured and updating of the list are important and we have made significant changes in this respect last year, both regarding price formation and the selection of the medical equipment, which, on the one hand, help the insured person to save money, and, on the other hand, increase the number of options to choose from.

Last year, we took an important step towards ensuring the transparency of the decision-making processes – as of 2014, we are completely disclosing the procedure of processing of the applications for new services. As a result, all parties and all stakeholders can keep posted with the proposals, processing of applications and expert assessments though our website.

Strategic partners and efficiency of treatment

Medical institutions and family physicians are the most important partners of the EHIF. We believe that it is important to ensure open cooperation with all our partners and the best possible healthcare service to the residents of Estonia, which would be of high quality, evidence-based and equally accessible for all insured persons. Thus, the financing contracts of the EHIF support patient-centred and comprehensive organisation of treatment that is based on assessment of the quality of treatment, the freedom of choice of the patient and efficient use of resources.

In the beginning of the year, we concluded updated 5-year contracts for financing treatment with the hospitals listed in the Hospital Network Development Plan, as of the second half of the year, updated contracts have been concluded with all contractual partners providing specialised medical care and nursing care. We also organised a selection competition to find additional contractual partners to provide specialised medical care and nursing care. In the modernisation of the contracts for financing care, we paid considerable attention to the terms and conditions for ensuring the accessibility and quality of healthcare services, whereat the financial annexes to the contracts are planned based on equal regional accessibility of treatment corresponding to the needs of the insured and their actual movement between service providers.

Last year, we also started to use a new partner management system – now, all healthcare institutions have one contract with the EHIF as well as one contract manager. As mentioned above, there was meaningful cooperation with family physicians throughout last year, as a result of which the general principles for the financing of primary medical care were agreed for the next five years by the end of last year. We have been actively making preparations for the development of a unified partner management system, where the primary focus would be on ensuring quality.

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Development of an effective quality system is one of the most important priorities of the Estonian healthcare system and health insurance and it is the duty of the EHIF to buy high quality health services for the insured persons. To perform this duty and develop a treatment quality system, development of treatment quality indicators based on cooperation between medical specialties and the EHIF was worked on throughout last year. We are also continuously contributing to the development of treatment and patient guidelines and paying increasing attention to implementation of the developed guidelines in the daily work of medical practitioners.

Promotion of the healthcare system and cooperation

In the beginning of 2014, the project "Assessing the sustainability of the Estonian health insurance system" was completed by the Praxis Centre of Political Studies. A model was developed in the course of the project which enables to assess the effect of various components (labour, prices, the structure of providing services, external risks, taxes) on the financial sustainability of the health insurance system.

Commissioned by the EHIF, the University of Tartu prepared an analysis of the organisation of dental care and prevention in the first half of the year.

In order to assess the remuneration methods used in health insurance and the pricing methods of the EHIF, we commissioned an audit of the pricing methods for specialised medical care last year to identify the potential room for improvement in the pricing methods of the EHIF and make proposals for elimination of any shortcomings, if possible. According to the report, the price model used by the Estonian Health Insurance Fund is functioning in its concept and is suitable for reimbursement of healthcare costs. As a result of consulting with foreign experts, a conclusion was reached that the system used in Estonia was one of the most detailed and accurate systems used for reimbursement of healthcare expenses.

A thorough analysis to map the current situation of the Estonian healthcare system keeping in mind comprehensive approach to the patient in the prevention and treatment of chronic diseases (hypertension, type 2 diabetes) was conducted last year in cooperation with the World Bank. The analysis concerned the health of the population as well as the measures implemented today that are specified in the Development Plan of the EHIF and will serve as an input into supporting the developments in the coming years. The summary of the results and conclusions of the World Bank analysis is available in the chapter "A World Bank survey highlighted several important development needs" of this report.

Project-based support to the healthcare system of Moldova will be a consistent activity, with the EHIF acting as an organisation offering its best expert competence to the health insurance system in Moldova.

We hosted delegations from various countries in 2014. Among others, the EHIF was visited by a high-level delegation from Bahrein and we have introduced the Estonian health insurance system abroad as well.

> « 2014 was a successful year for the health insurance system; the number of services provided to people increased and several future-oriented developments were initiated. Activities to increase awareness, transparency of decisions and involvement of the patients were prioritised.

Development of the healthcare infrastructure in the name of comprehensive healthcare information

The goals of the healthcare system – including comprehensive approach to the patient, the quality of care and effective cooperation between parties – are achieved with the help of an IT infrastructure that operates without failures and includes all parties of the healthcare system.

To achieve the goals, it is important for the healthcare information system to be more than just a tool for forwarding and archiving healthcare documents; contributions must be made to turn the information system into a national database, which enables everyone to view their health information, enables cooperation on various levels of healthcare and efficient coordination of care and provides the tools for analysis of the treatment quality and practical use of resources and for shaping healthcare policy.

Last year, the EHIF contributed to the preparations for creating a digital registry office, within the framework of which we are working in tight cooperation with the Estonian E-Health Foundation, the Ministry of Social Affairs and all providers of healthcare services. In the 1st stage of the project, we are planning full implementation of e-referrals, which is an important measure for better control over waiting times and for ensuring timely access to health services.

From the perspective of insured persons and employers, the preparations made for complete transfer to using electronic certificates of incapacity for work was a very important development last year. As of 2015, certificates of incapacity for work are only sent electronically. Thereat, we are also planning to improve the functionalities of the system in 2015 and make the system more convenient for all parties using the system.

Developing the organisation helps to ensure achievement of certain goals

In 2014, we launched more intensive reviewing of the functions of the organisation, we have placed more emphasis on ensuring the continuity of the processes and alleviated the risks endangering the operations of the organisation so that the EHIF as an organisation would be able to fulfil the duties placed on us even better.

In order to increase the clarity, transparency and reliability of the activities and decisions of the EHIF, we developed principles for avoiding conflicts of interest in cooperation with an independent external evaluator last year and established a regulation for declaring interests.

The Estonian Health Insurance Fund is operating with an aim to offer stable health insurance benefits to the insured persons today and in a longer perspective. 2014 was a successful year for the health insurance system; the number of services provided to the people increased and several future-oriented developments were initiated. Activities to raise awareness, transparency of decisions and involvement of the patients were prioritised.

The activities launched in 2014 will be continued in 2015, including the cooperation with the World Bank. The priorities of the EHIF in the coming years include development of strategic decision-making in order to ensure to our insured persons a comprehensive health insurance package that meets their needs, is complemented transparently and consists of services of measurable quality, while taking into consideration the justified expectation of the people for the healthcare approach to become more involving, more personal and more comprehensive.

Management report

Health insurance system

The health insurance system 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 to the insured person timely access to the various health insurance benefits, including medical care, pharmaceuticals and medical equipment as well as benefits for temporary incapacity for work, dental care and other financial benefits. 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 buying, we proceed from the framework of the Health Insurance Act and the following options can be listed with respect to purchasing of health services:

a) selection of health services, the so-called package of services;
b) design of prices of health services;
c) terms and conditions of the treatment financing contract and legal provisions;
d) selection of contractual partners and negotiations about contract volumes; and
e) checking that financing is justified.

The mission of the Health Insurance Fund 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;
- 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 Health and Labour is the representative of the Supervisory Board. A Management Board consisting of three members manages the EHIF. The EHIF had 214 employees as at 31 December 2014.

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 and entering into contracts for the provision of health services with medical institutions in order to ensure that the necessary services are provided to the insured persons. The EHIF works closely with all partners in the healthcare 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, including the quality and justification of the services purchased. Electronic checks are performed on a daily basis to ensure the accuracy of the submitted data and invoices. We also check medical invoices and documents with the help of our partners, a total of ca 12,000 medical files and records in a year. 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 from 2010–2014.

Table 1. Key indicators 2010–2014

	2010	2011	2012	2013	2014	Change compared to 2013
Number of insured persons at year end	1,256,240	1,245,469	1,237,104	1,231,203	1,232,819	0%
Revenue (thousand euros)	694,438	735,112	783,131	836,892	900,209	8%
Health insurance expenditure (thousand euros)	693,377	718,418	773,575	830,419	908,213	9%
Operating expenses of EHIF (thousand euros)	6,888	7,080	7,331	7,937	8,502	7%
Health insurance expenditure as percentage of GDP (%)*	4.7	4.4	4.4	4.4	4.7	0%
Total healthcare expenditure as percentage of GDP (%) **	6.3	5.8	5.8	5.9	-	-
Health service indicators						
Number of insured persons who used specialised medical care	797,048	807,875	795,581	796,698	800,326	0%
Average length of stay (days) in inpatient care	6.1	6.0	6.1	6.0	5.9	-2%
Emergency care as a percentage of expenses of specialised medical care (%)						
outpatient care	18	18	17	17	17	0%
day care	9	7	8	8	9	1%
inpatient care	67	64	66	64	63	-1%
Average cost per case in specialised medical care (euros)						
outpatient care	43	45	52	57	63	11%
day care	404	371	435	456	481	5%
inpatient care	982	1,008	1,124	1,178	1,289	9%
Volume inflation of specialised medical care (%)	-0.1	2.4	3.1	1.8	0.3	-2%
Referrals for treatment abroad and benefits arising from EU legislation (thousand euros)	3,810	8,210	7,193	7,847	10,022	28%
Indicators of benefits for pharmaceuticals						
Number of reimbursed prescriptions	6,689,886	6,945,735	7,438,670	7,625,135	7,883,659	3%
Number of insured persons who used reimbursed pharmaceuticals	822,440	841,533	841,387	848,636	850,206	0%
Average cost of reimbursed prescription for EHIF (euros)	13.6	13.2	13.3	13.6	13.9	3%
Average cost of reimbursed prescription for patient (euros)	7.7	7.0	6.6	6.4	6.5	1%
Indicators of benefits for incapacity for work						
Days paid for by the EHIF	4,600,139	4,937,836	4,954,761	5,228,586	5,362,002	3%
Cost of benefit per day	17.7	16.4	17.0	18.0	19.4	8%

*The indicators for 2010–2013 have been revised according to the GDP as adjusted by Statistics Estonia.
**Figures for 2014 will be published by the National Institute for Health Development in the end of 2015.

Strategic Goals and Their Achievement

Scorecard

	Weight	Performance Indicator	Unit	Comments
INSURED PERSON	**63%**			
	10%	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
	15%	Satisfaction with accessibility of medical care	%	One part of the general survey.
	12%	General satisfaction with primary care	%	One part of the general survey (responses from the persons who had visited the family physician were taken into account)
	3%	Satisfaction with quality of medical care	%	One part of the general survey of the population
	8%	Satisfaction with the organisation of purchasing of pharmaceuticals from pharmacies	%	Based on the number of people who had the opportunity to choose the cheapest prescription pharmaceuticals in a pharmacy (one part of the general survey)
	5%	Coverage of children with prophylactic dental check-ups	%	% of children according to birth year who have had prophylactic check-ups
	5%	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%	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 (the result of the previous calendar year +1%)
PARTNER	**25%**			
	10%	Involving the insured persons in activities that make it possible to improve monitoring chronic diseases	%	Coverage of all high-risk hypertension conditions in the quality system of family physicians (the result of the previous calendar year +1%)
	15%	Volume inflation of a case (all types of care in total)	%	Percentage of the volume inflation of cases of specialised medical care compared to the previous period
ORGANISATION	**12%**			
	2%	Employee satisfaction with the management and organisation of work of EHIF	%	% of employees who are satisfied according to the survey
	5%	Level of customer service	index	The service level of the customer service bureau, customer helpline and responding to e-mails is measured by the mystery shopping method
	5%	Reliability of information systems		Compliance with the criteria of the IT Baseline Security System in regard to critical services (insurance inspection, systems at the level that corresponds to the objective prescription centre)
TOTAL	**100%**			

2013 objective/ actual	2014 objective/ actual	Implementation %	Achievement of objectives
		55,1%	
67/61	67/58	8,7%	According to the survey, satisfaction of insured persons with the healthcare system has dropped compared to 2013. It is difficult to identify a specific explanation for this, as the organisation of the survey changed a bit as well.
58/47	55/43	11,7%	Satisfaction with the accessibility of medical care has decreased compared to 2013, due to the long waiting times for appointments to the preferred physicians.
-	88/79	10,8%	Satisfaction with family care system remained high in spite of failing to achieve the objective.
78/74	78/70	2,7%	Satisfaction with the quality of medical care remained on a comparable level with the year before. The scorecard objective was not achieved.
-	65/61	7,5%	The campaign of reasonable use of pharmaceuticals has been successful and, as a rule, cheaper pharmaceuticals are offered to the user.
40/29,6	32/26,2	4,1%	The measures for sending children to prophylactic dental check-ups did not yield expected results and the established goal was not achieved – the result was 26.2%.
53/54	54/51	4,7%	The awareness of the insured persons of the possibilities provided by the health insurance system has generally remained on the same level.
Breast cancer 67/71	Breast cancer 72/67.7	2,4%	The share of women covered with cancer screening increased last year, which suggests that the awareness of the insured persons has increased, however, the share of women involved in the breast cancer screening still remained below the values set as an objective.
Cervical cancer 72/72	Cervical cancer 73/73.7	2,5%	
		24,7%	
64/67	68/66	9,7%	The family physician's quality system is regularly updated and adding/removing of indicators may cause changes in the values set as objectives. The descriptions of the indicators that the quality system is based on changed in 2013 and thus the set objective was not achieved.
<2/1,8	<2/0,3	15,0%	The objective for the volume inflation of specialised medical care was achieved. An important part in achieving the objective was played by the new general terms and conditions for financing treatment concluded in the beginning of 2014, which provided specific guidelines for the terms and conditions of financing treatment.
		12,0%	
93/89	93/93	2,0%	The satisfaction of the employees of the EHIF with management and organisation and organisation of work of EHIF of work in 2014 was at 93%, which demonstrates that the measures applied in 2014 to increase satisfaction served their purpose and that the employees perceive the EHIF as a stable employer.
95/96	3,6/3,7	5,0%	The customer service index objective was achieved; the phone service was the best of the customer service of the EHIF, achieving a high result of 4.0.
K3/K3	K3/K3	5,0%	The information systems of the EHIF operated on the level excepted acceptability in 2014.
		91,8%	

The World Bank survey was performed in tight cooperation with the Health Department of the EHIF and with Estonian healthcare experts.

A World Bank survey highlighted several important development needs

All healthcare systems are faced with new challenges in the 21st century. One of the greatest challenges is the increasing number of the people with chronic diseases. The average life expectancy is increasing and modern science is capable of providing new and more effective treatment methods. This, in turn, significantly increases the probability of a person with one or several chronic diseases living a life of good quality and longer than was possible decades ago.

The precondition for this is of course a healthcare system that is capable of quickly adjusting to new challenges. In order to obtain globally acknowledged expert assessment to our system and to answer the question of whether today's healthcare system in Estonia and the model of strategic buying take into account the changed needs or if there is a need for updating, the Estonian Health Insurance Fund approached the internationally acknowledged experts of the World Bank last year.

We commissioned an analysis from the World Bank with an aim to obtain an assessment of whether the approach to the patient taken in Estonia follows the principle of integrated treatment and what are the factors contributing to or hindering this. The team of foreign experts were consulted by a domestic team consisting of representatives of the Estonian Health Insurance Fund, the Ministry of Social Affairs, the Faculty of Medicine of the University of Tartu, the National Institute for Health Development, the Health Board, the Estonian Hospitals Association, the Estonian Society of Family Doctors, and the Estonian Chamber of Disabled People. The survey focussed on the prevention and treatment of chronic diseases. Special attention was paid to the role and functioning of primary medical care and to the issues related to the equal treatment of different groups of population.

The results pointed to shortcomings of the healthcare system

The results showed that the healthcare system in Estonia is still hospital- and specialised medical care-centred. This is illustrated by analysis of the data from 2013, according to which appointments with specialists could have been avoided in case of 68% of the patients with hypertension and 20% of the patients with diabetes by more effective coordination of treatment on the primary level, while more consistent outpatient care would have enabled to prevent approximately a fifth of hospitalisation cases and one third of the patients with the diseases observed stayed in the hospital longer than the international standards prescribe. On the one hand, the results show the shortcomings of today's approach to the patient on the primary level and the economic interest of the providers of specialised medical care to treat the patients in outpatient as well as inpatient care that arises from the structure of the current financing model of the EHIF.

> « The results showed that the healthcare system in Estonia is still hospital- and specialised medical care-centred.

On the other hand, insufficient nursing care and rehabilitation as well as the accessibility of social services have a hindering effect. Another important factor are the choices of the patients who prefer specialised care to the family physician and turn directly to the Emergency Medicine Department if no referral is required. The room for development on the primary level is also demonstrated by the fact that in spite of regular contact with the family physician, the patients with chronic diseases are not provided enough of the preventive services prescribed. However, visiting a specialist also fails to provide a better outcome in this respect. The survey also showed shortcomings in the coordination of treatment on all levels of medical care after hospital stay. 3% of the patients hospitalised due to acute medical conditions such as unstable angina, acute myocardial infarction or heart failure (approximately 6,500 patients in 2013) received prescriptions for all three pharmaceuticals recommended in international treatment guidelines after hospital care.

The patient must be in the centre of the healthcare system

Such results unambiguously refer to the fact that raising awareness of health issues, more effective prevention and coordination of treatment would enable to achieve a better outcome for health and to use the resources more practically. In the past decades, Estonia has built a strong framework for our health system, which we can fully rely on and develop further. The cornerstones of our healthcare include well-functioning primary care, a strong hospital network, competent healthcare workers and a stable financing model. On the other hand, the conducted analysis and its conclusions confirm that today's system is not yet prepared to cope with following the principles of integrated care in the best possible manner and further development is needed.

Healthcare development is based on the principle that an individual is in the centre of the healthcare system and all other participants in the system exist and work for this individual. In case of a need for treatment, the location of the patient in the middle of the system means cooperation of higher quality than before between the family physician and medical specialists, between active treatment and follow-up treatment and rehabilitation, and between healthcare and social care. More generally, though, being in the middle of the system also means being more aware of health and taking more responsibility. In the 21st century, our health is largely endangered by chronic diseases. Successful management of these risks depend on the health behaviour or personal responsibility of each individual and the preparedness of the healthcare system to be at the service of an individual. A more strategic and coordinated national health awareness-related communication, which would support involvement of the whole society, is probably also needed.

Solving health problems begins with the family physician

A completely efficient and cooperation-oriented healthcare system is based on strong primary care. The primary level and the family physician and family nurse are the best experts with respect to the health of the people in their lists. The primary level is the place where personal health counselling, prevention and largely also the treatment of chronic diseases meet. In this context, primary healthcare as a whole requires systematic enforcement. More attention must be paid to developing standards for the approach to the patient (including treatment guidelines), to supporting following of the standards and to assessment of the results. Thereat, supporting structural changes and the development of family health centres of optimal sizes as well as the development of the financial part of the contracts entered into by the EHIF, including the performance pay, are not less important than facilitating clinical work. However, it must be kept in mind that positive changes have now occurred on the primary level, which manifest in the possibility to provide additional services, in the stable growth of financing and in the

quality-related priorities agreed in the new general medical care contracts. Thus, in addition to seeking additional possibilities, it is equally important to take full advantage of the existing ones.

One of the preconditions for a comprehensive approach to the patient is certainly cooperation between the primary level and specialised medical care, which is very important for the patient in the centre of the system. The survey confirmed that our people do not visit doctors rarely (specialists are visited in addition to the family physician), but it is important to take maximum advantage of these visits. Today, there is no clear distribution of

responsibility for comprehensive treatment of the patient between the different levels of medical care in the case of the most common chronic diseases. Continuous development of information systems is also of vital importance here. The potential of a healthcare information system as a concept requires systematic and extensive implementation to reach its actual potential. This includes the data collection and information exchange of the central system, including e-referrals, the software developments of the service providers, which enable to take into consideration the patient's comprehensive health information to support each individual treatment decision, as well as more effective cooperation between the parties in the name of the best result, including involving the patients.

> « The efforts of all parties should largely be focussed on increasing the ability of primary healthcare in the health system.

Development of the financing model needs analysing

To support a comprehensive treatment process, the today's framework of the EHIF's strategic buying also requires reviewing. There is reason for asking – is it possible for us, in certain cases and on certain conditions, to move from the so-called case-based reimbursement to reimbursement that takes into consideration the outcome of the treatment, taking into account the success of treatment, in specialised medical care? Conclusively, that would mean moving towards a comprehensive buying strategy, which may be possible in the case of chronic diseases, for example. However, it is clear that a prerequisite for changes is the ability to assess the change of the quality and cost of the treatment based on a specified model of operation over the comprehensive care episode or over the population. The outcome of treatment would not improve otherwise. Thus, it is important to work more systematically than before on agreeing the standards of care, on regular measurement and assessment of the quality of treatment. Establishing and measuring the indicators are also an important prerequisite for taking the aspect of quality into account more in financing of the services.

Conclusively, the efforts of all parties should largely be focussed on strengthening the capability of primary care in the healthcare system by applying various measures – effective principles of financing, healthcare communication and raising of the patient's awareness, clear distributions of responsibility and instructions through treatment guidelines and algorithms of the approach to the patient including several levels of healthcare, efficient use of information technologies for the purposes of diagnostics and treatment, activities concerning the quality of care, etc.

The report and materials of the World Bank survey are published on the website of the EHIF.[1]

1 www.haigekassa.ee/et/haigekassa/uuringud

The Health Department of the EHIF and the regional departments are tasked with developing central medical care, monitoring fulfilment of contracts and information exchange between family physicians and the EHIF.

Family physician is everyone's primary health adviser

Primary care is a well-functioning model for providing primary healthcare services, which ensures everyone good accessibility to the required efficient medical care and advice that are provided in a comprehensive manner. The significant keywords in the cooperation between a family physician and his or her patient are the same as in the case of any other well-functioning relationship in life – trust, empathy, openness.

Continuous strengthening of the strategic role of primary, i.e. primary care in coordination of care and provision of care services is important to the EHIF, especially considering the aging of the population and the growing percentage of chronic diseases.

> « The EHIF supports establishment of primary health care centres with modernisation of the cost model in 2015.

Preparations for the new contract period

In 2014, in the end of November, the Estonian Society of Family Doctors approved the general terms and conditions of the framework contract for funding for 2015-2019 presented by the EHIF. Enforcement of the key role of the family physician and family nurse in the health counselling of people and in coordination of care is an important priority, which matches the vision of the Estonian Society of Family Doctors of the role of a family physician in the Estonian healthcare system. Thus, the new general terms and conditions of the contract are more flexibly phrased to enable expanding of the package of primary healthcare services during the contract period. The section of quality has been updated as an important part in the new contracts. The EHIF and the Estonian Society of Family Doctors agreed that complementation of the quality requirements and development of the quality management system for family physicians' practices will continue in 2015.

The primary care financing model as a whole has completely justified itself and it is important to continuously develop the system further taking into consideration its strengths. In 2015, it is planned to complement the financing model of primary care in connection with the primary health care centres to be established. The EHIF is proceeding from the perspective of the services provided to the insured persons in the enforcement of primary care, i.e. from the perspective of the EHF, the concept of a primary health care centre means the family physician and his or her team and the services provided by them. To ensure successful functioning of the future primary health care centres, the EHIF is prepared to:

- continually increase the amount of primary healthcare in their contracts (including new services);
- review the cost model to ensure financing for the availability of the resources required for providing high-quality services;
- motivate reasonable congregation of family physicians' practices into primary health care centres (the model of which includes branches as well).

The accessibility of primary care is excellent

Good accessibility is certainly one of the important keywords in primary care. In 2014, as in previous years, the EHIF aimed to visit at least a third of the family physicians with a list to get acquainted with the organisation of work of the family physicians. Our partners assessed the accessibility of primary care in 34% of all lists, in the total of 272 lists. As a result of the visits, we are able to say that the accessibility of primary care in 2014 was very good – as a rule, everyone is able to get an appointment with their family physician within 5 working days.

One of the important values of primary care in solving health problems is being acquainted with the specific patient – a family physician basically knows an individual from his or her birth to death – monitoring the development in infancy, concentrating on prevention of diseases in adolescence and adulthood, and paying increasing attention to the coordination of coping with potential chronic diseases as the individual becomes older. Today, the Estonian primary care system has gone through a remarkable development and the ability of the family physicians to provide various services is higher than ever before. Therefore, we have also implemented new services in primary care in 2014, which help the family physician to organise his or her work even more efficiently.

« The primary care system has gone through a remarkable development and the ability of the family physicians to provide various services is higher than ever before.

The number of people using e-consultation services is increasing

The e-consultation service was launched in 2013, which assists the family physician in his or her daily work while helping to save time for the patient.

The EHIF supports the development of e-consultation in every way; it enables the family physician to coordinate the treatment process of his or her patient comprehensively and involve other specialists, if necessary, to find suitable treatment methods for the patient. The EHIF funded the total of 990 e-consultations in 2014, which were ordered by 72 primary care centres. Patients were most frequently referred to e-consultation for the services of an endocrinologist, otorhinolaryngologist, urologist, or pulmonologist. The only hospital to provide the service so far has been the North Estonia Medical Centre Foundation. Thus, we will be paying more attention to the development of e-consultation in 2015 and to new hospitals staring to provide the e-consultation service, including the Tartu University Hospital. For technical development of the service, we will continue to work with the Estonian E-Health Foundation and the developers of the family physician's software. We have also planned wider activities to increase awareness.

The EHIF started to finance family physician's appointments outside the working hours in 2014 to expand the possibilities of the family physician's organisation of work. The survey "Opinion of Population of Health and Medical Care" conducted in 2013 revealed that slightly over 40% of the population would like to visit the family physician or nurse outside of today's working hours – before 8 a.m., after 6 p.m. or in the weekend. The EHIF and the Estonian Society of Family Doctors developed a new service in 2013 for financing the work of the family physicians and nurses outside of the working hours. Since there was expectation from the population and the EHIF created a possibility for financing, many good family physicians have started offering appointments outside of the working hours to their patients. In 2014, the option of appointments outside of the working time

was used by the physicians and nurses of 23 lists in Harju County and 8 lists in the Viru region. Financing of appointments outside of the working hours has been used more by family nurses (5% more).

The operations fund has decreased the load on the Fee for Services Fund

As of 2014, a separate operations fund was added to the financing model of family physicians. The operations fund was established with an aim to support and motivate performance of the operations in the competence of the family physician on the primary level. The new fund expands the family physician's possibilities and decreases the load on the Fee for Services Fund, as the remuneration of the manual operations performed by the family physicians and included in the operations fund (minor surgery and gynaecology) is service-based. Thus, all family physicians with enough competence and a respective wish can perform surgical manipulations and gynaecological procedures without the financial restrictions of the Fee for Services Fund. The average use of the Fee for Services Fund of the ten family physicians who used the operations fund most in 2014 decreased by 4% compared to 2013. Thus, it can be claimed based on the first year of the fund that in case of the partners who have been actively using the possibilities provided by the operations fund, the load on the Fee for Services Fund has decreased. To enable the family physicians to deal with the health issues of their patients comprehensively and actively, we will continue to expand the package of primary level services in 2015.

The primary care system has a very important role in the Estonian healthcare system and one of the important strategic objectives of the EHIF in the coming years is to strengthen the primary level further by practical distribution of resources – including the forecasted growth of the financing of primary care – as well as contributing to raising the awareness of the population. To enable the family physician to act as the primary health adviser of the insured person, we will be working in tight cooperation with the Estonian Society of Family Physicians in developing the system.

Updating of the list of healthcare services is a year-round process, which involves the Health Department and Pharmaceuticals Department of the EHIF in addition to the external partners.

Updating of the list of healthcare services in cooperation between various parties ensures modern services for the insured

Continuous updating of the health insurance package and complementation of the package with modern evidence-based healthcare services is a strategic priority for the EHIF. In 2014, 93 applications submitted by 37 specialties, occupational associations and societies were processed within the framework of updating the list of healthcare services. For the first time, all materials submitted in the course of the whole process – applications, the additional data, assessments to the service being medically evidence-based, cost-effective and necessary to the society and to the impact on the budget as well as the final decision with explanations – were published on the website[2]. Stakeholders can keep up-to-date with processing of the submitted applications and get acquainted with the materials based on which the decisions are made, as well ask specifying questions and submit additional materials.

> Last year, 93 applications were processed within the framework of updating the list of services.

All submitted applications are treated the same, pursuant to the criteria provided for in legislation. The impact of the new service on the patient's health, i.e. the service being medically evidence-based and effective, is assessed, as well as the health benefit compared to that of the alternatives and the balance and acceptability of the additional cost to the health insurance budget. In cooperation with specialties and as a result of a discretionary decision, 39 new services

2 https://www.haigekassa.ee/et/partnerile/raviasutusele/tervishoiuteenuste-loetelu/loetelu-muutmine-2015

and pharmaceuticals were added to the list as of 2015 and amendments were made to 11 services in the list, which results in a higher number of changes than in previous years.

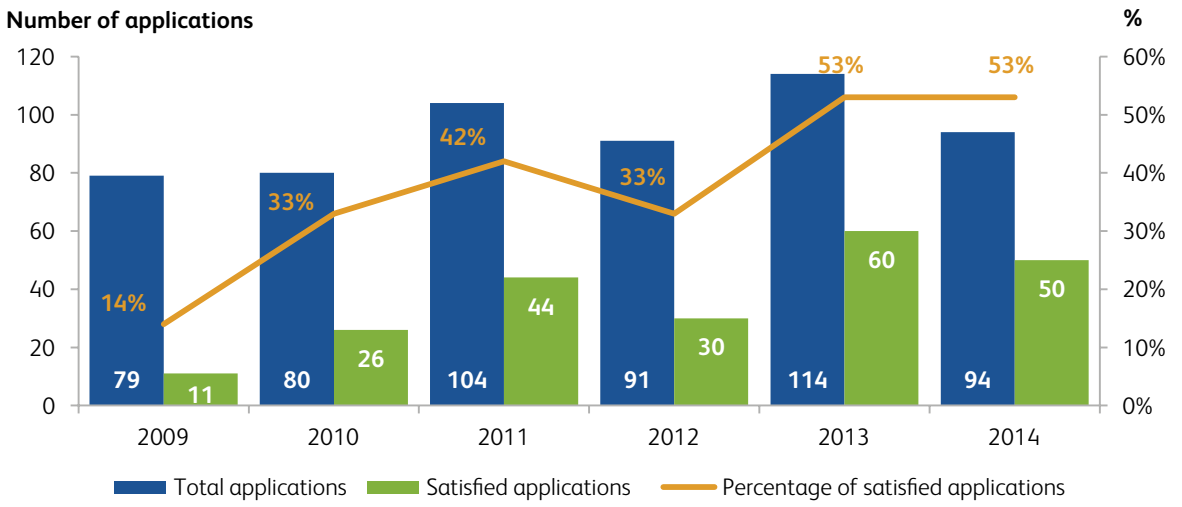

Figure 1. Number of applications, 2009–2014

Several new services in specialised medical care

In cooperation with the Estonian Association for Oral and Maxillofacial Surgery, resorbing implants required for adjustment of children's inherent scull and visceral cranium deformations were added to the list, the material of which dissolves in the body approximately within 2 years and does not hinder the development of the cranium. The children who required the surgery were sent abroad before, now, the little patients can be treated in Estonia.

In cooperation with the Estonian Ophthalmological Society, a surgery for bridging the cornea with riboflavin was added to the list, the aim of which is to postpone corneal transplantation as long as possible. The patients in need of this surgery were also sent abroad for treatment before.

Based on a joint application submitted by the Estonian Society of Nephrology and the Estonian Society of Cardiology, an immunoadsorption procedure was added, which is used to remove unwanted antibodies from the patient's blood plasma. The procedure has mainly become important in connection with kidney transplants, as the population of Estonian donors is small and there is an increasing number of patients who have received a kidney transplant in the waiting list for a transplant. Using immunoadsorptsion procedures enables to transplant a kidney to these patients as well, which significantly improves their survival rate and quality of life and enables to save the money spent on renal replacement therapy.

On the initiative of the Pharmaceuticals Department and with advice from specialists, post-lung, liver or kidney transplantation treatment schemes were updated and the list of haematological pharmaceuticals complemented.

> « One very important achievement in 2014 was updating of the references prices of independent inpatient nursing care and home nursing.

In cooperation with the Estonian Society of Family Doctors and specialists, the list of specialties using e-consultation was expanded. As of 2015, the EHIF pays for e-consultations and e-appointments with paediatricians, neurologists and haematologists on agreed conditions, in addition to the e-consultations with endocrinologist, urologist, rheumatologists, pulmonologists, and otorhinolaryngologists that were funded before. The change improves the availability of diagnostics and treatment, creating better possibilities for the family physician to refer a patient to a consultation with a specialist electronically.

Successful cooperation in the area of nursing services

One very important achievement in 2014 was updating of the reference prices of independent inpatient nursing care and home nursing in cooperation with the Society of Nursing Care Providers, the Home Nursing Society of the Estonian Nurses Association and the Estonian Nurses Association. The project was extensive and we are happy to admit that the cooperation with the representatives of the area was smooth. First, a common understanding was reached regarding which patients require which services. Then, the content of the service, the personnel, pharmaceuticals and materials required were described, and the requirements for the premises, machines and equipment specified in the regulation were taken into consideration. In cooperation with representatives of the specialities, descriptions of new services were compared to the expenses and use of resources last year and new prices were calculated for the services, which help to provide higher quality health services to the patient.

Discussions revealed that it would be necessary to differentiate the reference prices of nursing care bed days based on the differences between the patients with a higher or lower need for nursing care. This principle change in the prices of the services was not yet implemented in 2014, cooperation with the specialities will continue in 2015.

Home nursing service and home-based supportive therapy for cancer patients were merged taking into consideration that the services are based on similar medical indications and are provided to partially overlapping patient groups. The conditions for application of home nursing were complemented and the physician treating the patient is involved in the case of medical indications.

In order to inform the patients and their loved ones of the goals and content of various nursing services, an information booklet "Nursing Services in the Hospital and at Home" was prepared, which is available at primary care centres and health institutions and electronically on the website of the EHIF.

Ensuring accessibility of the services involves planning of the budget and contracts and continuous cooperation with healthcare institutions to investigate and analyse the reasons for waiting times. It also requires tight cooperation between the Central Department of the EHIF and the regional departments.

Complex operations are required to ensure the accessibility of outpatient specialised medical car

It is everyone's completely human and understandable expectation to find solutions to their health problems as quickly as possible. It is an objective of the national healthcare system to ensure the people access to scheduled doctor's appointments within a reasonable period of time depending on their health condition. The waiting time of a specific patient must depend on his or her medical indications.

An individual with an acute health problem must be able to see the family physician on the same day, in the case of a regular health check of a person with a chronic disease or some other need for consultation, within five working days. The accessibility of the family physician is very good in Estonia – based on the inspections performed by the EHIF, 99% of the family physicians' appointments take place within five working days. Patients also have access to 24-hour medical advice by calling the advisory line of the family physician, 1220. The Council of the EHIF has established six weeks as the maximum waiting time for scheduled outpatient specialised medical care. In case of scheduled inpatient care, the maximum waiting time is 8 months.

Scheduled inpatient care is generally provided within the established maximum waiting time – eight months. In case of outpatient care, waiting times for an appointment with a specialist vary considerably depending on the specialty and on the healthcare institution. In central and regional hospitals – which

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are often preferred by the patients to smaller service providers – the waiting times for an outpatient appointment with a specialist may sometimes reach 3-4 months. The waiting times are longer in the case of smaller healthcare institutions and more specific specialties. However, it must be stressed that emergency and urgent medical care is ensured to all patients whose health condition demands such treatment.

Accessibility problems mainly arise due to the low capability and the nature of the organisation of work of the service providers. The existence of available appointments in the registration system is, among other things, influenced by the number of appointments allocated by the healthcare institution for initial scheduled appointments and the numbers allocated for emergency and follow-up appointments, the availability of physicians, the availability of premises (e.g. surgical galleries) and equipment, etc.

Patients have expressed their dissatisfaction with the long waiting times to see specialists. According to the survey Opinion of Population of Health and Medical Care (Saar Poll, December 2013), only 47% of the population consider the current accessibility of medical care good. The current figure is the lowest of the period of the last five years.

Increasing the order has not shortened waiting times

In the public discussion over the long waiting times, the issue of insufficient financing of healthcare services often comes up and increasing the order from the EHIF appears to be a simple solution to shorten the waiting times. However, examining the budget of the EHIF and the statistics of providing healthcare services, it can be clearly stated that increasing the financing would not solve the problem. In spite of the fact that financing of specialised medical care and outpatient appointments has consistently increased in recent years (2008–2014), the waiting times have not become shorter. This allows to conclude that adding financial resources is not sufficient for shortening the waiting times in specialised medical care – complex application of several different measures is important.

In the autumn of 2014, the Management Board of the EHIF presented an action plan to the Council, which describes the possibilities for influencing the waiting times. The components for influencing the waiting times for specialised medical care were mapped divided into two sub-categories – the level of health insurance where the EHIF has a significant and executive role, and the level of the healthcare system where the measures and the implementation thereof depend on wider choices and decisions. The action plan is published on the website of the EHIF. Some of the measures mentioned in the action plan are described below.

One of the important measures for shortening waiting times is motivating the development of e-consultation and other e-services (e-referral, digital registration centre). This enables faster information exchange and helps to avoid needless appointments in specialised medical care. We have been working on implementation of the e-consultation service for several years and almost a thousand e-consultation services were ordered last year. According to the physicians themselves, the service will certainly be used increasingly in the coming years. Another important e-solution in organising the system of waiting times is full implementation of the electronic referral, which is expected to occur in 2017. Full implementation of the electronic referral by all healthcare institutions in Estonia will enable registration of patients in the waiting lists based on a referral issued in a common system including information presented with an agreed structure. Also, this system will enable differentiation of waiting times in the future based on the need as assessed by the referring physician.

Any operations supporting saving of the specialist's time also help to shorten waiting times. Thus, the EHIF has contributed to the development of nursing care, supporting independent appointments with nurses. Thus, we can now say that the percentage of independent nursing and obstetrician's appointments next to the physician's appointments has increased year by year, forming more than 8% of outpatient appointments today.

Awareness of insured persons can help to optimise waiting times significantly. Being aware that the role of the family physician is to coordinate solving of the patient's health problems between the various levels of healthcare and being able to find information about the contractual partners of the EHIF, the services purchased and the lengths of waiting times, everyone can find a healthcare institution with the shortest waiting time and receive an appropriate solution to his or her health problem. We consider it important for the EHIF to ensure that such information is accessible and up-to-date. Information about the waiting times to physicians of the same specialty at different healthcare institutions is available on our website. The largest group referring patients to the specialists – the family physicians – receive regular information about our contractual partners.

The need to turn to a specialist can be decreased through better and more effective functioning of primary care and an increased trust of the patients towards family physicians. The EHIF prioritises continuous development of primary level services. The accessibility of primary care is very good in Estonia. Most health problems can be solved by the family physician. In most cases, the family physician can also monitor chronically ill patients.

It may also prove necessary to develop the legal system in order to shorten waiting times – we have mapped the places where we see potential for development in this area as well, but here, the implementation depends on wider decisions.

Conclusively, the EHIF takes into account the waiting time information in the planning of the budget as well as contracts. In order to shorten the waiting times for specialised care, several measures must be implemented simultaneously – we have mapped the possibilities for influencing waiting times and are working on implementing solutions.

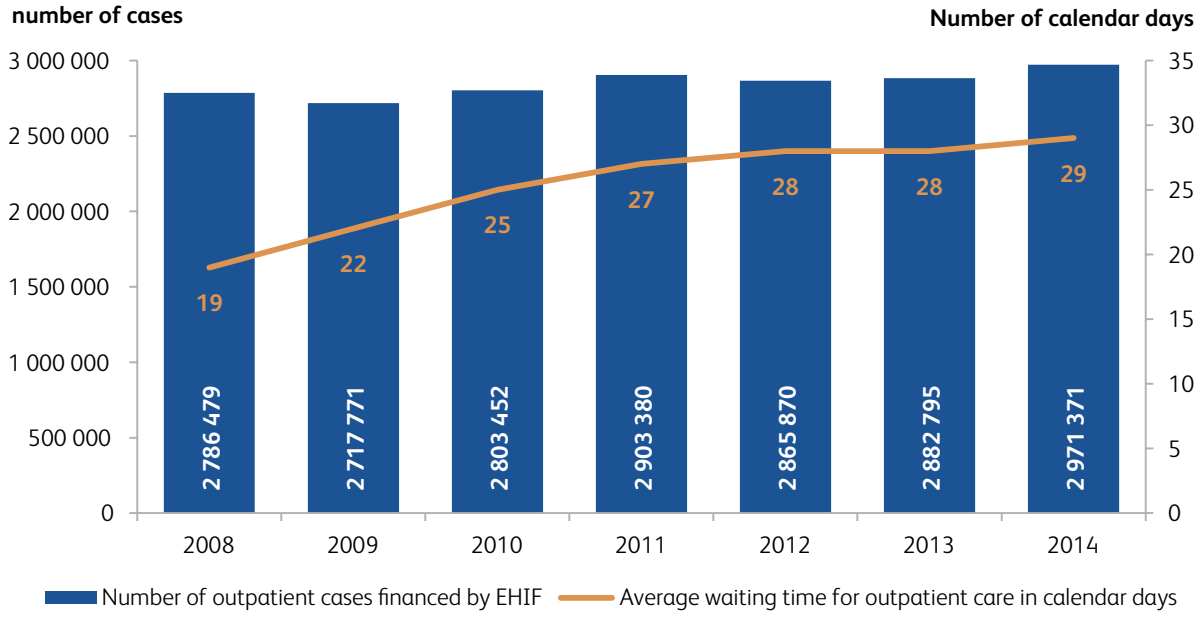


Figure 2. Average duration of outpatient waiting times and the number of outpatient cases financed by EHIF from 2008–2014

The aim of the work of the Pharmaceuticals Department is to ensure the availability of modern, evidence-based and cost-effective pharmaceuticals and medical equipment to insured persons. For this purpose, the EHIF works in cooperation with various parties to update the lists of reimbursed prescriptions and medical equipment for hospital as well as outpatient use.

Modern pharmaceuticals and medical equipment are a growing priority

Today, many diseases can be successfully controlled or treated without hospital stay, i.e. in outpatient care, but, as a rule, this requires pharmaceuticals or medical equipment that can be used at home. In 2014, the EHIF covered the costs of reimbursed pharmaceuticals for the insured persons in the amount of 110 million euros and the costs of medical equipment in the amount of 9 million euros. The list of the pharmaceuticals reimbursed by the EHIF includes approximately 2000 different medicinal products and the list of medical equipment hundreds of different pieces of equipment of various areas (equipment for diabetics, orthoses, wound dressings, etc.).

Decisions to finance pharmaceuticals are based on certain principles

Medicine is developing and health insurance is also expected to keep up to date, i.e. to pay for new treatment possibilities. It is not possible nor practical to finance all of the production of the healthcare industry from the health insurance funds. In order to separate the wheat from the chaff, the Health Insurance Act prescribes a certain procedure for making financing decisions. The main decision-making criteria include:

1) there must be an unfulfilled need (no alternative treatment methods);
2) the efficiency of the new pharmaceutical or piece of equipment must be proved;
3) the benefit arising from the new method must be suitably balanced with the accompanying additional expenses;
4) the EHIF must have sufficient funds for covering the additional expenses.

Significant developments occurred in the financing of reimbursed pharmaceuticals

2014 was positive in every way – as many as 19 different new active ingredients were deemed suitable for adding to the list of pharmaceuticals, which is more than three times more than in the year before. In several areas, we can even talk about a significant jump in development. For example, in the area of viral hepatitis C, which, if left untreated, may progress into liver

cirrhosis or occasionally cancer, which makes it important to treat the virus. Until last year, a pharmaceutical based on interferon and ribavirin, which freed about a half of those treated of the virus, was used in an attempt to achieve this goal. In 2014, a new type of pharmaceuticals, protease inhibitors, were taken into use, the combination of which with the treatment used so far successfully frees approximately 80% of the patients of the virus. About a hundred patients are estimated to require financing of such treatment every year.

Significant changes occurred in the treatment of prostate cancer as well. In 2014, after satisfying an application of the Estonian Society of Urologists, the EHIF started to reimburse post-surgery, i.e. adjuvant hormonal therapy.

Surgical castration had been reimbursed for the same purpose before. In the event of late-stage and metastasised cancer, the active ingredient abiraterone is now reimbursed. Put together, these changes affect hundreds of patients.

The highest number of patients – according to estimations, a several thousand – are affected by the commencement of financing a new type of anticoagulants. Anticoagulants are used to prevent the coagulation of blood with an aim to prevent blood clotting. Various health conditions increase the risk for blood clotting, for example, heart arrhythmias may cause disabling cerebral infarction as a result of blood clotting. Various blood thinning pharmaceuticals were reimbursed before as well, but many patients needed alternatives.

> « In many cases, treatment with pharmaceuticals is more reasonable than other treatment methods; this is proved by the increasing use of pharmaceuticals in hospitals and at home.

In addition to those described above, new active ingredients were added for the treatment of chronic obstructive pulmonary disease, gout, type 2 diabetes, and pancreatic and renal cancer. According to estimations, the total effect of the updates made in 2014, i.e. the additional expenses on the budget for pharmaceuticals, reaches up to 5 million euros.

Medical equipment is also important for independent management of a disease

The selection of medical equipment expanded in the area of wound treatment and ostomy care products and in the group of post-injury and post-surgery orthoses. For diabetics, reimbursement of lancets was added as a new group, which means that the whole equipment required for monitoring diabetes is now reimbursed by the EHIF. The greatest change in the group of glucometer test strips was establishment of reference prices. Consequently, the prices of the test strips dropped significantly and both the patient and the EHIF gained financially. As of the beginning of 2015, the availability and selection of the medical equipment for diabetics improved further as well as the selection of the equipment for the patients requiring daily self-catheterisation and for the patients with tracheostomy. The selection of ostomy care products, orthopaedic supplies, bladder catheters and the masks used for the treatment of sleep disorders also expanded.

Introduction of new treatment possibilities often also requires a novel approach in reimbursement

As a fresh approach, we have introduced a so-called risk- and cost-spreading in reimbursement. This means that if, for example, using a pharmaceutical is accompanied by a risk of a by-effect hindering continuation of the treatment or a risk of no therapeutic effect, the costs of the pharmaceutical will be covered by the manufacturer of the pharmaceutical. The aim of the risk- as well as cost-spreading is to achieve reasonable terms and conditions for paying for pharmaceuticals that are acceptable for the EHIF. For the patient, this means quicker access to new treatment possibilities. In 2014, 3 new pharmaceuticals were added to the list of reimbursed pharmaceuticals, which are reimbursed implementing this principle.

Pharmaceuticals have an important role in today's health care. In many cases, treatment with pharmaceuticals is more reasonable than other treatment methods; this is proved by the increasing use of pharmaceuticals in providing healthcare services in hospitals and in outpatient care. The EHIF does everything in its power to ensure the availability of modern, evidence-based and cost-effective pharmaceuticals to the insured persons in Estonia.

The communication organised in cooperation between the Health Department and the Public Relations Department plays and important role in the promotion of health and prevention of diseases.

Prevention of dental diseases benefits all

By contributing smartly to increasing the awareness of people, we can lower medical expenses and – importantly – thereby increase the quality of life of people. It is a priority of the EHIF to improve the awareness of people of oral health, thereby decreasing the prevalence of dental diseases.

The practice of other countries was examined

Having set the priorities, we commissioned and analysis from an external expert within the framework of which the practices of 10 other countries in the areas of dental care and dental disease prevention were examined. The study provided an overview of the health care system, prevention of dental diseases and provision of treatment in each of the countries, as well as the principles of reimbursement of the services for children and adults. The study helped to understand how the systems are functioning elsewhere and to find good practices, which could be considered in Estonia in the future. The results revealed that in all of the analysed countries, prevention of dental diseases in children and financing of the treatment from the budget of the compulsory health insurance were deemed important. Unequal access to dental care for the people in different economic situations among the adult members of the society and the long waiting times of those providing the services cheaper were mentioned as weaknesses in the case of several countries.

> « The main aim of reimbursement of dental care for children and adolescents is to ensure that young people reach adulthood with healthy teeth.

Awareness is increased by implementing various measures

Awareness of the population is an important keyword in the prevention of dental diseases. One of the means for increasing awareness is the project "Children's Dental Health" financed by the EHIF, which is becoming increasingly effective year by year. In 2014, we organised trainings for children as well as the personnel of children's institutions in cooperation with the Estonian Dentists Association, materials on oral health were put together for the child, the parent and the teacher. Various information days were also organised in cooperation with dentists and nationwide conferences were participated in. We published several articles about oral health in nationwide daily newspapers. In the course of the "Children's Teeth" project, we also performed on television for the first time, reaching children through a children's TV show. The activities for 2015 are also planned based on the diversity of the activities for raising awareness and the wide amount of information channels.

It is important to reach people in the right time, thus, we are aiming to cover all important target groups in the prevention of dental diseases, including pregnant women, infants and their parents, youths and the elderly. These groups are reached through trained specialists in kindergartens and schools, by distributing informative leaflets, as well as though messages spread in social campaigns.

The best results are achieved through cooperation

We continue to inform the population of the possibilities offered by health insurance – dental care is provided free of charge to children under 19 years of age by the contractual partners of the EHIF. The main aim of reimbursement of dental care for children and adolescents is to ensure that young people reach adulthood with healthy teeth.

In order to achieve results and the goals, the EHIF and the partners must cooperate with both parties sharing the same aim – to increase the awareness of the population of oral health, to raise a generation with healthy teeth and to maintain the health of an individual's teeth throughout his or her life.

As of 2015, the budgets as well as the contracts for the prevention of children's dental diseases and children's dental care are incorporated. This innovation enables a comprehensive approach to a patient and decreases the amount of administrative work for division of the invoices for dental care between prevention and treatment. The condition of the teeth of children aged 3, 6 and 12 will be mapped within a year, which will enable to assess the efficiency of various promotion activities in the longer perspective. As of this year, we will be sending information to family physicians about the prevention of dental diseases provided to the children in their lists and about the coverage of the treatment, which will enable the family physician to remind the parents in his or her list of the need to have their child's teeth checked.

One important task planned for this year is reviewing and updating of the list of dental care and orthodontics services financed by the EHIF in cooperation with the Estonian Dentists Association and Estonian Orthodontic Society and it is planned to analyse the possibilities to implement a mobile service in order to improve the geographic accessibility.

We are also planning to launch the preparations and implementation of a nationwide campaign of raising awareness, again with the aim to increase the awareness of the parents and children of dental health and hygiene, of the role of the dentist and to increase the extent of taking advantage of the healthcare service for the purposes of prevention and treatment. The activities targeting the awareness of children must also be highlighted as "a child's mouth is not only a reflection of the family, but the whole society."

The work to improve the accessibility of dental care for adults and on further development of potential financing models will also continue this year.

The contract managers, Legal Department and Health Department of the EHIF plan treatment financing contracts and continuously monitor the ability of the HNDP hospitals to provide services as well as the quality of the treatment.

Demanding choice – how much health services to purchase and from whom?

The 3-year contract period of the contractual partners of the EHIF found as a result of the specialised medical care and nursing care selection procedure ended in 2014 and the year 2014 will surely be remembered by many participants in the health system as the year when a selection procedure was carried out to find additional partners for the EHIF.

We describe the selection competition organised by the EHIF as a selection of additional partners, since the EHIF only organises a selection competition when the ability of the hospitals listed by the Regulation of the Government of the Republic on the Hospital Network Development Plan (HNDP) to provide healthcare services is not sufficient to satisfy the demand of the patients for healthcare services. Such principle of selection can sometimes cause confusion and, on this occasion too, the EHIF was quite a few times required to explain the principles and circumstances of the selection competition in challenge proceedings as well as in judicial proceedings on a few occasions. The clarity and integrity of the principles of selection are very important and thus the EHIF is always prepared to explain these principles.

How is the demand for health services assessed?

Pursuant to the Health Insurance Act, the EHIF is under the obligation to ensure equal regional availability of treatment to insured persons. In order to fulfil this obligation, we assessed the use of a service by the insured living in different counties in Estonia in the year before making the selection and compared it to the average use of the treatment in Estonia. If the difference from the average was significant and could not be explained by the demographic, geographical or epidemiological peculiarities of the region, we harmonised the demand of the county for the service with the average of Estonia. The results of the assessment of the demand where then compared to the financial possibilities of the budget of the EHIF for 2014. As

a result of this process, the so-called financed demand, i.e. the distribution of the budget of the EHIF by counties was formed, which was used as the basis for assessing the need for selection of additional partners.

In order to determine the amount of additional partners to be selected more accurately, the ability of the HNDP hospitals to cover the demand pursuant to the principles of geographical availability of treatment was taken into account. This means that if, based on the principles of geographic accessibility, the specialties and types of care must be available to people in their home county, but the HNDP hospital did not ensure it in the amount corresponding to the assessed financed demand, the EHIF organised a selection competition to find additional partners.

Occasionally, we are asked why the HNDP hospitals are not required to participate in the selection proceedings. The reason is that the HNDP hospitals are required by the law to provide health services and – especially significantly for insured persons – to ensure the needed medical help urgently and around the clock. The EHIF cannot not enter into a treatment financing contract with a healthcare institution on which the acts of law of the Republic of Estonia have placed the obligation to ensure around the clock accessibility of treatment. The selected partners have no such legal obligations and they have the right to withdraw from the contract with the EHIF at any time if, for example, the price level offered by the EHIF does not seem attractive enough or if other circumstances arise due to which the health care institution no longer considers it practical to continue to provide the service.

> « The HNDP hospitals are required by the law to provide the services and to ensure the required medical help around the clock.

The contract managers of the EHIF and the Treatment Financing Unit continuously monitor the ability of the HNDP hospitals to provide the services and the quality of the care. In the case of deficiencies, one of the possibilities is to adjust the volume of a HNDP contract, which may, in the case of lacking ability of the other HNDP hospitals providing the service in the same region based on the level of geographic accessibility, mean more extensive involvement of the selected partners, i.e. increasing the volume of the contracts of the existing selected partners or organising an additional selection competition.

In order to ensure stability to our partners, the Management Board of the EHIF decided to extend the period for which contracts were concluded with the selected medical institutions to 4.5 years, the next selection of additional partners will be organised in 2018.

The Pricing Unit of the Health Department is working to ensure that all healthcare services have optimal prices established on the basis of clear and transparent methods.

Key question in the pricing of healthcare services – what is the right price?

To enable the EHIF to pay for the care provided to insured persons, prices must be applied to all healthcare services. The healthcare industry is different from the fully competitive free market, as there is an asymmetry of information between the supplier and the buyer, the industry is complex and, in case of certain services, there are few service providers, but the standards are high. Pricing of healthcare services must be justified and clear to the different parties, thereat, the greatest challenge is finding the optimal price. Therefore, uniform pricing methods have been established, which are based on the principles of activity-based cost of accounting (the ABC method). Pursuant to these methods, the activities required for providing a specific healthcare service and the resources required to perform these activities (e.g. the time of the physician and the nurse, the equipment) must be described, while the services described are based on the actual practice of healthcare establishments. Another objective of pricing is to ensure effective and practical use of the health insurance funds.

The methods are suitable for reimbursement of treatment expenses

The methods used today were developed 10 years ago, after which the healthcare system has undergone several developments. An external expert analysis was commissioned from AS PricewaterhouseCoopers Advisors (PwC) in 2014 to assess whether the methodology was up to date.

In the course of conducting the expert analysis, the experts of PwC examined the documents and data describing the current situation and conducted interviews with representatives of the EHIF and healthcare institutions as well as experts from the global network of PwC.

The analysis highlighted that, according to the parties involved in the market, the methods used by the Estonian Health Insurance Fund are generally functioning in their concept and suitable for reimbursement of treatment expenses. Having consulted with several international healthcare experts in the course of the work, PwC concluded that the system used in Estonia was one of the most detailed and accurate systems for reimbursement of treatment expenses.

The methods can be improved further

The analysis of PwC also drew attention to several recommendations for developing the current system. According to PwC, the EHIF should inform external parties more clearly that the objective of the methods is to find the optimal cost of healthcare services in order to use it as the basis for establishing prices for the healthcare services.

> « According to the parties involved in the market, the methods used by the Estonian Health Insurance Fund are functioning in their concept and suitable for reimbursement of treatment expenses.

The expert assessment prepared by PwC stressed that the prerequisite for calculating prices as objectively as possible is high-quality and comparable source data in the form information about the actual expenses incurred by healthcare institutions. For this purpose, more accurate and unambiguous requirements and standards for submission of the information must be developed in cooperation with healthcare institutions.

The key question in pricing is what is the optimal price? To find the optimal price, it is important to agree on a method of comparison, i.e. the principle of which cost level will be taken into account in establishing the final reference prices. There are several options – the average cost level of healthcare institutions (currently used), references from other countries, references from other institutions, etc. For health insurance, it is important that the comparison method used would help to find the optimal expenses of healthcare institutions and, based on this, the right price. PwC advised to consider that even though the EHIF must base the calculations on optimal prices, some reference prices could be differentiated from the optimal prices to encourage or discourage provision of certain services by using financial motivators (for example, in 2015, the price of the e-consultation services was updated based on this principle).

The EHIF was also interested in suggestions for simplifying administration. In this respect, PwC advised to find the optimal price by adjusting the unit prices of the general expenses included in the prices by using various indexes (e.g. changing utility costs by using the consumer price index or changing amortisation by using the construction price index) instead of analysing the actual general expenses of healthcare institutions on an annual basis.

New development activities arising from the analysis

The analysis was extremely beneficial for the EHIF, confirming the relevance of methods used, the importance of the current plans and providing new ideas for the development of the methods. Based on the suggestions, the EHIF drew up an action plan for development of the methods in 2015. Among other things, in cooperation with healthcare institutions, it is planned to improve the quality of the information sent to the EHIF, but the main focus in 2015 will be on an external expert analysis, which will focus on developing various comparison methods and automatic variables.

International Relations Department ja Harju and Pärnu Regional Departments coordinates treatment of the persons insured by the EHIF in foreign countries.

Treatment options in the EU

Travelling within the European Union has been made as easy as possible for the travellers and the possibilities to receive cross-border healthcare services on equal grounds are expanding every year. It is not possible to provide all healthcare services in Estonia, and, in many cases, it would not even be economical. Thus, it is normal that several services are provided to insured persons abroad and these services form an important part of our benefits package of benefits. For example, insured persons can submit an application to the EHIF to obtain a prior authorization for the required scheduled treatment abroad in the case of services cannot be provided to insured person in Estonia. In such cases, the medical expenses of the services provided in a foreign country are covered by the EHIF. Insured persons also have had and continue to have the right to the the right for necessary health care on the basis of the European Health Insurance Card (EHIC) while temporarily straying in another EU Member State.

In 2013, there was a lot of discussion in the public sphere of the European Union, including in Estonia, over the Cross-border Health Services Directive that entered into force in October. For insured persons, the Directive means that they are now entiteled to travelling to another EU Member State with the purpose of receiving treatment just like visiting a medical specialist in Estonia. However, specific terms and conditions apply to this option.

> « The modest use of the possibilities offered by the Cross-border Health Services Directive mainly arises from the large differences between the prices of healthcare services in Estonia and in other countries.

The healthcare services received in a foreign country are reimbursed by the EHIF based on the principles of the new Patients' Rights Directive. This means that having received a service, a financial benefit can be claimed from the EHIF to pay for the service. Thus, all expenses related to the service must first be paid to the healthcare provider in a foreign country and an application for reimbursement of the expenses can only be submitted to the

EHIF later. Thereat, it must be kept in mind the EHIF only reimburses the healthcare services which the patient also has the right to receive at the expense of the EHIF in Estonia. The healthcare services that are provided in Estonia for a charge (e.g. dental care for adults) or that are not indicated to the patient on the basis of his or her health condition are not reimbursed. For reimbursement, an application must be submitted to the EHIF along with the original invoices issued for the medical service, the documents verifying payment of the invoice, the referral issued by a medical specialist, and the patient's medical report/ summary of the treatment. The application form is available on the website of the EHIF and at EHIF's client service offices. Insured persons can also apply for reimbursement of the pharmaceuticals and medical equipment purchased in a foreign country, which are included to the list of reimbursed pharmaceuticals or reimbursed medical equipment in Estonia.

Entry into force of the Directive did not bring great changes

Since the possibilities of the patients to receive treatment outside of Estonia expanded, greater changes in the expenses of cross-border treatment were also forecasted at first. The Directive-related expenses were expected to be 480 thousand euros in 2014, but the actual expenses were 101 thousand euros, i.e. 21% of the forecast.

One of the reasons why our patients have travelled less than expected after entry into force of the new Directive may arise from the differences between the prices of healthcare services in Estonia and in other EU Member States. The amount to be reimbursed is based on the price list of healthcare services used in Estonia, not in the foreign country, and if the price of the service received abroad is higher than the amount specified in the list of healthcare services of the EHIF, the patient must cover the price difference. Based on the example of today's practice, it can be said that, the patient's healthcare expenses in a foreign country can be covered in the extent of approximately 30%. The patient must also cover the appointment fees, co-payment fees, travel expenses, etc.

A gradually increasing trend can be observed in the number of patients who have received treatment abroad as well as in the relevant expenses, but this is caused by the increased awareness of people of the possibilities to receive non-financial benefits abroad as well as a general increase in free movement. Despite the general increase in the expenses and the number of the insured persons who have received treatment abroad, there is no reason to believe that people prefer to be treated abroad. In the EHIF's budget for 2014, we can see that the expenses on foreign treatment in the EU formed less than 1% of all expenses.

The Quality Unit of the Health Department contributes to the development of treatment quality in Estonia in cooperation with various parties involved in the healthcare system.

Contributing together in the name of better treatment quality

In recent years, the EHIF, in cooperation with various stakeholders involved in the healthcare system, has implemented various contributions aimed at improving treatment quality. The EHIF has: updated clinical guidelines, audit methods, quality requirements, terms and conditions of selection competitions, and treatment of financing contracts; trained healthcare workers; started preparing Estonian treatment standards, patient guidelines, and quality indicators;; and routinely surveyed patients with regards to the quality of the services provided. Consistent planning and monitoring together with regular assessment and develop¬ment of quality indicators are all required to ensure that healthcare services are provided with high quality.

During the last three years, approximately 200 healthcare workers have received training, regarding how to prepare clinical guidelines, including clinical pathways, perform searches, assess the clinical guidelines and evidence while forming recommen¬dations. This new approach can also be applied in their daily work.

After two years of work, clinical guidelines based on the highest standard of international evidence-based knowledge will be completed. These will take into consideration the organisation of the Estonian healthcare system and include interdiciplinary recommendations formed by panels of specialists. The activities agreed with regards to the implementation and mon¬itoring tasks add value to the document. The total of four Estonian clinical guidelines have been completed by 2014, of which three harmonise the approach to long-term diseases in family healthcare (arterial hypertension in adults, generalised anxiety disorder, asthma in adults) and one helps to ensure patient safety in the operating room (the use of surgical safety checklists in operating rooms). Eight more clinical guidelines with the accompanying patient guidelines are in various stages of completion. The guidelines for patients with arterial hypertension drawn up on the basis of the issues covered in the clinical guidelines have been approved. The patient guidelines are a tool for counselling the people with a long-term disease and for their active involvement in the treatment process.

The factors facilitating implementation of the clinical guidelines include the awareness of healthcare workers of the existing clinical guidelines and their content, unambiguously understood recommendations, clearly determined target groups of patients, and the support of managers and colleagues. Therefore, an important part of preparing clinical guidelines is a plan consisting of preparatory activities for implementation of the clinical guidelines (e.g. printing and distributing of the clinical guidelines, implementation trainings, changes in services or IT systems) and agreed indicators, which will be used to monitor implementation of the clinical guidelines. Assessment of the indicators at a later stage enables to analyse whether the clinical guidelines have improved the approach to treatment and provides an input for planning new corrective measures.

We have launched purposeful introduction of the new manual of clinical audits and the action plan. The auditing process has lasted a bit longer than the previous ones, because the exact focus of the audit and the assessment criteria are agreed at an early stage in the course of preliminary discussions. The auditing itself, however, is sim¬plified due to the new online operating environment, which enables to perform follow-up audits on the same principles, but more conveniently than before, or can be used by healthcare institutions for self-auditing as well as in performing target selections.

> « Implementation and systematic assessment of a new treatment standard is a long process that calls for tight cooperation between all parties.

The feedback report of the hospitals listed in the Hospital Network Development Plan was published for the third consecutive year in 2014. The report includes various aspects of the operations of the hospitals and changes in the aspects compared to the year before and enables to make comparisons between the hospitals and to learn from best practices. The EHIF also uses various indicators as relatively quick tools for assessing treatment activities to provide feedback to its contractual partners.

The Council of Treatment Quality Indicators is a fresh project created with the Faculty of Medicine of the University of Tartu. The Council was founded with an aim to develop a comprehensive system for regular assessment of healthcare services and for publishing of the respective information. Clinicians develop indicators for monitoring treatment on the national level, assess the results and give recommendations for improvements. The first sugges¬tions for the development of national indicators have already been made and are being processed. We are starting from describing the protocols of the indicators of obstetrics, intensive care, oncology and treatment for stroke and will then chart the potential sources of data at larger treatment institutions. This is the beginning of a huge project, which we will carry on by moving on to other specialties.

Implementation of a new treatment standard and systematic assessment of the results by applying different methods is a long process and calls for careful planning and tight cooperation between various parties. The behav¬iour of healthcare workers in their approach to treatment will change when the new knowledge has taken root and this is reflected in daily operations. Conclusively, we can finish with the words of Joel Starkopf, the Dean of the Faculty of Medicine at the University of Tartu, to characterise the listed quality-related activities: “I do believe that this will make Estonian medicine better.”

The System Development Unit of the IT Department contributes in cooperation with all other departments to developing IT solutions to support consistent development of the whole health insurance

Preparations for ensuring an integrated flow of treatment in the healthcare system

The movement of the patient in the course of diagnostics and treatment must be purposeful. This is achieved with the help of referrals, which, in addition to the next step, also reflect the explanation of why the appointment with the specialist is required, as well as through the electronic certificate of incapacity for work.

It is important to ensure an integrated flow of treatment, i.e. to enable to the patient smooth treatment by various specialists in the course of his or her health problem and to ensure to the specialists sufficient and comprehensive information about the patient's health problem. Access to comprehensive information allows to provide high-quality healthcare services and thus ensures the best outcome for the patient's health.

A uniform standard for the referral ensures the possibility of the required tests and analyses being performed before the first appointment with the specialist and allows the specialist to obtain a quick and clear overview of the patient's previous health condition.

The agreed principle that the patient can use one referral to make an appointment with just one specialist of a specific area and at one service provider will help to shorten waiting times. The e-referral enables to decrease the number of appointments to the family physician as well as specialists, as the patient no longer has to attend a physician's

« A uniform standard for the referral ensures the possibility of the required tests and analyses being performed before the first appointment with the specialist and allows the specialist to obtain a quick and clear overview of the patient's previous health condition.

appointment for the referral to be drawn up, but the physician can draw up the referral as a result of a consultation by e-mail or telephone. E-consultation as one of the types of referral enables to perform a consultation without the patient having to attend an appointment and if an appointment turns out to be necessary, only profiled patients get appointments (the right patient at the right time to the right specialist) and the specialist will prioritise the patients to be seen.

We have initiated development of a uniform standard for the e-referral and are planning to implement the e-referral service in 2017.

Electronic certificates of incapacity for work are beneficial for all parties

Sending of digital information of certificates of incapacity for work by healthcare institutions directly to the information system of the EHIF at least in the extent of 95% is the prerequisite for transfer to the paper-free e-certificate of incapacity for work. This level was achieved by the beginning of 2014. 2014 was the year of active accession to the system by employers in the transfer to paper-free certificates of incapacity for work. Raising of awareness among entrepreneurs increased interest in the service, as a result of which the number of those who acceded to the service grew rapidly. As at the beginning of December, employers were filling more than 80% of certificates of incapacity for work electronically, i.e. used paper-free certificates.

The transfer to the electronic certificates of incapacity for work have benefitted healthcare institutions, employers and above all the insured person. It is planned to fully implement the first generation of the e-certificates in the course of 2015.

Budget Implementation Report

Table 2. Budget implementation in thousand euros

	2013 actual	2014 budget	2014 actual	Budget implemen-tation	Change compared to 2013
REVENUE OF EHIF					
Health insurance component of social tax	829,699	897,394	893,759	100%	8%
Revenue from contracts for persons considered equal to insured persons	1,138	1,500	1,195	80%	5%
Recoveries from other persons	926	600	1,062	177%	15%
Financial income	613	645	652	101%	6%
Other income	4,516	3,293	3,541	108%	-22%
TOTAL BUDGET REVENUE	**836,892**	**903,432**	**900,209**	**100%**	**8%**
HEALTH INSURANCE EXPENSES					
Health service expenses	605,257	661,187	664,070	100%	10%
Disease prevention	7,230	7,648	7,591	99%	5%
Primary medical care	76,088	85,421	82,248	96%	8%
Specialised medical care	481,561	522,934	529,044	101%	10%
Nursing care	20,607	23,937	24,537	103%	19%
Dental care	19,771	21,247	20,650	97%	4%
Health promotion expenses	706	1,000	857	86%	21%
Expenses of pharmaceuticals reimbursed to insured persons	103,391	110,000	109,753	100%	6%
Expenses of benefits for temporary incapacity for work	94,101	96,371	103,902	108%	10%
Expenses of other financial benefits	9,327	9,948	9,358	94%	0%
Other expenses	17,637	19,030	20,273	107%	15%
Total health insurance expenses	**830,419**	**897,536**	**908,213**	**101%**	**9%**
OPERATING EXPENSES OF EHIF					
Labour expenses	4,947	5,346	5,261	98%	6%
Administrative expenses	1,337	1,571	1,450	92%	8%
IT expenses	976	1,080	962	89%	-1%
Development expenses	223	339	278	82%	25%
Other operating expenses	454	562	551	98%	21%
Total operating expenses of EHIF	**7,937**	**8,898**	**8,502**	**96%**	**7%**
TOTAL BUDGET EXPENSES	**838,356**	**906,434**	**916,715**	**101%**	**9%**
Profit/loss for budgetary year	**-1,464**	**-3,002**	**-16,506**	-	-
RESERVES					
Change in legal reserve	0	3,239	3,239	-	-
Change in risk reserve	1,078	1,289	1,289	-	-
Change in retained earnings	-2,542	-7,530	-21,034	-	-
Total change in reserves	**-1,464**	**-3,002**	**-16,506**	**-**	**-**

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, as well as persons considered equal to the above persons on the basis of the Health Insurance Act or a relevant contract.

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.

The changes in the number of insured persons in 2014 is characterised by an increase in the number of employed insured persons and a decrease in the number of persons insured by the state due to the unemployed returning to the labour market (see table 3).

Table 3. Number of insured persons

	31.12.2012	31.12.2013	31.12.2014	Change compared to 2013 (persons)	Change compared to 2013
Employed insured persons	575,277	584,094	600,998	16,904	3%
Persons considered equal to insured persons	602,249	594,408	583,101	-11,307	-2%
Other insured persons	59,578	52,701	48,720	-3,981	-8%
Persons insured by the state	57,619	50,391	46,275	-4,116	-8%
Persons insured under international agreements	1,642	1,903	1,993	90	5%
Persons considered equal to insured persons under voluntary contracts	317	407	452	45	11%
Total	**1,237,104**	**1,231,203**	**1,232,819**	**1,616**	**0%**

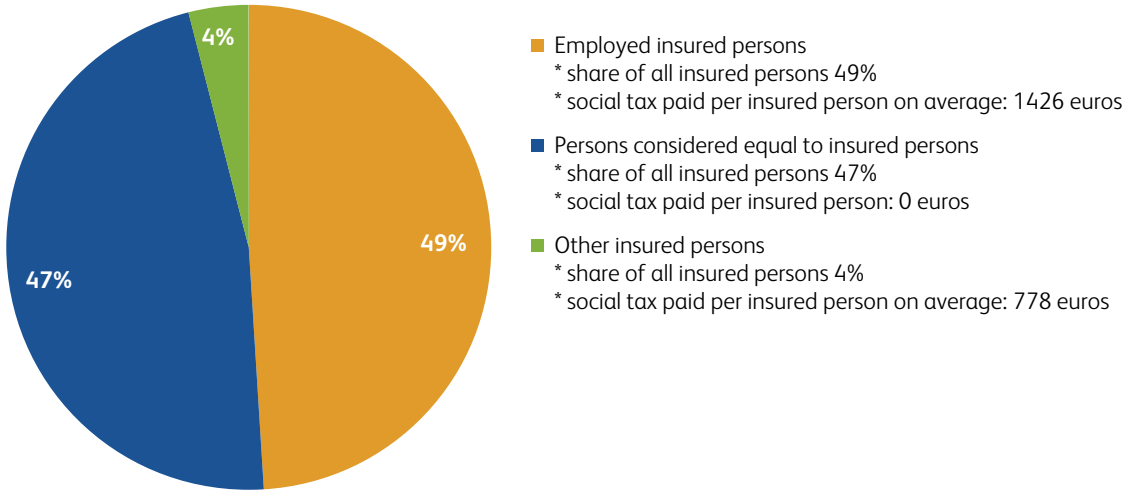


Figure 3. Breakdown of insured persons by category and social tax contribution

The increase in the total number of insured persons in 2014 was caused by the increase in employment and the positive effect of the launching of the employees' register on receiving health insurance information. When we analyse the share of insured persons by county (see Figure 4), we see that 99.9% of people in Hiiu County and 98% in Saare 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.

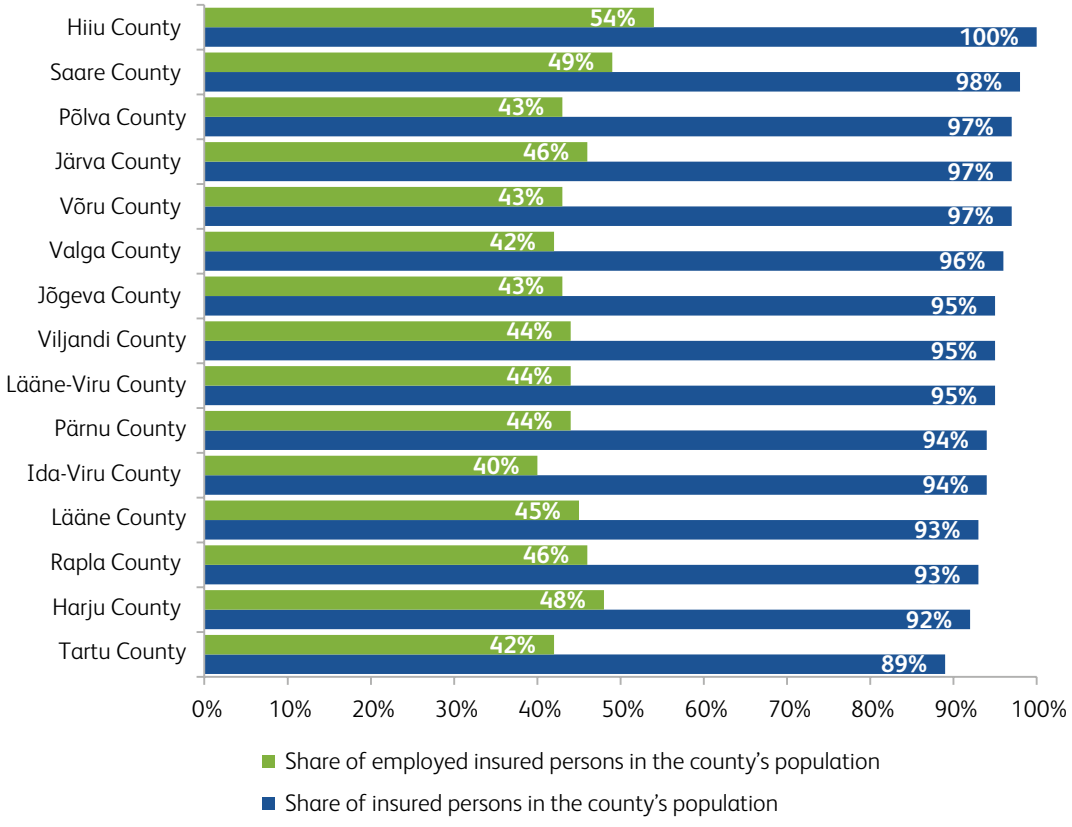


Figure 4. Share of insured persons and employed insured persons in the county's population

Revenues

An overview of the revenues of the EHIF in 2014 is given in Table 4.

Table 4. Revenue budget implementation in thousand euros

	2013 actual	2014 budget	2014 actual	Budget implementation
Health insurance component of social tax	829,699	897,394	893,759	100%
Revenue from contracts for persons considered equal to insured persons	1,138	1,500	1,195	80%
Recoveries from other persons	926	600	1,062	177%
Financial income	613	645	652	101%
Other income	4,516	3,293	3,541	108%
Total	**836,892**	**903,432**	**900,209**	**100%**

Health insurance component of social tax

Implementation of the revenue budget of the EHIF depends most on the revenue from the health insurance part of the social tax. In 2014, the revenue from the health insurance part of the social tax was 3.6 million euros lower compared to the budget, the budget was implemented in the extent of 99.6%. In the spring forecast of the Ministry of Finance, the forecast for the receipt of the health insurance part of the social tax was lowered by approximately 10 million euros compared to the approved budget (based on the economic forecast from the autumn of 2013).

95.9% of the social tax is paid by employers, the remaining 4.1% by the state for the unemployed and for recipients of social benefits (see Figure 5).

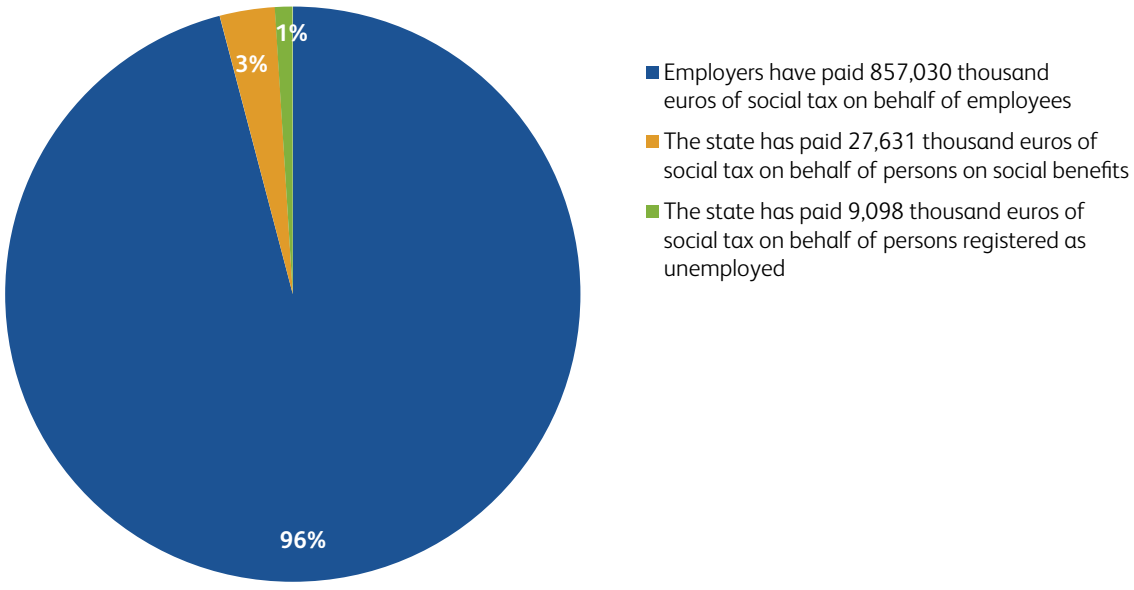


Figure 5. Breakdown of social tax revenues

An overview of the dynamics of revenues from the health insurance component of the social tax is given in Figure 6.

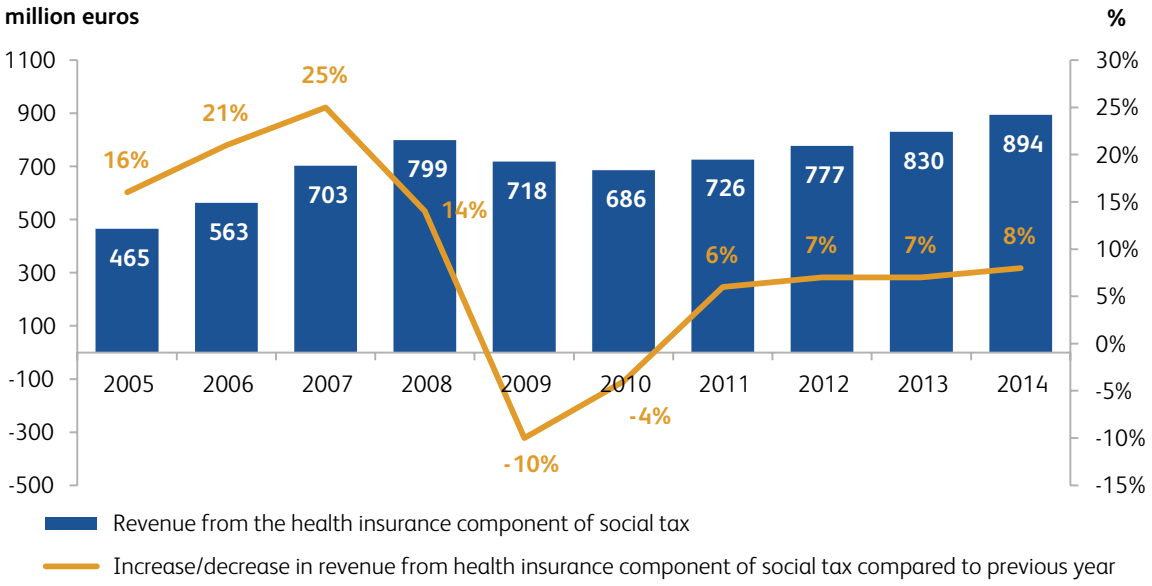


Figure 6. Increase and decrease in revenue from health insurance component of social tax from 2005–2014

Revenue from contracts with persons considered equal to insured persons

Revenue from contracts with persons considered equal to insured persons is revenue received on the basis of volunteer insurance agreements and the revenue from insuring the military pensioners of the Russian Federation living in Estonia.

Pursuant to §22 of the Health Insurance Act, and uninsured persons may insure themselves by entering into a contract with the EHIF and paying monthly insurance premiums, As at 31 December, there were 452 contracts with persons considered equal to insured persons, with the revenue in 2014 amounting to 628 thousand euros.

The revenue from insuring the non-working pensioners of the armed forces of the Russian Federation amounted to 567 thousand euros in 2014. Since 2012, the number of persons insured under international agreements has been decreasing, since the pensioners of the armed forces of Russia are using the right to apply for Estonian old-age pension granted to them in the end of 2011. As at 31 December, 445 persons were insured under international agreements.

Recoveries from other persons

Recoveries of health insurance benefits paid out to insurance companies as a result of traffic damage, recoveries for damage caused to the EHIF by groundless insurance entries filed to employers, claims submitted to health service providers, pharmacies, insured persons and other persons as a result of inspections are recognised as recoveries from other persons.

67 % of the implementation of the recoveries budget of 2014 is formed by benefits paid out to insurance companies as a result of traffic damage.

Since 2010, the EHIF has been comparing the insurance information of persons insured by employers, members of managing bodies and persons who have entered into contracts under the law of obligations in the health insurance database with the social tax declaration data of the Tax and Customs Board. On the basis of the data comparison, 7,700 entries of termination of insurance contracts were made in 2014. If the terminated insurance is the only valid insurance applying to the person (i.e. the no other valid insurances – as a person receiving pension for incapacity for work, as an employee or through another employer, etc. – apply to the person and the insured person has used health insurance benefits, a claim to recover the health insurance costs is filed to the employer. In 2014, claims were filed to employers in the amount of 55 thousand euros.

Financial income

The money of the EHIF has been kept in the 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.

Other income

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 to the competent authorities of other Member States. Other income also includes the revenue from processing invoices for health services and the foreign exchange gains related to operating income and health insurance expenses.

The EHIF received 1.5 million euros of income from government grants in 2014. 1.4 million euros was received 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 National Institute for Health Development allocated 28 thousand euros to the EHIF as cover for the expenses incurred within the scope of the national cancer prevention strategy. 6 thousand euros of targeted financing was received for operating expenses, for writing off study loans on the basis of a regulation of the Government of the Republic of Estonia.

The EHIF filed claims in the amount of 2 million euros to the competent authorities of other Member States in 2014 for the medical treatment provided to the insured persons of EU Member States in Estonia.

Health insurance expenses

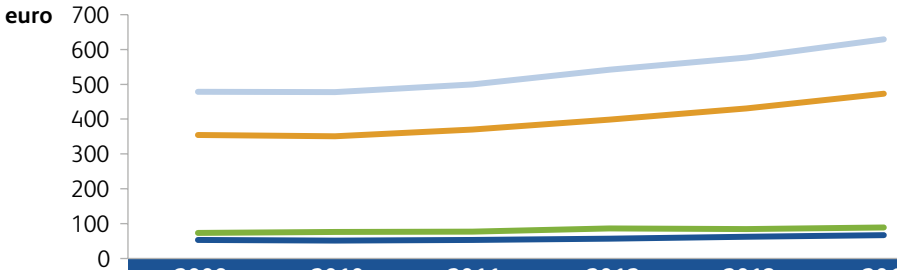
The overview of average health insurance expenses per each insured person is given in Table 5.

Table 5. Average expenses per insured person in 2014, euros

Age of insured persons	Number of insured persons as at 31.12.2014	Primary medical care	Other healthcare expenses*	Pharmaceuticals reimbursed to insured persons	Total expenses
0–9	161,844	69	265	24	358
10–19	111,006	52	304	25	381
20–29	150,708	53	287	36	376
30–39	159,533	55	328	51	434
40–49	156,522	58	328	64	450
50–59	164,361	74	480	112	666
60–69	151,060	76	693	168	937
70–79	111,821	90	967	214	1,271
80–89	57,914	86	1,043	187	1,316
90–99	7,900	77	928	111	1,116
100–...	150	72	1,118	57	1,247
Kokku	**1 232,819**	**67**	**473**	**89**	**629**

*Other healthcare expenses include specialised medical care, nursing care, dental care and monetary compensation of dental care.

The total average expenses per person increased by 150 euros in 2014 compared to 2009 (see Figure 7). By the age of insured persons, the average expenses have increased most in the age group of 70–79.



	2009	2010	2011	2012	2013	2014
Total expenses	479	478	500	542	577	629
Other healthcare services*	354	351	370	399	431	473
Pharmaceuticals	73	76	77	86	84	89
Primary medical care	53	51	53	57	62	67

*Other healthcare expenses include specialised medical care, nursing care, dental care and monetary compensation of dental care.

Figure 7. Average expenses per insured person 2009–2014, euros

1. Health services

The budget of health services in 2014 was 661.2 million euros. The budget was exceeded in nursing care and specialised medical care. The disease prevention, primary medical care and dental care budgets were under-implemented (see Table 6).

Table 6. Implementation of health services budget, thousand euros

	2013 actual	2014 budget	2014 actual	Budget implementation
Disease prevention	7,230	7,648	7,591	99%
Primary medical care	76,088	85,421	82,248	96%
Specialised medical care	481,561	522,934	529,044	101%
Nursing care	20,607	23,937	24,537	103%
Dental care	19,771	21,247	20,650	97%
Total	**605,257**	**661,187**	**664,070**	**100%**

Compared to the year before, financing of healthcare services increased by 59 million euros in 2014. Financing of specialised medical care increased by 47.5 million euros, financing of primary medical care by 6.2 million euros, financing of nursing care by 3.9 million euros, financing of disease prevention by 0.4 million euros and financing of dental care by 0.9 million euros compared to 2013.

Execution of the budget for healthcare services of 2014 was affected by the general increase in the prices of healthcare services as well as the need to ensure accessibility of healthcare services to insured persons. The EHIF organised proceedings for selection of additional partners in specialised medical care, nursing care and for disease prevention project in 2014. In order to ensure continuous care for the patients, agreements were reached for financing of the treatment in progress and treatment of the persons registered on waiting lists with the healthcare institutions with whom contracts were not entered into for the new period.

99% of the disease prevention budget was implemented. The largest part of the disease prevention budget is formed by financing of school health services. In case of school health services, the number of cases complied with the planned number, the budget for expenses was implemented 99%.

The under-implementation of the primary medical care budget is primarily related to the underuse of the Fee for Services Fun. Despite the lower-than-planned use of the resources designated for allowances for the second family nurse, the share of the lists with a second family nurse has increased compared to 2013 (from 23% to 27%, respectively). Some new types of allowances (e.g. the operations fund and remuneration of appointments outside working hours) were also under-implemented, but it did not have a significant effect on the execution of the budget. Implementation of the operations fund has decreased the load on the Fee for Services Fund for the active users. Appointments outside working hours have improved the accessibility of the family physician for insured persons in the evenings, which has been an expectation of the insured.

To ensure accessibility of services, specialised medical care was financed more than planned, the budget was implemented 101% in terms of the amount and 102% in terms of cases. Outpatient and day care were financed in larger amounts than planned in the budget. The budget for inpatient specialised medical care was under-implemented – more outpatient and day care were provided instead of inpatient care, which is a very positive trend. A selection competition for contractual partners was organised in specialised medical care in the beginning of 2014; the new contract periods with selected partners began on 1 April. Institutions with whom contracts were not entered into for the new period, received the total of 1.3 million euros of financing for treatment of the persons registered in the waiting lists. 42 thousand outpatient, thousand day care and approximately 7 thousand inpatient cases were filed as overtime – overtime was financed in the extent of 6.7 million euros.

In nursing care, the planned budget was exceeded due to the need to harmonise and improve the accessibility of the home nursing service by counties. The selection competition to find contractual partners organised in the first half of the year also had a significant impact on the implementation of the budget. Healthcare institutions with whom contracts were not entered into for the new period received 0.5 million euros of financing for treatment of the patients on the waiting lists.

In dental care, the number of the children whose dental care and/or prevention was financed by the EHIF in 2014 has increased by 1,100 children or 0.8% compared to the year before. The average cost of a case was less expensive than planned in the budget – the budget for expenses was implemented in the extent of 97%.

1.1 Disease prevention

Disease prevention is an important part of healthcare services, the objective of which is involving healthy people in medical examinations, population-based screening or preventive health activities in order to prevent or lower the frequency of preventable diseases and decrease the need for medical help.

Almost all healthcare workers in primary care, specialised medical care and nursing care are involved in disease prevention in the course of their regular daily work. The EHIF supports additional disease prevention through project-based work, in which involvement of a specific target group and coordinated management are important. We continue to prioritise programme-based continuation of evidence-based cancer screening, including launching of colorectal cancer screening, taking into consideration that the screening must be evidence-based, cost-effective and considering international experience and the organisation of healthcare in Estonia. In case of screenings and preventive services, we regularly evaluate the expedience of the project-based approach and the possibilities and reasons for integration of the activities in the regular system. For example, the project for perinatal diagnostics for hereditary diseases has been integrated into the healthcare system since 2014 and the new-born hearing screening, screening for phenylketonuria and hypothyroidism since 2015 and provision of the services continues by the general procedure (see Table 7).

Table 7. Implementation of the disease prevention budget in thousand euros and number of participants in projects

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of participants	Amount	Number of participants	Amount	Number of participants	Amount	Number of participants
School health	3,648	147,297	4,075	150,215	4,039	150,499	99%	100%
Youth reproductive health	973	32,345	1,061	34,000	1,049	31,871	99%	94%
Breast cancer screening	937	34,550	1,025	35,000	954	35,239	93%	101%
Cervical cancer screening	224	13,910	283	18,000	238	14,702	84%	82%
Phenylketonuria and hypothyroidism screening	191	13,632	204	14,500	192	13,559	94%	94%
New-born hearing screening	280	13,764	300	14,500	272	14,273	91%	98%
Health checks of young athletes	603	9,198	700	10,000	621	8,984	89%	90%
Other prevention	0	0	0	0	226	0	-	-
Perinatal diagnostics for hereditary diseases *	374	1,470	0	0	0	0	-	-
Total	**7,230**	**266,166**	**7,648**	**276,215**	**7,591**	**269,127**	**99%**	**97%**

**The activities of the perinatal diagnostics for hereditary diseases have been integrated into specialised medical care since 2014.

Disease prevention projects were finances in the amount of 7.6 million euros in 2014, the planned budget was implemented in the extent of 99.3%. The numbers of participants in the youth reproductive health development projects and health checks of young athletes, which are related to the age composition of the population (i.e. shrinking of the target group) were slightly lower than planned.

School health comprised the majority of the disease prevention budget, with the need assessed on the basis of the statistics on the number of pupils of the Ministry of Education and Research. The school health service was provided by 320 service providers

at 600 educational institutions in 2014. In addition to provision of preventive healthcare services, the importance of the role of the school nurse is evidenced by the number of pupils who visited the school nurse individually, which reached 40-65% of the total number of pupils in different areas.

At schools for students with special educational needs, services were provided to 2,300 pupils in 2014. Face-to-face and telephone counselling services are used most; another important duty of the school nurse at schools for students with special educational needs is providing assistance in taking various pharmaceuticals.

The short-term objectives of the project for youth reproductive health counselling and prevention of sexually transmitted infections were to achieve 20% of first-time approaches and 6% of approaches by young men. The percentage of first-time approaches formed 22% of all approaches this year. 41% of the total appointments with youth counselling workers were related to prevention of sexually transmitted diseases 41%, 39% by sexual counselling (including contraception) and 19% renewal of prescriptions. Additional activities are ongoing to increase the number of young men involved; currently, 16.7% of the first-time users of the youth counselling service are young men, forming 7.6% of the total number of users.

The volumes of the breast and cervical cancer screening projects are related to the longer-term objective to achieve the participation of at least 70% of the women invited in the breast and cervical cancer screenings, as, according to literature, evidence-based positive impact of the screenings on general mortality begins at this level.

The number of participants in the breast cancer screening project increased by 700 women in 2014 (a 2% change compared to the year before), the number of participants in the cervical cancer screening project increased by 800 women (a 6% change compared to the year before).

The communication of the screenings of 2014 was planned slightly differently than in previous years. We published press releases to increase general awareness and articles were published in larger daily newspapers about the importance of the screenings. Since involvement in the screenings was lower in bigger cities, we displayed posters with the birth years of those invited in outdoor media and, for the first time, used radio channels to spread information about the screenings. Based on the results of 9 months, we planned additional communication in the areas where participation in the screenings was lower.

Interest in participation in the breast cancer screening may also have been increased by the candid stories of famous people about their battle with breast cancer covered in the media.

The target group of the breast cancer screening project was the same as in the previous years (50–62 years of age). It has been proposed that the age group included in the breast cancer screening could be expanded, but an additional analysis must be performed before including the expected health benefit, accompanying expenses and the organisation of the screenings and the general quality of data must improve. From the 2nd quarter of 2015, the Estonian Cancer Screening Registry will be in charge of inviting women to the screenings. The expenses of the EHIF are primarily related to financing of the provision of the services, which is supported by the work to raise awareness and increasing the efficiency of the feedback to family physicians required to achieve involvement of the target groups. We continue to emphasise the role of family physicians in increasing the activity of the target group in participating in the screenings (see Figure 8).

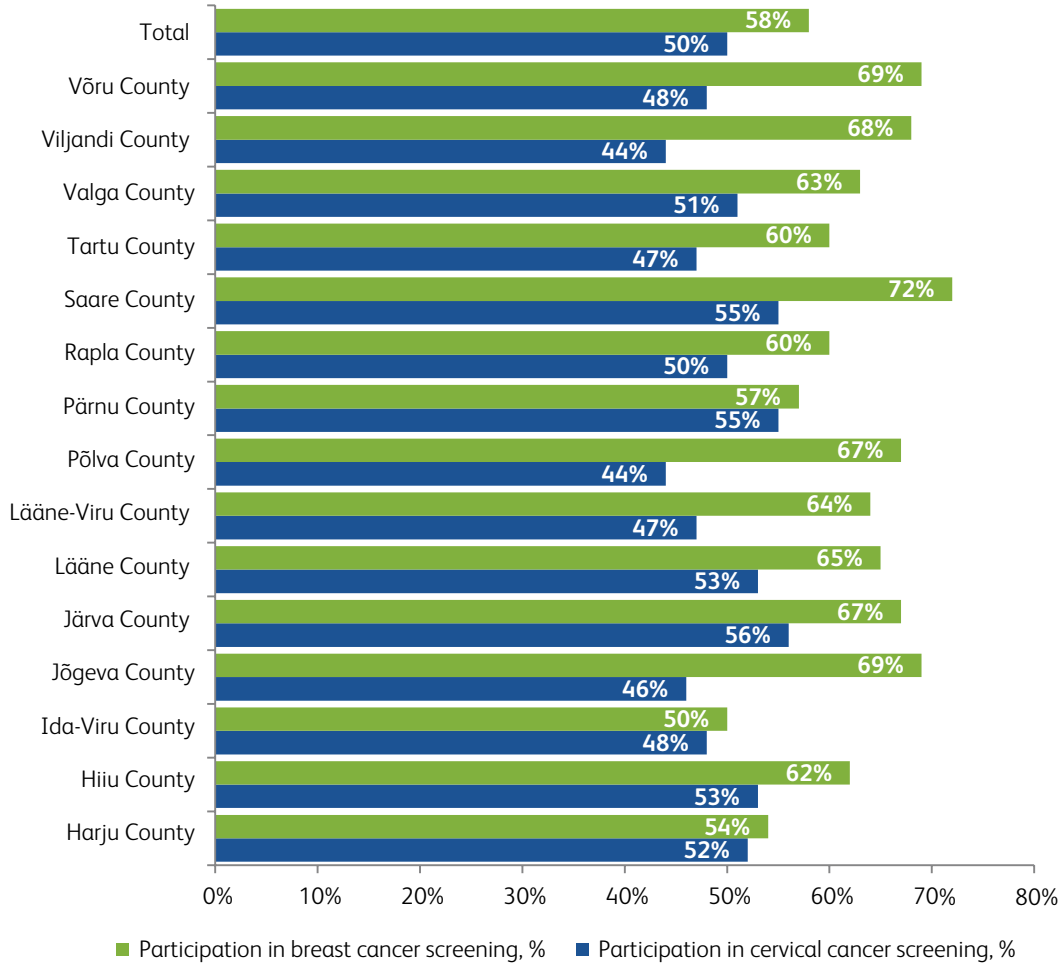


Figure 8 Participation in breast cancer and cervical cancer screening in 2014 based on the family physicians' lists by counties

The main aim of the project of screening new-borns for phenylketonuria and hypothyroidism is detection of metabolic diseases in new-borns at the earliest possible stage and thereby prevention of the brain damage and disabilities caused by late diagnosing. Another objective is to control the phenylalanine levels in the patients with phenylketonuria. The project involves 19 units providing healthcare services, including obstetrics departments and the neonatal and intensive care departments of children's hospitals. Two children with hypothyroidism and one child with phenylketonuria were diagnosed among the new-borns tested in 2014.

Throughout the years, the efficiency of the new-born hearing screening project has been evaluated on the basis of decreasing of the age of detecting hearing damage in children and beginning of habitation as early as possible. In 2014, hearing impairment was diagnosed in 36 children. Serious or very serious hearing impairment was diagnosed in eight children.

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. The activity has become more effective in targeting the young athletes in greater need of the health checks (intensity of practicing sport, age, previous health checks). It has been proposed that an age limit of 12-19 years of age should be applied to the project of health checks of young athletes (this restriction would be similar to the age limits applied to additional health checks in other European countries). A detailed need and impact analysis is required for the potential updating of the age limits. The purposefulness and long-term perspectives of the project must be evaluated in the coming years. Beginning of evaluation of the process and effectiveness of the project is planned for 2015.

Other prevention. The EHIF launched a cooperation project with the World Bank in 2014 to analyse the possibilities for development of the Estonian healthcare system („*Estonia – Toward Integrated Health Care*"). The analysis focussed on the approach to the patient of the primary level in 2014, including assessing following of the principles of integrated care (whether the service is provided on the correct level of the healthcare system and whether care is coordinated between different levels and continuous) in the whole healthcare system.

Preparations for colon cancer screening

In October 2014, the health technology assessment report *"Cost-efficiency of Colorectal Cancer Screening"* prepared on the proposal of the EHIF was completed. The report was prepared by the Department of Public Health of the University of Tartu within the framework of the programme TerVE for promotion of the capability of healthcare research supported by the EU. The report provided an evidence-based theoretical starting point for the planned screening.

Launching of the colorectal cancer screening in 2016 is a priority for the EHIF. According to the plans, the screening will be the first to be launched as a registry-based screening. Cooperation between all clinical parties (primary level, lab, specialists) in organising the patient's movement and the logistics of medical services is important. On the initiative of the EHIF, a multidisciplinary working group was called into being in 2014 with an aim to offer expert markets in the activities prepared for launching a population-based colorectal cancer screening. The main duties of the working group include practical steps which enable to plan the colorectal cancer screening programme with the primary level having the central role, connect the data acquisition of the colorectal cancer screening with a module added to the Cancer Screening Registry and provide an input for solving logistics-related issues.

1.2 Primary medical care

Implementation of allowance for appointments outside of working hours, introduction of the operations fund and complementation of the list of specialties referred to the e-consultation service were the biggest changes in primary medical care financing in 2014. 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.

Implementation of the budget for 2014 was most affected by the increase in maximum capitation fees in the component of salaries as well as the component of IT costs. The reference prices for the family physician's basic allowance also increased in 2014. As of the beginning of 2014, a separate operations fund is also financed for family physicians to motivate performing of manual operations by family physicians. Appointments outside of working hours were established as a new service.

Primary medical care received financing in the amount of 82.2 million euros in 2014. Compared to 2012, the budget grew mostly on the account of the use of the second family nurse allowance and the increase in capitation fee and basic allowance. The volume of financing of primary care was also significantly influenced by differentiation of the financing of primary healthcare in the form of the operations fund and appointments outside of working hours. The amount of performance pay has also increased, as an increasing number of family physicians have received positive results in the quality system (see Table 8).

Table 8. Implementation of primary medical care budget, thousand euros

	2013 actual	2014 budget	2014 actual	Budget implementation
Basic allowance	9,037	9,524	9,497	100%
Distance allowance	486	486	467	96%
Second family nurse allowance	1,830	3,539	2,994	85%
Total capitation fee	47,439	50,740	50,455	99%
Capitation fee for insured persons of up to 3 years of age	2,729	2,875	2,778	97%
Capitation fee for insured persons 3-6 years of age	3,082	3,306	3,289	99%
Capitation fee for insured persons 7-49 years of age	19,893	21,280	21,049	99%
Capitation fee for insured persons 50-69 years of age	12,741	13,693	13,746	100%
Capitation fee for insured persons over 70 years of age	8,994	9,586	9,593	100%
Fee for Services (FFS) Fund	15,336	18,082	16,419	91%
Operations fund	0	500	358	72%
Performance pay	1,246	1,367	1,389	102%
Allowance for appointments outside of working hours	0	431	137	32%
Advisory line	714	552	532	96%
Primary medical care reserve*	0	200	0	0%
Total	**76,088**	**85,421**	**82,248**	**96%**

*The funds for monitoring pregnancies and conducting autopsies are budgeted for under the primary medical care reserve, which are reported under the Fee for Services Fund in budget implementation.

Financing of primary care has become more differentiated: the largest part is still formed by capitation fee (61%), but its share in the total financing of primary care has decreased by 1% compared to 2013. The Fee for Services Fund forms 20% of the total budget and basic allowance 12%. The second family nurse allowance forms 4% of the primary care budget, which is 2% more than in 2013. The share of the quality bonus system (2%) has remained in the level of 2013. The advisory line of the family physician, 1220, and distance allowance form 1% of the general healthcare budget. The operations fund and the allowances for appointments outside of working hours were only introduced in 2014 and were still used modestly last year.

The total number of practice lists has tripled in 2014 and the number of insured persons in a list has decreased by 23 persons prelist, on average. The number of insured persons on practice lists for whom capitation fee was paid has decreased by 14 thousand persons for Estonia in total (see Table 9). There is the total of 467 general healthcare service providers. 26% of those are group practices with several practice lists and 74% are single lists.

The number of practice lists smaller than the reference size with less than 1,200 people in the serviced area, in the case of which the EHIF pays capitation fee for 1,200 persons, has remained the same as last year (19 practice lists). Additional capitation fee is paid for the total of 11,000 persons.

Basic allowance is the monthly allowance paid to family physicians in order to cover the rent of their premises, utilities and transport expenses. Basic allowance was paid to 56 practice lists at the coefficient of 1.5 to those family physicians, who had several places of appointments.

The 6% increase in capitation fee compared to 2013 arises from the increase in the reference price of the capitation fee in 2014 as a result of the salary agreement for medical professionals. The number of insured persons for whom capitation fee was paid has decreased by 1% compared to 2013.

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 7% compared to 2013. The average percentage of the fee for services fund of the capitation fee increased from 32% to 33% in 2014, but it must be kept in mind that the planned financial volume of the Fee for Services Fund significantly grew due to the increase in the maximum capitation fee. Implementation of the Fee for Services Fund remained on the level of 2013 in 2014 (average implementation 91%). Under-implementation of the Fee for Services Fund arises from the different practices of family physicians in prescribing tests to patients and may also depend on the age composition of a practice list as the need for tests may differ by different age groups. As at the end of the year, 7% contractual partners had exceeded the budget for the Fee for Services Fund, while implementation of the Fee for Services Fund remained under 80% in the case of 21% of contractual partners. 27 service providers filed invoices to the EHIF for working overtime within the Fee for Services Fund in 2014 in the total amount of 22 thousand euros.

The operations fund was implemented for family physicians from 2014. The objective of the operations fund is to help the operations that the family physician is able to perform remain on the primary level. Thus, the services that are being provided by family physicians themselves (services related to surgical manipulations and gynaecology) have been moved from the Fee for Services Fund to the operations fund. Thus, all family physicians who wish and have the required competence are able to perform surgical manipulations and genealogical procedures without being restricted by the financial volume of the Fee for Services Fund. The financing of the operations fund is service-based and thus the expenses of the operations fund also include the e-consultation service and the autopsies ordered by the family physician. In 2014, the highest number of operations fund services per practice list was used by the family physician in the area of Pärnu – both the volume of the services provided per practice list and the expenses of the operations fund were the highest in the area of Pärnu. The most-used services included bandaging of patients with burns and other surgical procedures.

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, since 2014, e-consultations are also offered in the specialities of pulmonology, rheumatology and otorhinolaryngology. The use of the e-consultation service in 2014 was considerably more modest than expected. The EHIF financed 990 e-consultations in total in the extent of 25 thousand euros. In 2014, more attention was paid to the development of e-consultation and involving Southern Estonian hospitals in providing the e-consultation service.

The total number of practice lists that receive the distance allowance is 186, of which 129 are located 20–40 km from the nearest hospital and 57 are further than 40 km from the nearest hospital. The number of distance allowance recipients decreased by four lists compared to the same period the year before.

Implementation of the second family nurse services during family physician appointments proved to be considerably more successful than expected in 2013. Therefore, continuation of the growth in 2014 was planned, however, the grown remained slower that the forecasts. It is important for the EHIF that the number of the practice lists that have found the second family nurse for better serving of the list would continue to grow. According to the feedback from family physicians, the greatest obstacle in the way of applying for the second family nurse allowance is failure to meet the requirements for the premises.

Table 9. Number of practice lists of family physicians and number of insured persons on the lists and number of appointments outside of working hou

	2013 actual	2014 actual	Change compared to 2013
Number of practice lists			
Number of practice lists	801	804	0%
Number of lists receiving distance allowance	190	186	-2%
Number of lists receiving second family nurse allowance	182	236	30%
Average size of practice lists (number of insured persons)	1,563	1,540	-1%
Number of persons			
Total number of persons for whom capitation fee was paid	1,251,810	1,237,832	-1%
insured persons under 3 years of age (maximum capitation fee 5.53 euros/month)	41,849	39,639	-5%
insured persons 3-6 years of age (maximum capitation fee 4.14 euros/month)	63,092	62,726	-1%
insured persons 7-49 years of age (maximum capitation fee 2.57 euros/month)	656,113	644,886	-2%
insured persons 50-69 years of age (maximum capitation fee 3.47 euros/month)	310,961	312,133	0%
insured persons over 70 years of age (maximum capitation fee 4.24 euros/month)	179,795	178,448	-1%
Number of appointments outside of working hours			
Family physician's appointments outside of working hours	0	4,462	-
Family nurse's appointments outside of working hours	0	4,960	-
Number of calls to the advisory line			
Number of calls	236,674	246,526	4%

The number of participants in the quality bonus system (QBS) has increased constantly since 2007, however, in recent years, the participation rate has remained at the same level (97%). The results of the quality bonus system are summarised once a year, based on the activities of the year before. In 2014, based on the performance in 2013, the maximum performance pay for successful disease prevention and chronic disease monitoring was paid to 435 family physicians, 147 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 2006-2013 are given in Figure 9.

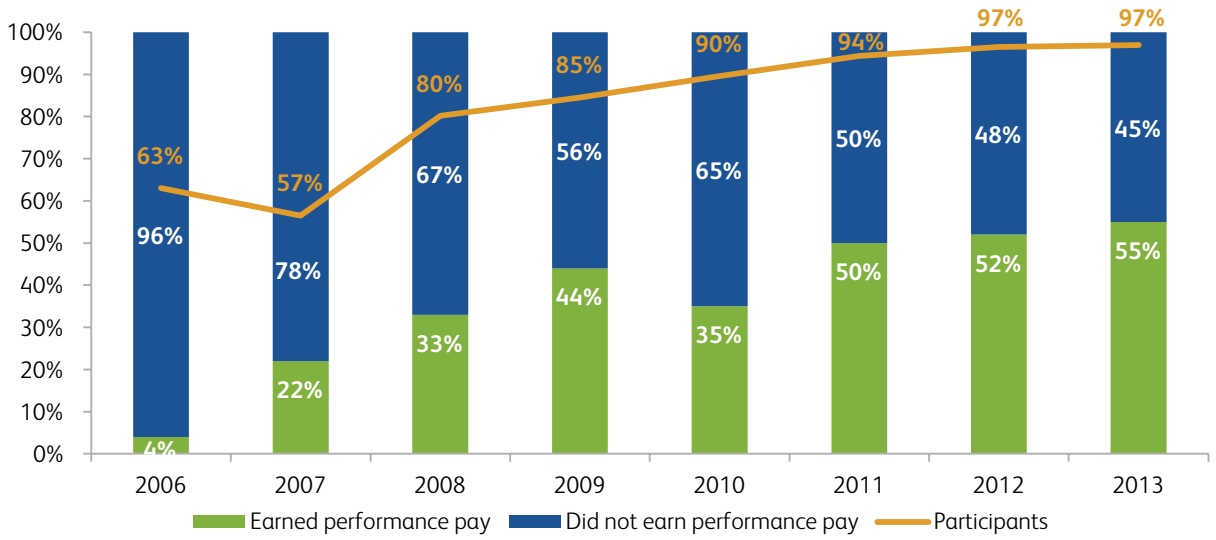


Figure 9. Shares of practice lists that participated in quality system and earned performance pay from 2006-2013

Appointments outside of working hours were introduced from 2014. The satisfaction survey of the population commissioned by the EHIF has revealed that there is expectation from the people to be able to see a physician in the evening as well. Thus, new services were added to the list of services provided by the Estonian Health Insurance Fund in 2014, which enable to pay remuneration to the family physician and family nurse for appointments outside of the working hours. Even though the service was used less than forecasted in 2014, introduction of the new service is one of the ways for improving the accessibility of primary care. In 2014, the option of appointments outside of working hours was used by the family physicians and nurses in Harju (in 23 practice lists) and Viru (in 8 practice lists) areas. Physicians have received allowance for appointments outside of working hours in 31 practice lists and nurses in 30 practice lists. The EHIF plans to implement measures to increase awareness of the possibilities of receiving allowance for appointments outside of working time in 2015.

The number of appointments in primary medical care has increased compared to the figures of 2013. Based on the information received by the EHIF, a growth trend can be observed in the number of family nurse's appointments, with introduction of the second family nurse allowance in 2013 certainly one of the reasons. The number of family physician's appointments has also increased compared to 2013. The percentage of the insured who visit the family physician has ranged from 75% - 80% in recent years (see Table 10).

Table 10. Number of family physician and family nurse appointments from 2008-2014

	2008	2009	2010	2011	2012	2013*	2014
Appointments with family physicians	4,368,668	4,182,361	3,994,334	4,411,214	4,523,318	4,425,781	4,472,867
Appointments with family nurses	370,853	418,305	480,269	535,240	592,690	892,307	1,077,126
Prophylactic appointments	450,309	387,782	394,360	363,182	326,747	301,812	297,241
Total appointments	**5,189,830**	**4,988,448**	**4,868,963**	**5,309,636**	**5,442,755**	**5,619,900**	**5,847,234**
Number of persons who had appointments	983,466	973,129	957,090	981,575	973,882	986,213	987,635
Number of persons on practice lists	1,286,597	1,280,795	1,271,082	1,255,971	1,247,223	1,251,810	1,237,832
Share of persons who had appointments with family physicians among persons on practice lists	76%	76%	75%	78%	78%	79%	80%

*The data have been adjusted in comparison with the report for 2013.

Implementation of the budget for the advisory line of the family physician 1220 decreased by 25% in 2014 compared to 2013, which was caused by the fact that in 2013 both the reference price of the calls to the advisory line as well as the monthly fee for 24-hour preparedness were adjusted according to the actual data. The 4% increase in the number of calls in 2014 compared to 2013 may be considered a positive trend. The number of calls grew steeply in the beginning of the year as a result of a campaign organised in the first quarter with an objective to increase the awareness of the population of the possibilities of primary healthcare, including the advisory line of the family physician, as well as the seasonal increased occurrence of viral diseases. Figure 10 highlights the amount of the service provided in 2014 by months.

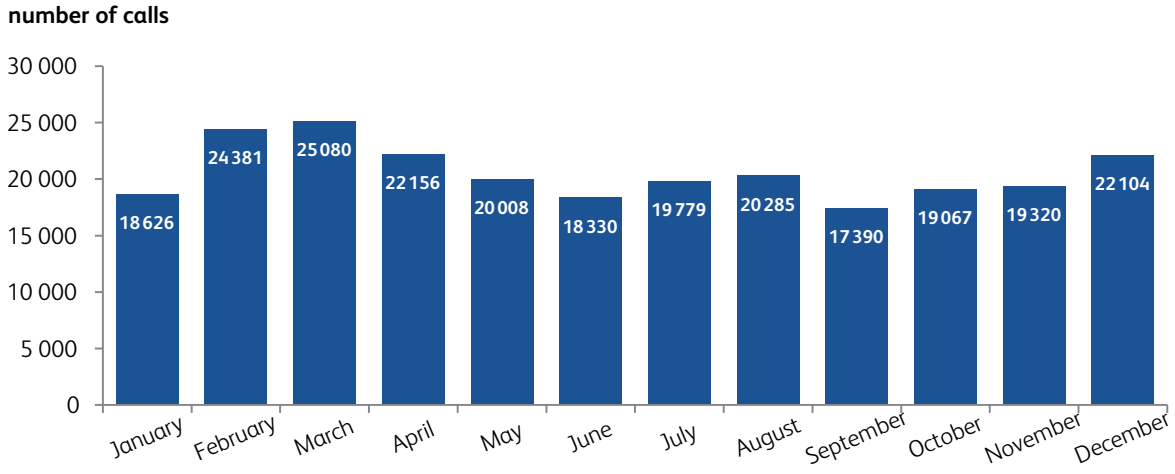


Figure 10. Number of calls to the advisory line by months in 2014

The percentage of lost calls decreased in 2014 (4% in 2013 and 3.4% in 2014) and the waiting times of the calls became shorter. The accessibility of the advisory line 1220 service improved thanks to the new software for servicing calls, Solidus, introduced in the last quarter of 2014, which ensured qualitative growth and flexibility in managing queues.

Accessibility of primary medical care

The EHIF regularly inspects the accessibility of primary care pursuant to the family physician's job description, according to which a patient with an acute health problem must be able to get an appointment with the family physician on the day of turning to the physician and all other patients within five working days. Another purpose of the inspections is to assess whether the family physicians grant the patients access to primary care pursuant to legislation and the terms and conditions of the contract entered into with the EHIF. The EHIF inspected 272 practice lists in 2014.

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 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. All patients with acute health problems were able to get appointments with their family physician on the day they contacted the doctor. Patients with non-acute health problems were able to get an appointment with the family physician within five working days in 99% of the inspected cases. 92% of the patients were able to get an appointment within three working days. Thus, it can be said that the accessibility of primary care was on the same level as in the year before. In general, the accessibility of primary care in Estonia is very good.

The organisation of work was very good in 16% of the inspected practice lists, mostly good in 70% of the lists, satisfactory in 12% of the lists and dissatisfactory in 2% of the lists (5 inspected practice lists). In case of observing deficiencies, the need to eliminate the deficiencies was recorded. Most of the deficiencies could be eliminated during the visit. A follow-up inspection by the EHIF was deemed necessary in case of 22 practice lists.

1.3 Specialised medical care

In the specialised medical care budget, an increase in financing in the amount of 41 million euros as planned compared to the same period last year. Regarding the number of cases, the objective of the budget was to keep the accessibility of healthcare services at least at the level of 2013, an increase by 33 thousand cases was planned in the budget. The budget was planned taking into account the changes in the list of healthcare services that entered into force on 01.01.2014, including the salary increase resulting from the collective agreement entered into between professional associations of healthcare workers and the Estonian Hospitals Association in 2012 and the administration and other expenses increased as a result of an application by the Estonian Hospitals Association.

In terms of the amount, the budget was implemented 101%, and in terms of cases 102%. Compared to the year before, financing of specialised medical care increased by 47 million euros, while the number of cases financed was lower by 88 thousand cases than in the year before (see Table 11).

Table 11. Implementation of specialised medical care budget in thousand euros and cases by type of care

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Total specialised medical care	**466,739**	**3,182,139**	**512,654**	**3,216,846**	**518,764**	**3,272,491**	**101%**	**102%**
Total outpatient care	162,975	2,882,795	183,737	2,921,659	188,659	2,971,371	103%	102%
Total day care	30,878	67,740	31,748	66,839	34,600	71,912	109%	108%
Total inpatient care	272,886	231,604	297,169	228,348	295,505	229,208	99%	100%
Preparedness fee	**9,694**	**380**	**10,280**	**380**	**10,280**	**380**	**100%**	**100%**
Centrally contracted health services*	**5,128**	**1,921**	**0**	**0**	**0**	**0**	**-**	**-**
Total	**481,561**	**3,184,440**	**522,934**	**3,217,226**	**529,044**	**3,272,871**	**101%**	**102%**

*Since 2014, the services financed through centrally contracted health services before are not processed separately, but are financed through the specialties of specialised medical care.

The outpatient care budget was prepared taking into consideration partial movement of day care services under outpatient care and the more complex approach to cases in outpatient care than the approach used so far. Therefore, potential higher prices of outpatient care cases were planned in the budget. In practice, the prices of outpatient cases increased faster than expected. Compared to the year before, above all, the number of laboratory tests, tests and procedures, pharmaceuticals and blood products has increased. The number of outpatient appointments per case has increased by 2%, while 2.4% invoices for outpatient care were submitted per person than in the year before. The number of insured persons who used outpatient specialised care increased by 0.6% compared to the year before.

The day care budget was planned on the assumption that some day care cases would be transferred under outpatient care, while most of the cases of health services that had been centrally controlled so far would be added to day care. For the average cost of a case, the centrally contracted services to be added were taken into account (more expensive cases than the average). The budget was prepared on the presumption that the number of day care cases would not grow – in practice, the number of day care cases increased in all main specialties and the average growth compared to the year before was 6%. The average cost of a case was a bit higher than planned in the budget.

The number of inpatient care cases was planned presuming that the rapid decline of recent years would slow down. In terms of cases, the budget was implemented 100%, but the average cost of a case was lower than planned. Under-implementation of the inpatient care budget was influenced most by the lower-than-planned use of inpatient healthcare services in oncology – the

movement between different types of treatment was faster than forecasted in oncology, more invoices were filed for outpatient care and day care instead of inpatient care.

The volume inflation of specialised medical care cases (the change in the use of services provided in the course of one case, which is evaluated in comparable prices) was 0.3% in specialised medical care in total, including 2.5% in outpatient care, 2.6% in day care and 2.4% in outpatient care. In addition to movement between types of treatment, the figure of volume inflation is also affected by the number of cases submitted per one person who received treatment. The number of treatment invoices submitted per one treated person in specialised medical care in 2014 was 2.3% higher than in the previous period.

In order to ensure accessibility, the volume of the contracts entered into in the beginning of the year was increased, among other instances, the Management Board of the EHIF decided to increase the volume of outpatient specialised care contracts in Harju County by the total of 640 thousand euros and 14 thousand cases in the second half of the year. The volumes of the contracts were increased on the basis of the use of the service by insured persons by counties in the first six months, failure of the partners' waiting times to conform to the promised level and the capability of healthcare institutions. Due to increased need, haemodialysis contracts were also increased in the extent of 342 thousand euros (134 cases) in the second half of the year.

Taking over of the obligation to pay for services provided in excess of the provided volume. As of 2014, the EHIF pays to selected partners on the same principles as to hospitals in the list of hospitals of the Hospital Network Development Plan (HNDP. The obligation to pay for services provided in excess of the provided volume is taken over twice a year instead of once a year as before. The coefficient of payment in outpatient care and day care has increased – in case of an amount that does not exceed 5% of the total financial amount of a contract, the coefficient of 0.7 is used instead of the coefficient of 0.3 used so far to pay for the treatment invoices for services provided in excess of the provided volume.

The percentage of healthcare services provided in excess of the provided volume and remunerated by applying a coefficient formed 2% of the specialised medical care cases finances in 2014 and 1% of the amount. 50 thousand cases were paid at the coefficient in the total amount of 6.7 million euros. In outpatient care, 3.0 million euros was paid for 42 thousand cases provided as services provided in excess of the provided volume, 400 thousand euros for over a thousand cases in day care and 3.4 million euros for 7 thousand cases in inpatient care. The HNDP hospitals submitted invoices for services provided in excess of the provided volume for 6.5 million euros, selected partners for 0.2 million euros.

Selection competition for contractual partners. On 31.03.2014, the contracts entered into in specialised medical care with additional partners in addition to the HNDP hospitals ended. Therefore, the EHIF organised a new selection competition and the new contract period with the selected partners began on 01.04.2014. Agreements were reached with the healthcare institutions with whom new contracts were not concluded for the specific speciality and location of providing the service regarding financing of unfinished treatment and treatment of the persons registered in the waiting lists. 1.3 million euros was paid for 12 thousand cases based on agreements entered into for buying up cases in 2014.

Accessibility of specialised medical care

Healthcare institutions regularly submit information to the EHIF regarding the waiting times for specialised medical care, nursing care and dental care. The HNDP hospitals submit monthly overviews of the actual waiting times for scheduled outpatient appointments with specialists in the previous month (retroactive report on the waiting times) and a prospective report on the waiting times – the number of appointments in the waiting lists for specialised medical care, nursing care and dental care as at on the 1st day of the month and the waiting time for an available appointment. The selected partners submit a prospective report on the waiting times once per quarter. The waiting times are also checked by making visits to healthcare institutions and based on individual cases – in 2014, the partners of the EHIF checked the waiting times by making 170 visits to 160 healthcare institutions. Larger healthcare institutions were inspected several times in a year, including organising an inspection of long waiting times in central and regional hospitals in May/June and November/December. The summaries of these inspections are published on the website of the EHIF:

- Inspection of long waiting times in May and June 2014[3];
- Mapping of the situation of accessibility in November and December 2014.

Based on the waiting time reports submitted to the EHIF, there is the total of 181 thousand appointments registered on the waiting lists for specialised medical care as at 01.01.2015 (see Table 12).

Table 12. Appointments registered in waiting lists for specialised medical care

	01.01.2014		01.01.2015		Change compared to 2014
	Number of appointments in waiting lists	Within the maximum permitted waiting time	Number of appointments in waiting lists	Within the maximum permitted waiting time	Number of appointments in waiting lists
Outpatient care	142,922	50%	157,801	49%	14,879
Day care	4,936	98%	7,319	91%	2,383
Inpatient care	12,147	90%	15,977	89%	3,830
Total	**160,005**	**54%**	**181,097**	**54%**	**21,092**

Compared to the same period the year before, the number of appointments registered in the waiting lists has increased by 21 thousand appointments (including 15 thousand appointments in outpatient care). The number of appointments within the maximum permitted waiting times[4] has increased by 12 thousand (including 7 thousand appointments in outpatient care). The increase in the number of appointments registered in the waiting times mainly arises from improvement of the systems for organising the waiting lists and extension of the open period of waiting lists. There has been no significant change in the waiting times compared to the same period last year.

The waiting times for scheduled treatment to physicians of the same specialties differ by healthcare institutions. Insured persons have the right to turn to any healthcare institution of their choice irrespective of their place of residence, insurance region or the name of the medical institution/physician written on the referral.

The number of appointments registered in the waiting lists of the HNDP hospitals has increased by 17% or 20 thousand. The number of appointments registered in the waiting lists of the selected partners has increased by 3% or one thousand appointments. The number of appointments in the waiting lists primarily grew in the case of the HNDP hospitals – in case of outpatient, inpatient and day care. The waiting times of selected partners are generally shorter, yet, insured persons mainly wish to find solutions to their health problems at the HNDP hospitals.

3 https://www.haigekassa.ee/et/inimesele/arsti-ja-oendusabi/ravijarjekorrad

4 Ambulatoorses ravis on ravijärjekorra lubatud maksimumpikkus 6 nädalat, päevaravis ja statsionaarses ravis üldjuhul 8 kuud.

45% of the appointments registered in the waiting lists of the HNDP hospitals and 85% of the appointments in the waiting lists of the selected partners generally remain within the maximum permitted time. The decrease in the percentage of appointments in the waiting lists within the maximum permitted time compared to the same period the year before is mainly caused by an increase in the number of appointments registered in the waiting lists of the HNDP hospitals.

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. The HNDP hospitals also submit a retroactive report on the waiting times for outpatient specialised medical care since 2013 – information on the actual waiting times for initial scheduled outpatient appointments in the month before.

Table 13. Actual waiting time for specialised outpatient care appointments in HNDP hospitals in the period from 01.10–31.12.2014

	Q4 2013		Q4 2014		Change compared to 2013
	Number of appointments	Within the maximum permitted waiting time	Number of appointments	Within the maximum permitted waiting time	Number of appointments
Total regional hospitals	79,585	65%	82,825	63%	3,240
Total central hospitals	118,911	72%	120,889	71%	1,978
Total general hospitals	64,797	89%	70,195	88%	5,398
Total	**263,293**	**74%**	**273,909**	**73%**	**10,616**

In Q4 2014, 73% of the initial scheduled outpatient specialised medical care appointments occurred within the maximum permitted waiting time (up to 42 calendar days). Compared to the same period the year before, the number of initial scheduled appointments has increased by 11 thousand appointments, while the number of appointments occurring within the maximum permitted waiting time has increased by 4 thousand appointments (see Table 13).

The differences between the percentages of the outpatient care appointments within the maximum permitted waiting time in the waiting lists of the HNDP hospitals (37%) and the actual data (73%) is caused by the appointments with very short waiting times that are not recognised in reports submitted as at the first day of the month. The data from different reports correlate, though, and indicate similar problems.

By healthcare institutions, the percentage of appointments with longer than the permitted waiting times is, according to the prospective as well as retrospective reports, the highest in regional hospitals – the North Estonia Medical Centre, the Tallinn Children's Hospital and the Tartu University Hospital. The percentage of the appointments with longer than the maximum permitted waiting times is also high in central hospitals – the East-Tallinn Central Hospital, the Ida-Viru Central Hospital, the West-Tallinn Central Hospital, the Pärnu Hospital – especially in case of the specialties in the case of which the central hospital is performing the functions of a regional hospital as well and no referrals are required (e.g. ophthalmology at the East-Tallinn Central Hospital). In general hospitals, the waiting times generally remain within the maximum permitted time. The waiting times in general hospitals are longer in case of a few narrower specialties, in case of which there is no full time specialist employed at the healthcare institution and the patients are seen two or three times per month by the specialists from regional or central hospitals.

By specialties grouped based on the structure for planning the budget of the EHIF, the waiting times in the HNDP hospitals are the longest for ophthalmology (see Figure 11). In spite of increased funding, the waiting time for this specialty at the HNDP hospitals are long, the demand exceeds the capability of the healthcare institutions to provide the service. Patients do not need the family physician's referral to see an ophthalmologist, establishing the requirement for a referral may help to shorten the waiting times. The accessibility of treatment in the main specialties is evaluated in the subsection "Budget implementation

and cases by specialties" of this chapter. A more detailed overview of the accessibility of healthcare services is published on the website of the EHIF.

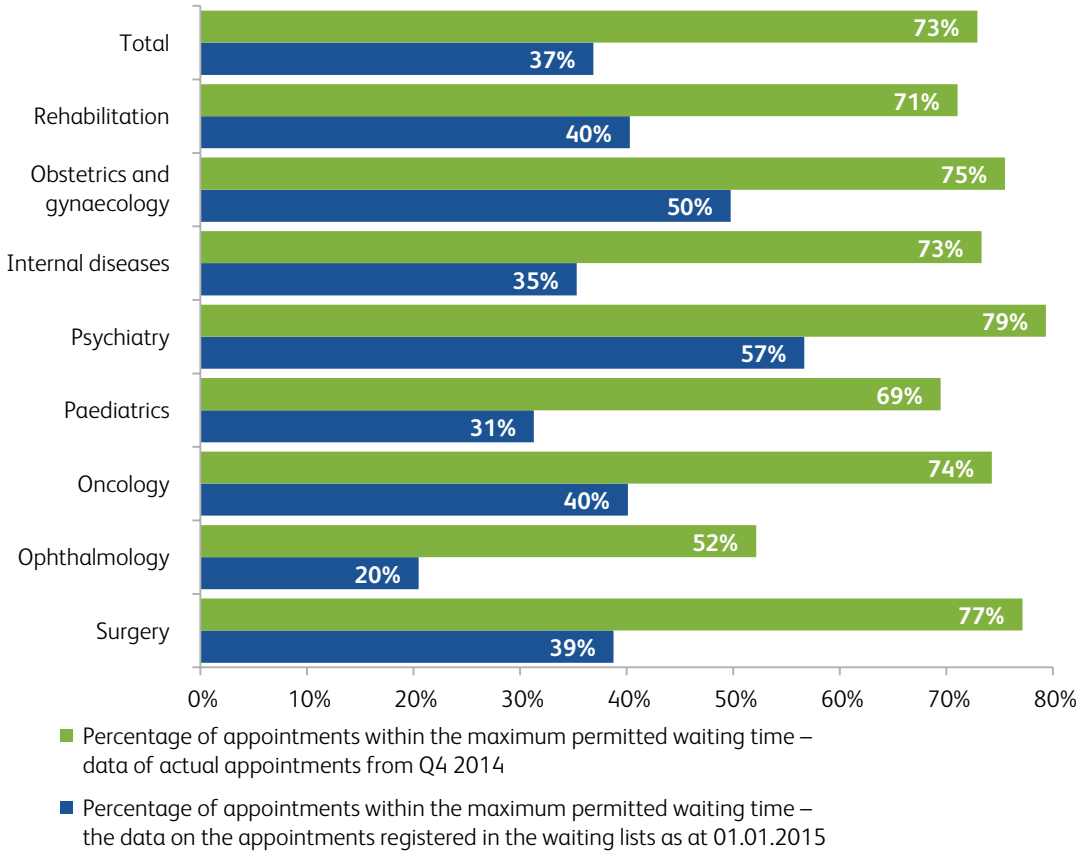


Figure 11. Waiting times for outpatient specialised medical care and the actual waiting times for appointments in the HNDP hospitals

The waiting time for an outpatient specialised medical care appointment are mainly long in the hospitals in Tallinn and Tartu. The patients' desire to receive treatment in central or regional hospitals exceeds the possibilities of the hospitals to provide outpatient appointments. The key issues in improving accessibility are increasing the role of the primary level and improving the cooperation between family physicians and specialists. In many cases, it is not necessary to see a specialist – regional and central hospitals have repeatedly pointed out that due to the lack of adequate selection of patients, a large share of the outpatient appointments in specialised medical care are basically primary level work. Family physicians have highlighted the problem that no cooperation scheme with specialist has developed in Estonian healthcare, which would ensure consistent logistics of patients.

The level of contacting family physicians differs by counties – the insured in Harju County visit family physicians the least, the insured in Viljandi County the most (see Figure 12). The use of healthcare services depends on the age distribution of the population of the county (e.g. the percentage of the elderly remains below the average in Harju County), the accessibility of specialised medical care (in addition to the waiting time, the distance between the patient's place of residence and the healthcare institution) and several other factors. According to a general assessment, higher use of the family physician's services decreases the need for specialised medical care.

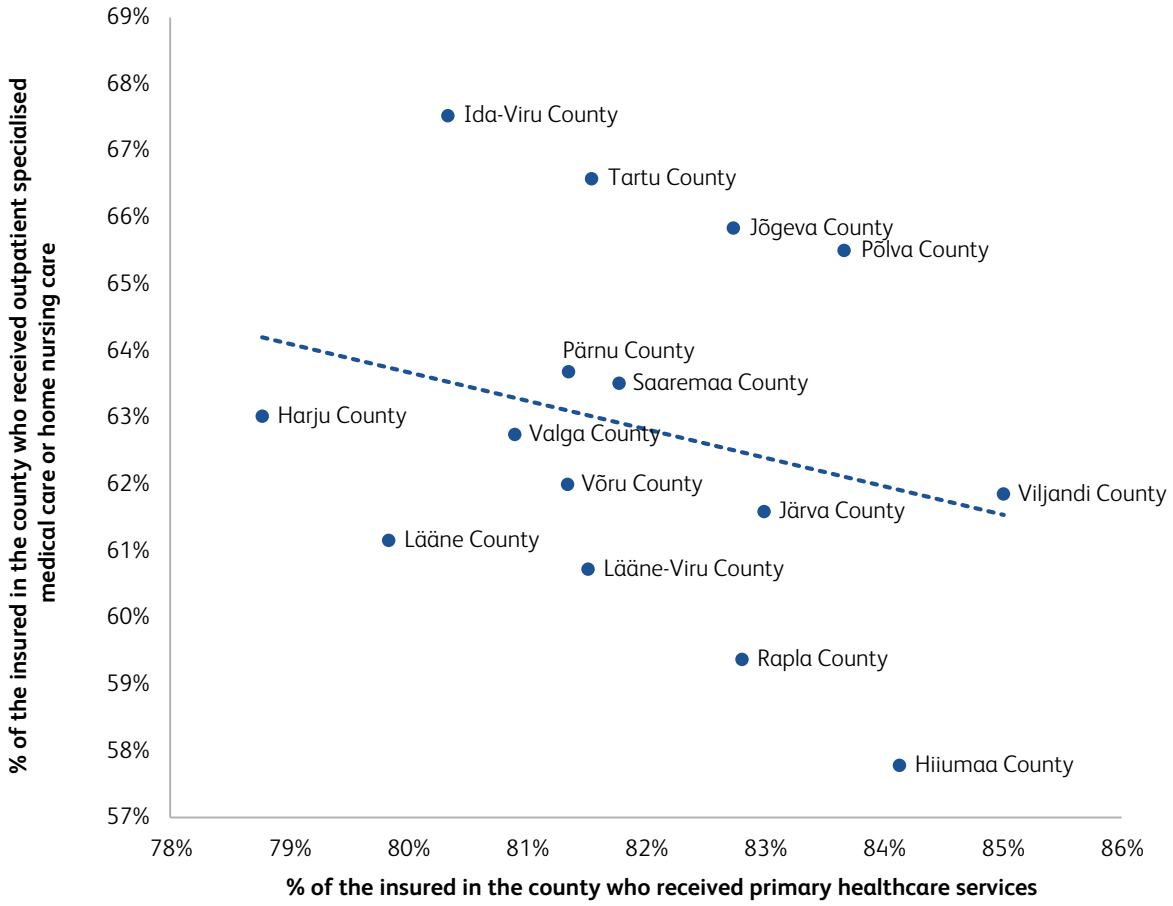


Figure 12. Use of primary healthcare and outpatient specialised medical care and nursing care in 2014

It is reasonable to start solving a health problem with the family physician – the family physician and family nurse together can solve most health problems. The accessibility of primary care is very good and family physicians are mostly able to grant the patient an appointment within the prescribed period of time (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 must get an appointment within five working days).

Key indicators of specialised medical care

An overview of the key indicators of specialised medical care in 2014, including a comparison with the year before, is given in Table 13.

Table 14. Key indicators of the use of specialised medical care from 2011–2014

					Change		
	2011 actual	2012 actual	2013 actual	2014 actual	2012/ 2011	2013/ 2012	2014/ 2013
Average cost per case in euros	123	138	147	158	12%	7%	7%
in outpatient care	45	52	57	63	16%	10%	11%
in day care	371	435	456	481	17%	5%	5%
in inpatient care	1,008	1,124	1,178	1,289	12%	5%	9%
Volume inflation (%)	2.4	3.1	1.8	0.3	1%	-1%	-2%
Number of inpatient days	1,436,100	1,412,328	1,385,260	1,356,592	-2%	-2%	-2%
Average length of inpatient stay (days)	6.0	6.1	6.0	5.9	2%	-2%	-2%
Number of outpatient appointments	3,801,950	3,785,111	3,796,893	3,888,729	0%	0%	2%
in outpatient care	3,732,239	3,714,476	3,724,438	3,811,137	0%	0%	2%
in day care	69,711	70,635	72,455	77,592	1%	3%	7%
Outpatient appointments per case	1.28	1.29	1.29	1.31	1%	0%	2%
in outpatient care	1.29	1.30	1.29	1.31	1%	-1%	2%
in day care	1.07	1.09	1.07	1.21	2%	-2%	13%
Number of persons who used specialised medical care services	807,875	795,581	796,698	800,326	-2%	0%	0%
in outpatient care	786,099	774,661	775,566	780,302	-1%	0%	1%
in day care	52,230	51,549	52,554	54,870	-1%	2%	4%
in inpatient care	161,550	155,653	155,982	153,032	-4%	0%	-2%
Number of cases per person	3.97	3.97	3.99	4.08	0%	1%	2%
in outpatient care	3.69	3.70	3.72	3.81	0%	1%	2%
in day care	1.24	1.26	1.29	1.31	2%	2%	2%
in inpatient care	1.48	1.49	1.48	1.50	1%	-1%	1%
Number of cases per insured person	2.57	2.56	2.58	2.65	0%	1%	3%
in outpatient care	2.33	2.32	2.34	2.41	0%	1%	3%
in day care	0.05	0.05	0.06	0.06	0%	20%	0%
in inpatient care	0.19	0.19	0.19	0.19	0%	0%	0%
Emergency care as a percentage of medical expenses (%)							
ambulatoorne	18	17	17	17	-1%	0%	0%
in day care	7	8	8	9	1%	0%	1%
in inpatient care	64	66	64	63	2%	-2%	-1%
Emergency care as a percentage of cases (%)							
ambulatoorne	17	17	17	17	0%	0%	0%
in day care	9	10	10	11	1%	0%	1%
in inpatient care	62	64	63	61	2%	-1%	-2%
number of surgeries	163,718	154,969	155,289	157,691	-5%	0%	2%
in outpatient care	19,808	18,345	17,719	18,459	-7%	-3%	4%
in day care	52,507	50,479	51,609	53,926	-4%	2%	4%
in inpatient care	91,403	86,145	85,961	85,306	-6%	0%	-1%

There was no significant change in the number of insured persons in the course of 2014 – in the beginning of the year, 1,231,203 persons were insured by the EHIF, at the end of the year, 1,232,819 persons (a change of 0.1%). The number of persons who used specialised medical care increased by 0.5% in 2014 with 2.3% more treatment invoices submitted by one person who received treatment compared to the year before. Based on the above, it can be claimed that the use of specialised medical care by the insured has slightly increased.

The average cost of a case has increased in all types of treatment. The list of healthcare services that entered into force on 1 January, 2014, included a general price increase resulting from the salary agreement of medical professionals, among other things. In addition to the price increase, the average cost of a case has increased due to the volume inflation of cases (a change in the structure of the services included in one treatment invoice compared to the same period in the year before). The total volume inflation in specialised medical care was 0.3% in 2014.

In outpatient care, the number of persons who received treatment (1%), the number of outpatient appointments (2%) and the number of treatment invoices submitted per person (2%) all increased compared to the year before. The number of outpatient appointments is growing slower than the number of persons who received treatment – there are more insured persons in the case of whom the number of specialist's appointments is lower than the average (e.g. one specialist's appointment, in the emergency department, etc.).

In inpatient care, similarly with the trend of recent years, both the number of persons who received treatment and the average number of days in inpatient care have decreased. The average cost of a case in increasing as a result of the increase in the prices of healthcare services and due to the fact that treatment of less serious conditions is being moved to outpatient care and day care. In addition to the above, the number of high-cost cases was relatively high in 2014 – all high-cost cases occurred in inpatient care.

Conclusively, the EHIF as a strategic buyer was able to control the volume inflation of specialised medical care in 2014. More services than before are provided in outpatient dare or day care. The use of inpatient care is decreasing, an increasing number of healthcare services (including surgeries) are performed in day care or outpatient care instead of the inpatient care used so far. The decrease in the percentage of emergency care in the use of inpatient care indicates that scheduled hospital treatment has become more accessible for the insured.

High-cost specialised medical care cases

High-cost (with the cost of over 65 thousand euros) medical care cases are planned on the basis of the use in the same period in the year before. While in 2013, 34 high-cost medical care cases were submitted to the EHIF with the cost of 3.2 million euros, in 2014, the EHIF financed 46 high-cost cases with the total cost of 4.5 million euros. Thus, the financing of high-cost medical care cases increased by 1.2 million euros. By specialties, the impact of high-cost cases was the most significant in paediatrics, where the decrease in the expenses of high-cost cases formed 2% of inpatient care budget implementation. The number of high-cost medical care cases was higher than in the year before in surgery, oncology, gynaecology and internal diseases. Considering the total volumes of these specialties, the percentage of the high-cost cases did not have an important role in the total implementation of the budget of the specialty (see Table 15).

Table 15. High-cost cases by specialties in thousand euros and by cases

	2013 actual		2014 actual		Change compared to 2013	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Surgery	978	11	1,434	15	47%	36%
Oncology	-	-	312	3		
Paediatrics	1,272	12	979	10	-23%	-17%
Internal diseases	926	10	1,668	17	80%	70%
Obstetrics and gynaecology	-	-	84	1	-	-
Centrally contracted services	70	1	-	-	-	-
Total	**3,246**	**34**	**4,477**	**46**	**38%**	**35%**

Budget implementation and cases by specialties

As of 2014, the logic for grouping specialties in the planning of the budget and monitoring of budget implementation has changed. Surgical specialties such as orthopaedics and urology are no longer mentioned separately in reports, since the treatment in the above mentioned specialties was often provided within the specialty of general surgery. The reference year data was regrouped based on the new principles in the tables of the report. The healthcare services that were centrally contracted in previous year were integrated into the budgets of the main specialties in 2014 according to their actual previous use and these services are no longer monitored separately in budget implementation.

The main specialties in the specialised medical care budget of the EHIF of 2014 were primary follow-up care, surgery, ophthalmology, oncology, paediatrics, psychiatry, internal diseases, obstetric care, gynaecology and rehabilitation. Below is an overview of the budget implementation of the main specialties in specialised medical care in alphabetic order.

Primary follow-up care

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

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Primary follow-up care	**1,770**	**2,232**	**2,264**	**2,503**	**2,163**	**2,606**	**96%**	**104%**
Inpatient	1,770	2,232	2,264	2,503	2,163	2,606	96%	104%

Primary follow-up care is not a medical specialty, but rather a special case of service provider-based financing of organisation of medical care. A patient is referred to primary inpatient follow-up care if outpatient care is not yet possible at the end of active inpatient treatment. In the context of financing of primary follow-up care at general hospitals and selected partners, this mostly means a situation where patients who have been treated in a higher level hospital are referred to their local healthcare institutions for follow-up care. Follow-up care is not specified as a separate specialty in the contracts entered into with most regional hospitals or central hospitals. In case of these medical institutions, follow-up care is included in the treatment invoice under the main specialty, if necessary.

An increase in the financing of primary follow-up care in the amount of 0.5 million euros and an increase in the number of cases by 300 cases compared to the year before was planned in the budget. In terms of the amount, the budget was implemented in the extent of 96% and, in terms of cases, in the extent of 104%. Compared to 2013, financing increased by 0.4 million euros and 400 cases (see Table 16).

The number of primary follow-up care cases provided in 2014 was higher than planned and the cost cheaper. The cases were shorter compared to the year before – the volume inflation of the specialty was -5.3% (i.e. volume deflation). The total of 2,500 people received follow-up care in 2014, compared to the year before, the number of persons who received primary follow-up care increased by 17% (350 persons).

Accessibility of primary follow-up care

The accessibility of primary follow-up care is good and there is usually no waiting time. The patient is referred to primary follow-up care from the active care unit depending on the need, on agreement between the providers of active care and follow-up care.

Surgery

Tabel 17. Kirurgia eelarve täitmine tuhandetes eurodes ja ravijuhtude arv

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Surgery	**129,872**	**847,609**	**141,243**	**879,432**	**142,377**	**878,488**	**101%**	**100%**
outpatient	32,317	758,588	36,835	792,394	37,521	788,861	102%	100%
day care	7,880	22,705	8,307	22,920	8,749	24,295	105%	106%
inpatient	89,675	66,316	96,101	64,118	96,107	65,332	100%	102%

The specialty of surgery includes cardiac surgery, paediatric surgery, neurosurgery, maxillofacial surgery, orthopaedics, otorhinolaryngology, thoracic surgery, urology, vascular surgery and general surgery. Endoprosthetic replacement, installation of cochlear implants and organ transplantations are included in contracts as service-based special cases of surgery.

An increase in the financing of surgery in the amount of 11.4 million euros and an increase of 32 thousand cases, a 3.8% increase in the number of cases, were planned in the budget compared to the year before (see Table 17). The budget was planned presuming that the treatment would continue to move from inpatient care to day care and outpatient care. The increase in the number of outpatient cases in the budget was also related to the decision to start reporting andrology under urology in the composition of the specialty of surgery, instead of gynaecology. The relatively rapid increase in the average cost of inpatient cases planned in the budget was related to including the list of cardiac surgery and neurosurgery services, i.e. adding new treatment possibilities. In many cases, though, the new, expensive technologies were not taken into use, e.g. the baclofen pumps designed for alleviating chronic pains that cannot be controlled with pharmaceuticals or spinal cord neurostimulators.

The budget was implemented 101% in terms of the amount and 100% in terms of cases, i.e. the cases were slightly more expensive than planned. Compared to 2013, financing of the specialty increased by 12.5 million euros and 31 thousand cases. The volume inflation of the specialty in 2014 was -0.6% (volume deflation), including the volume inflation of 2.4% in outpatient care, 0.1% in day care and 2.9% in inpatient care. In most cases, replacement of the hospital care used so far with day care or outpatient care is preferred by the patient as well. Movement of a case between different types of treatment increases the average cost of all types of treatment (in the event of less serious cases moving to other types of treatment, the average cost of an inpatient care case increases compared to the average cost before – the number of inpatient cases, however, decreases, etc.). Even though the average costs of all types of treatment increase, the average cost of the specialty in total decreases. The average cost of a case was slightly more expensive than planned – the budget forecasted somewhat quicker movement of cases between the types of treatment within the specialty.

The EHIF financed the treatment of 406 thousand people in the speciality of surgery in 2014. The number of persons who received treatment increased by 1.6% or 6 thousand persons compared to the year before. The number of treatment invoices submitted per one person treated increased by 2.0% compared to the year before, including by 2.3% in outpatient care, by 0.3% in day care and by 0.3% in inpatient care.

The increase in the price of a case in outpatient care is primarily related to the laboratory tests, tests and procedures added in orthopaedics and general surgery. Exceeding of the day surgery budget arises from orthopaedics, where contracts were entered into for financing day care in the amount exceeding the budgeted amount by 400 thousand euros in order to ensure accessibility. The average cost of a case in inpatient care was lower than planned as the impact of the amendments made to the list of healthcare services was not implemented in the presumed extent – the volume inflation of an inpatient case was marginal (0.3%).

170 thousand euros for 2,000 cases was paid based on the contracts entered into to buy out waiting lists, which did not have a significant impact on the implementation of the budget of the specialty of surgery as a whole.

Accessibility of surgery

The accessibility of surgery is good and the percentage of appointments within the maximum permitted waiting time is higher than the average. In the case of narrower surgical specialties (e.g. vascular surgery, neurosurgery, cardiac surgery, paediatric surgery, urology), however, the percentage of appointments exceeding the maximum permitted waiting time is significantly higher than the average – the waiting times for appointments with these specialists (the waiting time for the 4th available appointment) are also often longer than the average.

Ophthalmology (eye diseases)

Table 18. Implementation of ophthalmology budget in thousand euros and cases

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Ophthalmology	**18,615**	**370,600**	**20,281**	**370,030**	**21,346**	**378,238**	**105%**	**102%**
outpatient	9,539	354,242	11,176	353,934	11,532	360,869	103%	102%
day care	7,426	14,593	7,511	14,342	8,087	15,545	108%	108%
inpatient	1,650	1,765	1,594	1,754	1,727	1,824	108%	104%

An increase in the financing in the amount of 1.7 million euros was planned for ophthalmology compared to the year before; the planned number of cases was the same as in the year before (see Table 18). In planning the average cost of an outpatient case, addition of new services and the resulting increase in the average cost of a case was taken into consideration.

The budget was exceeded in terms of all types of treatment, among other things, inpatient cases were more expensive than planned. The average cost of a day care case matched the planned cost. Financing of ophthalmology increased by 2.7 million euros and 7,600 cases compared to 2013.

Exceeding the budget in terms of cases arises from the fact that 2.2% more treatment invoices were submitted per one treated person than in the year before. The EHIF financed the treatment of 182 thousand insured persons in ophthalmology in 2014 – the number of persons who received treatment decreased by 0.2% or 300 persons compared to the year before.

In addition to the added cases, budget implementation was also influenced by the faster-than-planned increase in the cost of the cases. The volume inflation of an ophthalmology case in 2014 was 3.8%, including 3.6% in outpatient care, 0.6% in day care and -0.4% in inpatient care (volume deflation in case of inpatient care).

The number of persons who received outpatient care has decreased by 0.2% compared to the previous period (by 300 persons). The number of cases is increasing due to the number of treatment invoices submitted per person increasing. The increase in the average cost of a case is primarily related to the higher number of tests and procedures provided in outpatient care than was planned and due to the pharmaceuticals used in providing the healthcare service.

A significant share of the use of day care (97% of the amount, 95% of cases) is formed by cataract surgeries. Due to changes in contractual partners, implementation of the budget for cataract surgeries (and consequently the whole ophthalmology day care budget) was significantly influenced by the contracts entered into for buying out waiting lists, on the basis of which 455 thousand euros was paid for 878 cataract surgeries. Buying out of waiting lists formed 6% of the implementation of the budget for ophthalmology day care for 2014, both in terms of cases and the amount.

In inpatient care, the number of cases was higher and the cases more complex.

500 thousand euros for 3,200 cases was paid in ophthalmology on the basis of the contracts entered into for buying out waiting lists – the impact on budget implementation was, above all, significant in day care, where 455 thousand euros was paid for 878 cataract surgeries.

Availability of ophthalmology

The availability of ophthalmology is not good and the waiting lists in the HNDP hospitals are the longest in ophthalmology. The waiting times for the specialty remain long in the HNDP hospitals in spite of an increase in financing, the demand exceeds the possibilities of healthcare institutions to provide the service. An ophthalmologist can be contacted without a referral from the family physician, establishment of the requirement to obtain a referral may help to shorten the waiting times – it is important to ensure the specialised medical care for the patients who need it more urgently based on their medical indications. The waiting times at the selected partners may be shorter than in the HNDP hospitals. Insured persons have the right to contact any contractual partner of the EHIF in Estonia, the details of the contractual partners are published on the website of the EHIF.

Oncology

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

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Oncology	**63,022**	**140,015**	**71,418**	**147,372**	**70,539**	**145,567**	**99%**	**99%**
outpatient	30,735	121,507	35,177	128,057	36,101	126,059	103%	98%
day care	1,967	3,548	1,745	3,362	2,060	3,782	118%	112%
inpatient	30,320	14,960	34,496	15,953	32,378	15,726	94%	99%

The main specialty of oncology also includes the use of haematology treatment. The healthcare services related to bone marrow transplantation are specified as a service-based special case of the specialty in contracts.

The planned increase in the financing of oncology was faster than the average due to the need to keep the accessibility of treatment stable in the situation of increasing of the frequency of instances. The increase in the need for treatment of oncological diseases is related to the aging of the population as well as development of the treatment and diagnostic possibilities. The increase in the amount planned in the budget compared to the year before was 8.4 million euros, the number of cases increased by 7,400. Unlike the general budget of specialised medical care, an increase in the number of inpatient cases was also planned in oncology (see Table 19).

Budget implementation both in terms of cases and the amount was 99%. The financing increased by 7.5 million euros compared to the year before, the number of cases by 5,600 cases. The amount planned for inpatient care was used to provide more outpatient and day care. Movement between the types of treatment was faster than planned.

The total of 47 thousand insured persons received treatment in oncology in 2014, the number of persons who received treatment was on the same level than in the year before (an increase of 0.1%). The increase in the number of cases in 2014 was primarily caused by the increase in the number of treatment invoices submitted per person, which was 3.8% compared to the year before – including 3.8% in outpatient care, 3.0% in day care and 2.2% in inpatient care.

Outpatient and day care cases were more expensive than planned and inpatient care cases less expensive. The cost of outpatient and day care cases has primarily increased due to more extensive use of blood/blood products and pharmaceuticals.

The volume inflation of an oncology case in 2014 was 0.5%, including 5.2% in outpatient care, -0.8% in day care and -5.2% in inpatient care (volume deflation in day care and inpatient care). The volume deflation of day care has been facilitated by a decrease in the prices of pharmaceuticals.

Accessibility of oncology

The accessibility of oncology has been deemed a priority. Provision of the services has mainly been centralised to the North Estonia Medical Centre and the Tartu University Hospital. In a lesser volume, oncological treatment is also provided by the Tallinn Children's Hospital and the East-Tallinn Central Hospital. The percentage of the appointments within the maximum permitted waiting time is higher than the average of specialised medical care. In general, the waiting times remain within the maximum permitted limits. As at 01.01.2015, the waiting times at the North Estonia Medical Centre, the Tartu University Hospital and the East-Tallinn Central Hospital for outpatient oncology was in conformity with the two weeks described as an objective for ensuring the quality of cancer treatment in Estonia. The waiting time for a scheduled outpatient oncologist's appointment at the Tallinn Children's Hospital was three weeks.

Paediatrics

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

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Paediatrics	**21,616**	**154,984**	**22,916**	**152,202**	**21,984**	**155,474**	**96%**	**102%**
outpatient	6,082	125,081	7,313	123,486	7,136	125,238	98%	101%
day care	241	2,502	989	2,205	1,159	2,840	117%	129%
inpatient	15,293	27,401	14,614	26,511	13,689	27,396	94%	103%

An increase in the financing in the amount of 1.3 million euros was planned in the budget for paediatrics; a decrease in the number of cases I the amount of 2,800 cases was planned due to the decrease in the number of children (see Table 20). In planning the average cost of a case, additional financial means were added to the outpatient care budget for using biological treatment. The average cost of a day care case was planned taking into consideration haematology treatments being added to the paediatrics budget. The reason for the average cost of a case of outpatient care planned in the budget was planning a higher number of high-cost cases in the budget than before.

The budget was implemented in the extent of 96% in terms of the amount and 102% in terms of cases. Compared to the year before, the financing increased by 0.4 million euros, the number of cases by 500. The average cost of a case was lower than planned in case of all types of treatment. The volume inflation of the specialty in 2014 was -1.6% (volume deflation), including 1.9% in outpatient care, -1.2% in day care and -3.7% in inpatient care (volume deflation in day care and inpatient care). In outpatient care, the numbers of the cases with the main diagnosis of mental and behavioural disorders (F00–F99) or the factors influencing health status and contact with health services (Z00–Z99, in outpatient care, these are often the cases which should be in the competence of the family physicians) increased most compared to the year before. The amount of pharmaceuticals used in day care was lower than predicted. Inpatient care cases were shorter and simpler than planned, while the average cost of a case was also influenced by high-cost medical care cases. In 2013, the EHIF financed 12 high-cost medical care cases with the total cost of 1.3 million in paediatrics; in 2014, there were 10 high-cost medical care cases with the total cost of one million euros in paediatrics.

The EHIF financed the treatment of 76 thousand children in paediatrics in 2014. There was no significant change in the number of persons treated compared to the year before (annual growth of 0.3%, i.e.by 200 persons). The number of cases per one person who received treatment also has not changed significantly (annual growth of 0.03%). Treatment provided to children (0–18 years of age) is also included under other specialties in addition to paediatrics – e.g. at the healthcare institutions with no separate specialty of paediatrics, paediatric surgery is financed from the budget for internal diseases. Considering all specialties in total, the number of children who used specialised medical healthcare services increased by 1%, i.e. by 1,400 children in 2014 compared to the year before. The number of insured children in the end of 2014 is not significantly different from the number in the end of 2013 (a decrease of 0.1%) – the use of specialised medical care by children has increased.

33 thousand euros was paid for 655 cases in paediatrics on the basis of contracts entered into for buying out waiting lists, which had no significant influence on the implementation of the budget of the specialty.

Accessibility of paediatrics

As a rule, the accessibility of paediatrics is good and the waiting times of the specialty that exceed the average are primarily connected to the Tallinn Children's Hospital. The longer waiting time to see the specialists of narrower specialties, e.g. a paediatric cardiologist, are not specified separately in the reports of the Tallinn Children's Hospital. The waiting time for an appointment with a general paediatrician at the Tallinn Children's Hospital does not exceed the maximum permitted waiting time.

Psychiatry

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

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Psychiatry	**20,465**	**237,558**	**27,320**	**238,432**	**26,790**	**240,417**	**98%**	**101%**
outpatient	6,379	226,824	7,809	227,632	7,699	229,317	99%	101%
day care	979	479	349	543	452	623	130%	115%
inpatient	13,107	10,255	19,162	10,257	18,639	10,477	97%	102%

An increase in financing in the amount of 6.9 million euros was planned in the budget for the specialty of psychiatry and an increase in the number of cases by 900 cases (see Table 21). The increase in the budget was higher than the average due to modernisation of the part of psychiatric services in the list of healthcare services – the reference price was harmonised with the standard price, descriptions of the services were updated, and several new services were added.

The budget was implemented in the extent of 98% in terms of the amount and in the extent of 101% in terms of cases. The financing of psychiatry increased by 6.3 million euros compared to the year before, the number of cases by 2,900. The average cost of a case was lower than planned. The volume inflation of the specialty in 2014 was -2.1% (volume deflation), including -1.4% in outpatient care, 17.4% in day care and -3.2% in inpatient care (volume deflation in outpatient care and inpatient care).

The EHIF financed the treatment of 65 thousand people in the specialty of psychology in 2014 – the number of people who received treatment increased by 2.8% or 1,800 persons compared to the year before. The number of treatment invoices submitted per person decreased by 1.6% compared to the year before. Taking into consideration the volume deflation of cases, it can be concluded that the extent of treatment of less serious conditions increased in psychology.

63 thousand euros was paid for 1000 cases in psychiatrics on the basis of contracts entered into for buying out waiting lists, which had no significant influence on the implementation of the budget of the specialty.

Accessibility of psychiatry

The accessibility of psychiatry is good and the waiting times are generally within the maximum permitted limits.

Internal diseases

Table 22. Implementation of internal disease budget in thousand euros and cases

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Internal diseases	**155,818**	**832,750**	**166,402**	**843,520**	**172,715**	**873,998**	**104%**	**104%**
outpatient	50,318	753,741	55,175	766,107	57,949	796,102	105%	104%
day care	9,775	7,324	10,140	7,079	11,258	8,107	111%	115%
inpatient	95,725	71,685	101,087	70,334	103,508	69,789	102%	99%

The specialty of internal diseases includes dermatovenerology (skin diseases), endocrinology, gastroenterology, infections (infective diseases), cardiology, occupational diseases, nephrology (kidney and urinary tract diseases), neurology, pulmonology (lung diseases), rheumatology and internal diseases. Dialyses are listed as service-based special cases in the specialty of internal diseases (haemodialysis and peritoneal dialysis).

An increase in the financing of internal diseases in the amount of 10.6 million euros was planned in the budget compared to the year before and an increase in the number of cases by 11 thousand cases (see Table 22). An increase in the number of outpatient cases at the expense of day care and inpatient cases was expected as a structural change.

The budget was implemented both in terms of cases and the amount in the extent of 104% – the average cost of a case matched the planned cost, the number of cases was higher than planned in the budget. In order to ensure accessibility of the services, the contract volume was increased compared to the initial plans. Many healthcare institutions exceeded their contractual volumes, the percentage of the work exceeding the contractual volumes formed 2% of the financing of the specialty in 2014, both in terms of the number of cases and the amount. Compared to the year before, the financing of the specialty increased by 16.9 million euros, the number of cases by 41 thousand.

The number of outpatient care and day care cases were higher than planned and higher than the actual use in the year before. The number of outpatient cases of internal diseases decreased by 3% compared to the year before – presumably, an increasing number of services than have been provided in inpatient care before ane now provided in day care and inpatient care.

The EHIF financed the treatment of 364 thousand persons in the specialty of internal diseases in 2014. The number of the persons who received treatment increased by 1.6%, i.e. by 5,700 persons compared to the year before. There is a significant connection between the increase in the number of cases and the increase in the number of invoices submitted per one person treated – an increase of 3.3% compared to the year before.

The volume inflation of the specialty in 2014 was -0.7% (volume deflation), including 1.9% in outpatient care, 2.3% in day care and 4.3% in inpatient care. The absolute number of inpatient cases is lower than planned in the budget as well as compared to the use in the year before. On average, inpatient care is provided to treat more complex conditions than before that require longer treatment and less serious cases have at least partly moved to outpatient and day care.

Based on the main diagnoses provided on treatment invoices, the number of the treatment invoices the main diagnosis of which is included in the group M00–M99 (musculoskeletal and connective tissue diseases) has increased the most – an increase of 6,300 cases compared to the year before. The increase in the number of treatment invoices with the main diagnoses included in the group Z00–Z99 (factors influencing health status and contact with health services) has also increased significantly – an increase of 6,100 cases compared to the year before, primarily in outpatient care. The invoices for outpatient treatment of the internal diseases included in this group are generally issued for cases that cost significantly less than the average, with the specific health condition not determined. Such invoices should very likely rather be in the competence of the family physician, some are also the cases of issuing a separate invoice for a repeat appointment.

In terms of the services specified on treatment invoices, the percentage of financing of laboratory tests, tests and procedures and pharmaceuticals has primarily increased in the financing of internal diseases.

160 thousand euros was paid for 2,300 cases on the basis of contracts entered into for buying out waiting lists in the speciality of internal diseases – buying out of waiting lists had no significant impact on the implementation of the budget for internal diseases.

Accessibility of the specialty of internal diseases

The accessibility of the specialty of internal diseases varies and longer-than-average waiting times primarily occur in regional and central hospitals, where the demand of the patients in the specific healthcare institution and/or for a specific physician exceeds the possibilities of the healthcare institution to provide the service. In general hospitals, problems with waiting times occur in case of the specialties, where there are few physicians or where treatment is provided by specialists from regional or central hospitals seeing patients at the general hospital a few times per month.

Obstetric care and gynaecology

Table 23. Implementation of obstetric care and gynaecology budget in thousand euros and cases

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Obstetric care and gynaecology	**44,172**	**521,452**	**46,716**	**502,496**	**47,080**	**511,634**	**101%**	**102%**
outpatient	22,231	475,064	23,249	456,333	23,929	466,155	103%	102%
day care	2,610	16,589	2,707	16,388	2,835	16,720	105%	102%
inpatient	19,331	29,799	20,760	29,775	20,316	28,759	98%	97%

As of 2014, the budget for obstetric care and gynaecology does not include andrology services, which are budgeted under urology within the specialty of surgery. As of 2014, gynaecological services were complemented by perinatal diagnostics of hereditary diseases that was financed from the budget of prevention before. Births and the cases related to artificial insemination are listed under obstetric care and gynaecology as service-based special cases.

An increase in the amount of 2.5 million euros was planned in the budget in the financing of the specialty compared to the year before and a decrease in the number of cases by 19 thousand cases (see Table 23). The decrease in the number of outpatient cases was caused by moving of andrology cases and budget under surgery.

The budget was implemented in the extent of 101% in terms of the amount and in the extent of 102% in terms of cases. Compared to the year before, the financing of gynaecology increased by 2.9 million euros and the number of cases decreased by 10 thousand. Outpatient care and day care were provided in a larger extent than planned, while the use of inpatient care (including the number of births) was lower than planned in the budget. The average cost of a case was slightly higher than planned in case of all types of treatment.

The treatment of 196 thousand people was financed by the EHIF in gynaecology in 2014. The number of persons who received treatment decreased by 3.6% or 7,200 persons compared to the year before. The decrease in the number of persons who received treatment was related to the fact that, in 2013, financing of andrology treatment was also listed under gynaecology. The number of women who received gynaecological treatment in 2014 increased by 0.7% or by 1,200 women compared to 2013. Exceeding of the budgeted number of cases is caused by the increase in the number of treatment invoices submitted per person (an increase of 1.7% compared to the year before).

The volume inflation of the specialty in 2014 was 1.3%, including -0,3% in outpatient care (volume deflation, which is, among other things, caused by the fact that a higher number of treatment invoices were submitted per one person treated), 2,5% in day care and 4,0% in inpatient care.

In terms of inpatient gynaecology, the budgets for births as well as other gynaecology were under-implemented. The EHIF financed 13.3 thousand birth instead of the 13.birth planned in the budget in 2014 (69 of these on the basis of a contract for buying out waiting lists). The number of births decreased by 0.9% compared to the year before in 2014, however, the rapid decrease of the years before has slowed down.

190 thousand euros was paid for 1100 cases in obstetric care and gynaecology on the basis of contracts entered into for buying out waiting lists, which had no significant influence on the implementation of the budget of the specialty.

Accessibility of obstetric care and gynaecology

The accessibility of gynaecology is satisfactory, as the waiting times generally remain within the maximum permitted waiting times.

Rehabilitation

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

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Rehabilitation	**11,389**	**74,939**	**14,094**	**80,859**	**13,770**	**86,069**	**98%**	**106%**
outpatient	5,374	67,748	7,003	73,716	6,792	78,770	97%	107%
inpatient	6,015	7,191	7,091	7,143	6,978	7,299	98%	102%

In rehabilitation, an increase in the financing in the amount of 2.7 million euros was planned compared to the year before and an increase in the number of cases by 5.9 cases (see Table 24). In terms of the average cost of an outpatient case, an increase was planned in the budget with an aim to provide to the patient more procedures and tests in the course of one rehabilitation case that could be included in one treatment invoice.

The budget was implemented in the extent of 98% in terms of the amount and 106% in terms of cases. Compared to the year before, the financing of rehabilitation increased by 2.4 million euros, the number of cases by 11 thousand. The average cost of a case was significantly lower than planned in outpatient as well as inpatient care. The plan of the procedures and tests being included in one and the same treatment invoice in outpatient care did not materialise – the number of treatment invoices submitted in outpatient care per person increased by 9.1%. In inpatient care, the number of cases per one person treated decreased by 1.2%. The volume inflation of the speciality in 2014 was -7.6% (volume deflation), including -7.9% in outpatient care (volume deflation) and 17,3% in inpatient care.

The EHIF financed the treatment of 56 thousand people in 2014 – an increase of 5.5%, i.e. 3,000 persons compared to the year before, including an increase of 6.6% or 3,000 persons in the number of persons who received outpatient care and an increase of 2.8% or 200 persons in the number of persons who received inpatient care.

100 thousand euros was paid for 1,400 cases in rehabilitation on the basis of contracts entered into for buying out waiting lists, which had no significant influence on the implementation of the budget of the specialty.

Accessibility of rehabilitation

There is still room for growth for the accessibility of rehabilitation, the increase in financing did not shorten waiting times. Over the two periods, the number of primary appointments has grown, but mainly due to the waiting times for appointments which exceed the maximum permitted waiting times.

Performance of specialised medical care contracts

In 2014, the EHIF paid to healthcare institutions 529.9 million euros for 3.3 million cases of specialised medical care. The cases treated in the HNDP hospitals comprised 82% and the amount paid to them comprised 93% of the specialised medical care budget implementation.

As of 2014, the financial volumes of the contracts entered into in specialised medical care are no longer agreed on the quarterly basis, but for the first and second half of the year, whereat the volume unperformed in the first half of the year is not automatically transferred to the second half of the year. Performance of a contract in the course of six months significantly depends on the organisation of work of the healthcare institution – it is the duty of healthcare institutions to ensure uniform accessibly of medical care. It is important for the EHIF that the accessibility of medical care does not deteriorate at the end of a period.

The summarised data of the performance of the specialised medical care contracts entered into with the HNDP hospitals and with selected partners for 2014 is given in Table 25. Table 26 presents the data of the contracts entered into with the HNDP hospitals by healthcare institutions. The data of performance of the contracts provided in Tables 25 and 26 also include the healthcare services financed form the state budget under the Artificial Insemination and Embryo Protection Act, which is included in the implementation of the budget of the EHIF under other expenses (see Chapter 6).

Table 25. Performance of specialised medical care contracts in thousand euros

	Contract for 1st half of 2014		Implementation of contract for 1st half of 2014		Contract for 2nd half of 2014		Implementation of contract for 2nd half of 2014	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
HNDP hospitals	**249,664**	**1,338,578**	**251,504**	**1,356,110**	**238,887**	**1,288,882**	**240,291**	**1,318,828**
Regional hospitals	139,306	514,092	139,704	519,049	132,281	489,683	133,323	502,593
Central hospitals	77,482	567,910	79,093	582,961	74,846	548,512	75,527	564,634
General hospitals and local hospitals	32,876	256,576	32,707	254,100	31,760	250,687	31,441	251,601
Selected partners	**19,329**	**312,133**	**18,644**	**295,489**	**18,801**	**307,517**	**18,178**	**290,792**
Total financing contracts	**268,993**	**1,650,711**	**270,148**	**1,651,599**	**257,688**	**1,596,399**	**258,469**	**1,609,620**
Buying out of waiting lists (contract period 01.04.–31.12.14)	1,449	14,798	797	9,504	0	0	454	2,148
Total	**270,442**	**1,665,509**	**270,945**	**1,661,103**	**257,688**	**1,596,399**	**258,923**	**1,611,768**

The amount paid to the HNDP hospitals increased by 12% compared to 2013, the amount paid to selected partners (with performance of the contracts entered into for buying out waiting lists) by 1%. The number of cases treated in the HNDP hospitals increased by 5%, while the number of cases treated by the selected partners decreased by 4% compared to 2013. Despite the changes in the financing (financing of the services provided by the HNDP hospitals is increasing more rapidly), the number of appointments registered in the waiting lists is primarily growing in the regional and central HNDP hospitals. The insured above all want to find solutions to their health problems in larger hospitals. The data of the performance of contracts presented in Tables 25 and 26 include all treatment invoices submitted to the EHIF for reimbursement (including the treatment invoices for services provided in excess of the provided volume to be paid at a coefficient in the amount for which the EHIF has taken over the obligation to pay remuneration). Regional hospitals submitted invoices in the amount of 2.9 million euros for remuneration

of services provided in excess of the provided volume[5]; central hospitals in the amount of 3.0 million euros; general hospitals and local hospitals in the amount of 0.6 million euros; selected partners in the amount of 0.2 million euros.

The amount paid to regional hospitals (the North Estonia Medical Centre, the Tallinn Children's Hospital and the Tartu University Hospital) increased by 10% in 2014 compared to the year before, the number of cases treated in regional hospitals was 4% higher than in 2013. The cases of regional hospitals formed 31% and the amount 52% of the performance of specialised medical care contracts in 2014. The Tartu University Hospital and the North Estonia Medical Centre provided services in excess of the provided volumes both in the 1st and 2nd half of the year. The North Estonia Medical Centre received 2 million euros for 11 thousand cases for services provided in excess of the provided volume and the Tartu University Hospital received 0.8 million euros for 4 thousand cases. The Tallinn Children's Hospital provided services in excess of the provided volumes in the 1st half of the year, but since the average cost of a case was lower than agreed, the healthcare institution did not need to apply for payment for services provided in excess of the provided volume in the 1st half of the year. In the 2nd half of the year, the Tallinn Children's Hospital did not perform the contract in terms of neither cases nor the amount.

The amount paid to central hospitals (the East-Tallinn Central Hospital, the Ida-Viru Central Hospital, the West-Tallinn Central Hospital, the Pärnu Hospital) increased by 13% compared to the year before in 2014, the number of cases treated in central hospitals was 5% higher than in 2013. The cases treated in central hospitals formed 35% and the amount 29% of the performance of specialised medical care contracts in 2014. All central hospitals provided outpatient care at least in the volume agreed in the contract both in the 1st and in the 2nd half of the year. All central hospitals applied for payment for some treatment invoices as services provided in excess of the provided volume in the 1st as well as the 2nd half of the year. For 2014 in total, the East-Tallinn Central Hospital received 1.7 million euros for 16 thousand cases for services provided in excess of the provided volume; the Ida-Viru Central Hospital received 0.3 million euros for 1,300 cases; the West-Tallinn Central Hospital received 0.6 million euros for 6,500 cases; the Pärnu Hospital received 0.4 million euros for 3,400 cases.

General hospitals and local hospitals (Hiiumaa Hospital, Jõgeva Hospital, Järvamaa Haigla SA, Kuressaare Hospital, South-Estonian Hospital, Läänemaa Haigla SA, Narva Hospital, Põlva Hospital, Rakvere Hospital, Rapla County Hospital, Valga Hospital, Viljandi Hospital) treated 3% more cases in 2014 compared to 2013. The amount paid to these healthcare institutions increased by 8% compared to the year before. The share of general hospitals and local hospitals in the performance of specialised medical care contracts in 2014 formed 15% in terms of cases and 12% in terms of the amount. Järvamaa Haigla SA, Rakvere Hospital, Southern-Estonian Hospital, Läänemaa Haigla SA and Viljandi Hospital reached the agreed numbers of outpatient care cases in the 1st as well as the 2nd half of the year and submitted some invoices to apply for payment for services provided in excess of the provided volume – these hospitals received the total of 0.5 million euros for 2,400 cases. Jõgeva Hospital and Valga Hospital reached the numbers of outpatient care cases agreed in their contracts and submitted some invoices to apply for payment for services provided in excess of the provided volume in the 1st half of the year – they received the total of 61 thousand euros for 300 cases of payment for services provided in excess of the provided volume. Põlva Hospital and Rapla County Hospital reached the numbers of outpatient care cases agreed in their contracts and submitted some invoices to apply for payment for services provided in excess of the provided volume in the 2nd half of the year – they received the total of 0.1 million euros for 680 cases of payment for services provided in excess of the provided volume. Hiiumaa Hospital, Kuressaare Hospital and Narva Hospital did not submit treatment invoices to apply for payment for services provided in excess of the provided volume in 2014 – although Hiiumaa Hospital reached the number of cases agreed in the contract in the 2nd half of the year, the healthcare institution had no reason to apply for payment for services provided in excess of the provided volume due to the average cost of a care remaining lower than planned.

The contracts with the selected partners and performance of the contracts was affected by the selection competition to find new contractual partners conducted in specialised medical care in the beginning of the year. In order to ensure continuous treatment for patients, agreements were reached with the healthcare institutions with whom contracts were not entered into for the new contract period (from 01.04.2014) for financing of the treatment in progress and appointments registered on waiting lists. The number of cases in the contracts entered into with the selected partners for the new period was similar to the number in the previous period (there may have been some regional changes). The relatively lower performance of the contracts entered into with the selected partners was also caused by the change in the structure of service providers. The healthcare institutions whose contract volumes decreased significantly as a result of the selection competition struggle to remain within the maximum permitted waiting times. The contracts with the selected partners were under-performed in a significant extent in the 2nd quarter, after entry into force of the results of the selection competition. In the 2nd half of the year, the percentage

5 Overtime – services provided in excess of the provided volume which is paid for on the terms and conditions agreed by the EHIF

of under-performance of the contracts had decreased, at the end of the year, the selected partners even applied for payment for services provided in excess of the provided volume – in total, the selected partners received 0.2 million euros for 5,025 cases for services provided in excess of the provided volume. 1.3 million euros was paid for 12 thousand cases in 2014 on the basis of the contracts entered into for financing waiting lists.

The table below provides the data of the performance of the specialised medical care contracts of the HNDP hospitals in 2014 by healthcare institutions.

Table 26. Performance of specialised medical care contracts of HNDP hospitals in thousand euros

	Contract for 1st half of 2014		Implementation of contract for 1st half of 2014		Contract for 2nd half of 2014		Implementation of contract for 2nd half of 2014	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Regional Hospitals								
Tallinn Children's Hospital	**10,382**	**89,348**	**10,347**	**90,484**	**10,433**	**89,006**	**10,153**	**87,108**
outpatient	3,764	79,302	3,802	78,953	3,910	78,957	3,837	76,014
day care	852	1,839	826	2,050	851	1,838	802	1,877
inpatient	5,766	8,207	5,719	9,481	5,672	8,211	5,514	9,217
Tartu University Hospital	**62,979**	**247,201**	**62,738**	**250,332**	**59,294**	**233,979**	**59,641**	**239,860**
outpatient	19,978	217,384	19,792	220,574	18,510	206,511	19,074	212,342
day care	2,976	6,695	2,945	6,709	2,838	6,094	2,795	6,142
inpatient	40,025	23,122	40,001	23,049	37,946	21,374	37,772	21,376
North Estonia Medical Centre	**65,945**	**177,543**	**66,619**	**178,233**	**62,554**	**166,698**	**63,529**	**175,625**
outpatient	19,183	155,745	19,622	156,337	18,226	146,319	18,925	155,295
day care	2,505	3,626	2,540	3,791	2,523	3,511	2,482	3,264
inpatient	44,257	18,172	44,457	18,105	41,805	16,868	42,122	17,066
Central hospitals								
East-Tallinn Central Hospital	**34,505**	**237,809**	**35,682**	**248,087**	**32,714**	**228,049**	**33,251**	**234,212**
outpatient	13,598	215,699	14,241	225,087	13,039	207,555	13,290	213,562
day care	3,662	7,907	3,686	8,122	3,136	6,793	3,213	6,983
inpatient	17,245	14,203	17,755	14,878	16,539	13,701	16,748	13,667
West-Tallinn Central Hospital	**18,701**	**159,433**	**18,944**	**159,119**	**18,455**	**154,227**	**18,510**	**154,840**
outpatient	7,564	145,590	7,564	145,601	7,322	141,647	7,423	142,215
day care	1,527	2,756	1,547	2,574	1,699	2,623	1,716	2,635
inpatient	9,610	11,087	9,833	10,944	9,434	9,957	9,371	9,990
SA Ida-Viru Keskhaigla	**12,007**	**79,765**	**12,013**	**81,569**	**12,206**	**78,391**	**12,189**	**80,337**
outpatient	4,126	71,751	3,982	72,981	3,956	70,679	3,856	72,175
day care	952	1,809	961	1,845	969	1,763	999	1,779
inpatient	6,929	6,205	7,070	6,743	7,281	5,949	7,334	6,383
Pärnu Hospital	**12,269**	**90,903**	**12,454**	**94,186**	**11,471**	**87,845**	**11,577**	**95,245**

Tabel jätkub pöördel »

	Contract for 1st half of 2014		Implementation of contract for 1st half of 2014		Contract for 2nd half of 2014		Implementation of contract for 2nd half of 2014	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
outpatient	4,063	81,433	4,244	84,319	3,905	78,917	4,112	86,311
day care	801	2,401	774	2,675	780	2,322	730	2,469
inpatient	7,405	7,069	7,436	7,192	6,786	6,606	6,735	6,465
General hospitals and local hospital								
Järvamaa Haigla AS	**2,377**	**21,590**	**2,374**	**21,829**	**2,303**	**20,800**	**2,289**	**21,545**
outpatient	1,097	19,743	1,101	19,993	1,063	19,030	1,041	19,683
day care	115	397	120	403	100	356	100	373
inpatient	1,165	1,450	1,153	1,433	1,140	1,414	1,148	1,489
Kuressaare Hospital	**3,238**	**25,650**	**3,153**	**23,666**	**3,086**	**24,684**	**3,009**	**24,384**
outpatient	998	22,947	961	21,217	959	22,125	951	22,055
day care	173	359	151	303	167	355	164	284
inpatient	2,067	2,344	2,041	2,146	1,960	2,204	1,894	2,045
Läänemaa Haigla SA	**1,862**	**16,610**	**1,895**	**17,136**	**1,762**	**15,636**	**1,763**	**15,987**
outpatient	609	15,021	645	15,522	573	14,139	578	14,554
day care	65	296	71	325	62	281	59	260
inpatient	1,188	1,293	1,179	1,289	1,127	1,216	1,126	1,173
Rakvere Hospital	**3,722**	**24,046**	**3,737**	**24,232**	**3,585**	**25,301**	**3,567**	**25,941**
outpatient	1,186	20,427	1,170	20,467	1,248	22,045	1,219	22,655
day care	151	641	160	703	118	525	124	555
inpatient	2,385	2,978	2,407	3,062	2,219	2,731	2,224	2,731
South-Estonian Hospital	**2,777**	**19,680**	**2,876**	**20,065**	**2,743**	**19,589**	**2,816**	**20,403**
outpatient	867	16,935	863	17,053	870	16,972	862	17,629
day care	221	707	221	715	181	579	189	630
inpatient	1,689	2,038	1,792	2,297	1,692	2,038	1,765	2,144
Narva Hospital	**6,422**	**52,457**	**6,242**	**51,419**	**6,147**	**49,194**	**5,933**	**46,897**
outpatient	2,191	45,793	2,045	44,807	2,003	43,064	1,886	40,798
day care	233	560	220	532	208	519	224	542
inpatient	3,998	6,104	3,977	6,080	3,936	5,611	3,823	5,557
Viljandi Hospital	**5,167**	**34,609**	**5,220**	**34,633**	**4,859**	**33,540**	**4,858**	**33,468**
outpatient	1,449	30,849	1,462	30,884	1,407	30,061	1,398	30,191
day care	146	520	134	495	135	481	135	486
inpatient	3,572	3,240	3,624	3,254	3,317	2,998	3,325	2,791
Valga Hospital	**1,749**	**16,738**	**1,800**	**16,883**	**1,758**	**16,968**	**1,732**	**16,609**
outpatient	645	15,094	645	15,094	655	15,349	644	15,021
day care	148	464	164	526	154	471	148	483
inpatient	956	1,180	991	1,263	949	1,148	940	1,105

	Contract for 1st half of 2014		Implementation of contract for 1st half of 2014		Contract for 2nd half of 2014		Implementation of contract for 2nd half of 2014	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Hiiumaa Hospital	**689**	**5,822**	**663**	**5,452**	**678**	**5,579**	**613**	**5,699**
outpatient	210	5,179	183	4,838	187	4,922	176	5,177
day care	38	172	32	146	29	153	18	114
inpatient	441	471	448	468	462	504	419	408
Põlva Hospital	**1,847**	**14,739**	**1,832**	**14,795**	**1,859**	**14,840**	**1,891**	**15,191**
outpatient	625	12,850	625	12,930	633	12,949	615	13,167
day care	115	547	115	549	114	544	124	596
inpatient	1,107	1,342	1,092	1,316	1,112	1,347	1,152	1,428
Rapla County Hospital	**1,808**	**15,872**	**1,687**	**15,104**	**1,744**	**15,743**	**1,765**	**17,010**
outpatient	707	14,310	703	13,778	718	14,320	751	15,566
day care	118	303	84	251	122	289	105	257
inpatient	983	1,259	900	1,075	904	1,134	909	1,187
Jõgeva Hospital	**1,218**	**8,763**	**1,228**	**8,886**	**1,236**	**8,813**	**1,205**	**8,467**
outpatient	415	7,741	410	7,862	434	7,793	404	7,452
day care	31	109	32	108	31	108	31	105
inpatient	772	913	786	916	770	912	770	910
Total HNDP hospitals	**249,664**	**1,338,578**	**251,504**	**1,356,110**	**238,887**	**1,288,882**	**240,291**	**1,318,828**
outpatient	83,275	1,193,793	84,060	1,208,297	79,618	1,153,354	81,042	1,181,862
day care	14,829	32,108	14,783	32,822	14,217	29,605	14,158	29,834
inpatient	151,560	112,677	152,661	114,991	145,051	105,923	145,091	107,132

Healthcare services on treatment invoices for specialised medical care

In 2014, the EHIF financed specialised medical care services (except preparedness fees) in the amount of 518.8 million euros.

The most significant part of the services included in treatment invoices for specialised medical care in 2014 was formed by tests and procedures (see Figure 13). Financing of tests and procedures is increasing somewhat faster than the general financing of specialised medical care, the increase in the number of uses is also faster than the average (7% vs 6%). The number of financed laboratory tests has also increased significantly faster than the average. The increased percentage of tests and procedures and laboratory tests in the financing reflects technological development. However, it is important to ensure that the performed tests and procedures are necessary, prevention of repeat tests is important for ensuring the patient's safety, but also practical use of the health insurance funds.

The number of bed days has decreased. The cost is increasing at the average pace of specialised medical care, because in the beginning of 2014, the amount of the resource of the physician's time was increased in the calculation of the reference price of a bed day. The amount of the component of salary in the reference price of a bed day also increased in connection with the salary agreement for medical professionals.

In terms of the amount, the increase in the financing of outpatient appointments was the fastest, the increase in the number of uses remains relatively modest compared to the increase in the amount. The percentage of the component of salary in the reference price of outpatient appointments is relatively high (e.g., labour costs form 80% of the price of an initial appointment with a physician). The increase in prices resulting from the salary agreement for medical professionals had the most significant impact on outpatient appointments.

The financing of pharmaceuticals from the budget of specialised medical care mainly includes chemotherapy in oncology and haematology, biological treatment and the use of other specific high-cost pharmaceuticals (e.g., the pharmaceuticals used in organ transplantation). In case of pharmaceuticals (unlike other groups of services), the number of uses is increasing faster than the cost. A more detailed overview of pharmaceuticals in the budget for healthcare services is provided in Chapter 3 of this report.

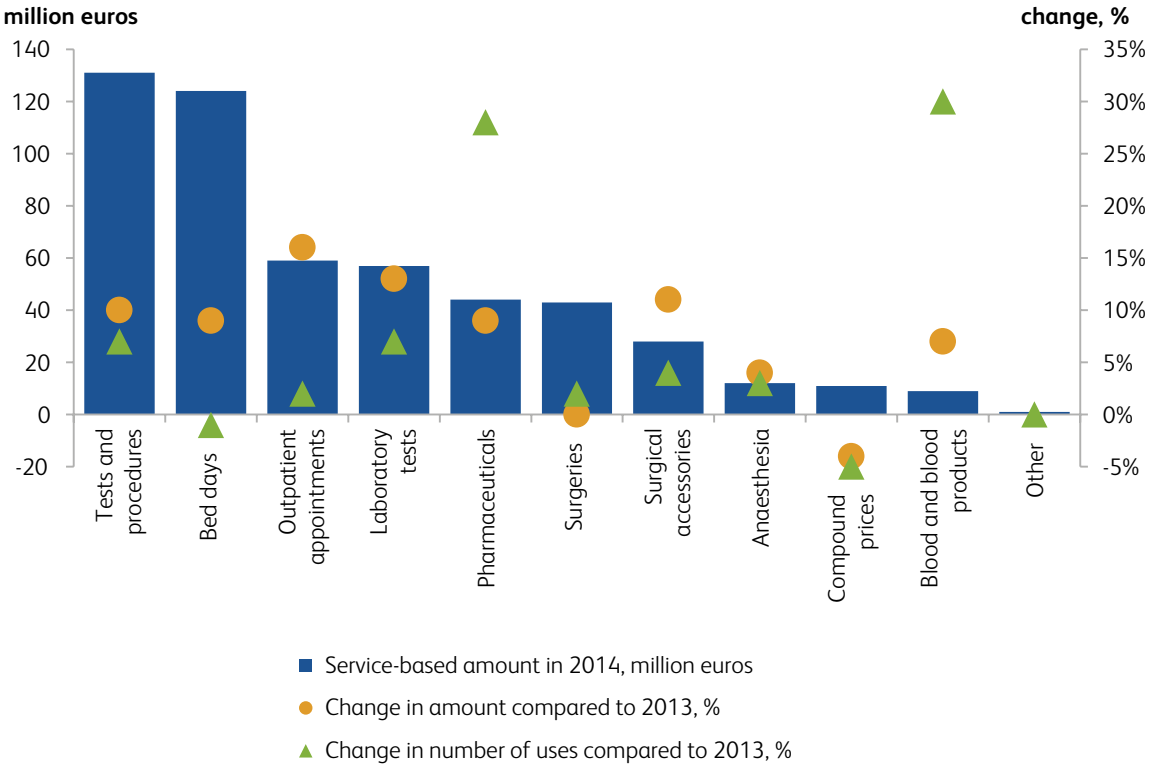


Figure 13. Services included in treatment invoices for specialised medical care in 2014 by types of services

1.4. Nursing care

The planned financial amount of nursing care in 2014 was 23.9 million euros, which exceeds the financing of nursing care services in 2013 by 16% (see Table 27). As of 1 January, 2014, the prices of healthcare services increased as a result of a salary agreement. The preferential growth of the budget compared to other types of healthcare services was caused by the need to support the increasingly growing importance of nursing activities.

In connection with the new Regulation "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" that entered into force on 20.01.2014, several changes were developed for the price list of nursing care services (the reference price of an inpatient nursing care bed day and the reference price of home nursing were updated) as well as the financing of nursing care in general. The changes made in the list of healthcare services entered into force on 01.01.2015.

The EHIF paid 19% more for the nursing services provided to the insured in 2014 than in 2013. The financing of both outpatient nursing care and inpatient nursing care increased by 19%. The growth is partly caused by the increase in the number of cases as well as the higher reference price of the service. The number of inpatient nursing care cases increased by 2%. The budget of inpatient nursing care was exceeded in connection with financing of the care for persons registered in waiting lists in institutions with whom financing contracts were not concluded for the new period as a result of the selection competition. The number of geriatric evaluation cases decreased by 3%.

The number of cases increased most in home nursing 8%. The preferential growth of the number of home nursing cases has been the priority of the EHIF in nursing care to improve the accessibility of the home nursing service. Exceeding of the budget for home nursing was also related to improvement of the accessibility of the service in addition to buying out of waiting lists. The council of the EHIF decided to keep 300 thousand euros in the nursing care budget for 2014 as a reserve. The resources planned for the reserve were used to improve the accessibility of home nursing.

2/3 of home nursing cases are provided by the selected partners. In the selection competition organised in the 2nd half of 2014 to find additional partners, more attention than before was paid to improving and harmonising the geographic accessibility of the service. The selected service providers were announced and the contracts concluded so that a service provider must, above all, provide services in the area where the selection competition was won – for example, if a service provider participated in the selection competition for provision of a service in a parish outside of a town, performance of the contract will entail provision of the service in this specific parish. Earlier, when there was no such restriction, provision of services tended to accumulate from rural areas to cities. Improvement of the accessibility of the home nursing service is also the priority of the EHIF because, unlike inpatient nursing care, the service is provided without the patient's financial contribution.

Table 27. Implementation of nursing care budget in thousand euros and cases

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Inpatient nursing care	16,362	18,647	19,197	19,293	19,493	19,055	102%	99%
Hone nursing*	4,152	34,101	4,337	32,580	4,946	36,844	114%	113%
Geriatric assessment	93	1,439	103	1,466	98	1,400	95%	95%
Reserve	0	0	300	0	0	0	-	-
Total	**20,607**	**54,187**	**23,937**	**53,339**	**24,537**	**57,299**	**103%**	**107%**

*As of 2014, home-based supportive therapy for cancer patients is reported under home nursing.

The number of home nursing visits increased by 9% compared to the same period in the year before. The number of persons receiving the service has also increased. The average number of visits per person has grown from 29.3 visits per person in 2013 to 29.8 visits per person in 2014 (see Table 28).

Table 28. Nursing care visits and persons receiving the service

	2013 actual		2014 actual		Change compared to 2013	
	Appointments	Persons	Appointments	Persons	Appointments	Persons
Number of visits and persons	231,949	7,923	252,490	8,461	9%	7%

Accessibility of nursing care

96% of the appointments registered in the waiting lists for nursing care occur within the maximum permitted waiting time – in general, the waiting times remain within the maximum permitted limit, in a few healthcare institutions, however, there may be long waiting times for nursing care. An overview of the accessibility of healthcare services (including nursing care) is available on the website of the EHIF.

Performance of nursing care contracts

In 2014 the EHIF paid medical institutions 24.5 million euros for 57 thousand nursing care cases. The cases provided by the HNDP hospitals form 42% of the performance of nursing care contracts in terms of the number of cases and 58% in terms of the amount. The data of the performance of the specialised medical care contracts in 2014 is given in table 29 below.

Table 29. Performance of nursing care contracts in thousand euros

	Contract for 1st half of 2014		Implementation of contract for 1st half of 2014		Contract for 2nd half of 2014		Implementation of contract for 2nd half of 2014	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
HNDP hospitals	**7 057**	**11 871**	**6 928**	**11 948**	**7 214**	**12 427**	**7 183**	**12 142**
Regional hospital	718	1,167	718	1,154	718	1,165	705	1,122
Outpatient nursing care	88	590	88	596	89	589	89	582
Inpatient nursing care	630	577	630	558	629	576	616	540
Central hospitals	3,224	4,669	3,123	4,350	3,256	4,899	3,256	4,475
Outpatient nursing care	256	1,850	288	2,039	286	2,061	286	2,100
Inpatient nursing care	2,968	2,819	2,835	2,311	2,970	2,838	2,970	2,375
General hospitals and local h.	3,114	6,035	3,086	6,444	3,240	6,363	3,222	6,545
Outpatient nursing care	468	3,266	455	3,505	522	3,511	523	3,576
Inpatient nursing care	2,647	2,769	2,631	2,939	2,718	2,852	2,698	2,969
Selected partners	**5,052**	**15,334**	**5,019**	**15,362**	**4,989**	**16,334**	**4,910**	**16,746**
Outpatient nursing care	1,473	11,606	1,480	11,667	1,795	12,893	1,718	13,364
Inpatient nursing care	3,579	3,728	3,538	3,695	3,194	3,441	3,192	3,382
Total financing contracts	**12,109**	**27,205**	**11,946**	**27,310**	**12,203**	**28,761**	**12,093**	**28,888**
Outpatient nursing care	2,284	17,312	2,312	17,807	2,692	19,054	2,616	19,622
Inpatient nursing care	9,824	9,893	9,635	9,503	9,511	9,707	9,477	9,266
Buying out of waiting lists (contract period of 01.07.–31.12.2014)	0	0	0	0	532	1,483	498	1,101
Outpatient nursing care	0	0	0	0	130	1,095	117	815
Inpatient nursing care	0	0	0	0	402	388	381	286
Total	**12,109**	**27,205**	**11,946**	**27,310**	**12,735**	**30,244**	**12,591**	**29,989**
Outpatient nursing care	2,284	17,312	2,312	17,807	2,822	20,149	2,733	20,437
Inpatient nursing care	9,824	9,893	9,635	9,503	9,913	10,095	9,858	9,552

In entering into contracts for financing treatment in nursing care, the EHIF took into consideration to improve the accessibility of home nursing, above all – this need was also pointed out by the National Audit Office in the recommendations of the nursing care audit introduced to the EHIF in the end of 2014 and published in 2015. In inpatient nursing care, the primary aim of the

EHIF is harmonisation of the geographic accessibility. Nursing care contracts were performed in the amount of 99% in terms of the amount and 100% in terms of cases, in inpatient nursing care, the amount was reached in the extent of 99%, the number of cases in the extent of 95%, in home nursing care, the amount was reached in the extent of 99% and the number of cases in the extent of 102%.

Compared to 2013, the amount paid to the HNDP hospitals increased by 28%, the amount paid to the selected partners (including performance of the contracts entered into to buy out waiting lists) by 9%. The number of nursing care cases provided in the HNDP hospitals increased by 9%, and by the selected partners by 3%.

The amount paid to regional hospitals (the North Estonia Medical Centre and the Tartu University Hospital) increased by 8% compared to the year before in 2014, the number of nursing care cases provided in regional hospitals was 2% lower than in 2013. The contracts of 2014 were performed in the extent of 99% in terms of the amount and in the extent of 98% in terms of cases. The North Estonia Medical Centre provides inpatient nursing care; in both the 1st and the 2nd half of 2014, the health-care institution fulfilled the amount of the contract 100%, while the average cost of a case was slightly higher than agreed. The Tartu University Hospital provides inpatient nursing care as well as home nursing care and geriatric evaluation. Performance of the contract in the 1sta half of the year was in conformity with the plans, in the 2nd half of the year, the healthcare institution provided inpatient nursing care in a slightly lower volume than agreed, the home nursing service and geriatric evaluation were provided as agreed. The Tallinn Children's Hospital does not provide nursing care services.

The amount paid to central hospitals (the East-Tallinn Central Hospital, Ida-Viru Keskhaigla SA, the West-Tallinn Central Hospital, Pärnu Hospital) increased by 37% compared to the year before in 2014, the number of cases in central hospitals was 14% higher than in 2013. The contracts of 2014 were performed in the extent of 98% in terms of the amount and in the extent of 92% in terms of cases. Compared to 2013, the volume of the nursing care provided has significantly increased in Ida-Viru Keskhaigla SA and in the West-Tallinn Central Hospital. In the East-Tallinn Central Hospital, the contractual volume of inpatient nursing care is under-performed compared to the plans, however, the number of home nursing cases exceeds the plans. In total, however, the contract remained somewhat under-performed. The contract of the West-Tallinn Central Hospital was performed in terms of the amount, but due to the significantly higher cost of an inpatient nursing care case than planned, the contract is under-performed by approximately 700 cases in terms of the number of cases. The contract of the East-Tallinn Central Hospital remained under-performed both in terms of the amount as well as in terms of cases. The Pärnu Hospital has performed the nursing care contract as planned.

General hospitals and a local hospital (Hiiumaa Hospital, Jõgeva Hospital, Järvamaa Haigla SA, Kuressaare Hospital, South-Estonian Hospital, Läänemaa Haigla SA, Narva Hospital, Põlva Hospital, Rakvere Hospital, Rapla County Hospital, Valga Hospital, Viljandi Hospital) provided 8% more nursing care cases in 2014 than in 2013. The amount paid to general hospitals for nursing care services increased by 24% compared to the year before. The increase in the provision of nursing care services compared to 2013 was most significant in the Narva Hospital and Rakvere Hospital. Nursing care contracts were implemented in the extent of 99% in terms of the amount and in the extent of 105% in terms of cases, in inpatient nursing care and home nursing, contracts were also implemented in the extent of 99% in terms of the amount and in the extent of 105% in terms of cases.

The number of nursing care cases provided by the selected partners increased by 3% in 2014 compared to 2013, the amount paid to the selected partners in nursing care increased by 9% compared to the year before. The provision of nursing care services by the selected partners was also influenced by the selection competition of contractual partners organised in 2014. With the healthcare institutions with whom contracts were not entered into for the new period, agreements were reached for continuing the treatment of the patients with ongoing treatment until the end of the year – 117 thousand euros was paid for 815 home nursing cases in the 2nd half of 2014 on the basis of the contracts entered into for financing of waiting lists, and 381 thousand euros for 286 inpatient nursing care cases. Nursing care contracts were executed in the extent of 99% in terms of the amount and in the extent of 100% in terms of cases, in inpatient nursing care, in the extent of 99% in terms of the amount and in the extent of 97% in terms of cases, and in home nursing, in the extent of 98% in terms of the amount and in the extent of 101% in terms of cases.

An overview of the performance of nursing care contracts by healthcare institutions is published on the website of the EHIF.

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.

Table 30. Implementation of dental care budget in thousand euros and cases

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases	Amount	Number of cases
Children's dental care	15,032	309,240	16,192	300,797	15,735	309,697	97%	103%
Prevention of dental disease in children	294	18,986	331	19,813	300	18,179	91%	92%
Orthodontics	3,560	46,267	3,840	46,217	3,689	45,905	96%	99%
Emergency dental care for adults	885	20,160	884	18,618	926	19,976	105%	107%
Total	**19,771**	**394,653**	**21,247**	**385,445**	**20,650**	**393,757**	**97%**	**102%**

An increase in the amount of 1.5 million euros compared to the year before was planned in the budget for dental care; in the number of cases, a decrease by 9,200 cases was planned, which was caused by the forecasted decreased in the number of children aged 0–19. The dental care budget was implemented in the extent of 102% in terms of cases and in the extent of 97% in terms of the amount. The financing of dental care increased by 0.9 million euros compared to the year before, the number of cases decreased by 900 (see Table 30).

Children's dental care and prevention of dental diseases are planned together in the budget of the EHIF as of 2015 – the target groups of the services are largely overlapping, differentiation of prevention and treatment as was done so far is not necessary. The EHIF financed the dental care services (except orthodontics) provided to 147 thousand children in 2014. The number of children whose dental care and dental disease prevention services were financed by the EHIF has increased by 1,100 children in the comparison between the two periods. The number of cases has decreased by 350 compared to the year before, but this is primarily caused by the decrease in the number of treatment invoices submitted per person.

The target group of the prevention of dental diseases in children in 2014 were the children born in 2002, 2005, 2007, and 2008. The figure below demonstrates the financing of the dental care of the children in the target group of prevention by counties. Here, the county is based on the practice list of the family physician which the child is included in. The obligation to suggest preventive dentist's appointment lies on family nurses and school nurses – this is established in the job descriptions of the family nurse and the healthcare workers working together with the family nurse as well as in the regulation governing the work of the school nurse. The highest percentage of the children with the birth years under observation visited a dentist in Saare County (85%). The percentage of the children who visited the dentist was the lowest in Rapla County and Lääne County (65%) (see Figure 14). The cooperation between family nurses, school nurses and dentists needs continuous improvement. To ensure continuous provision of dentist's services in all Estonian counties, the EHIF will organise a selection competition to find contractual partners in 2015.

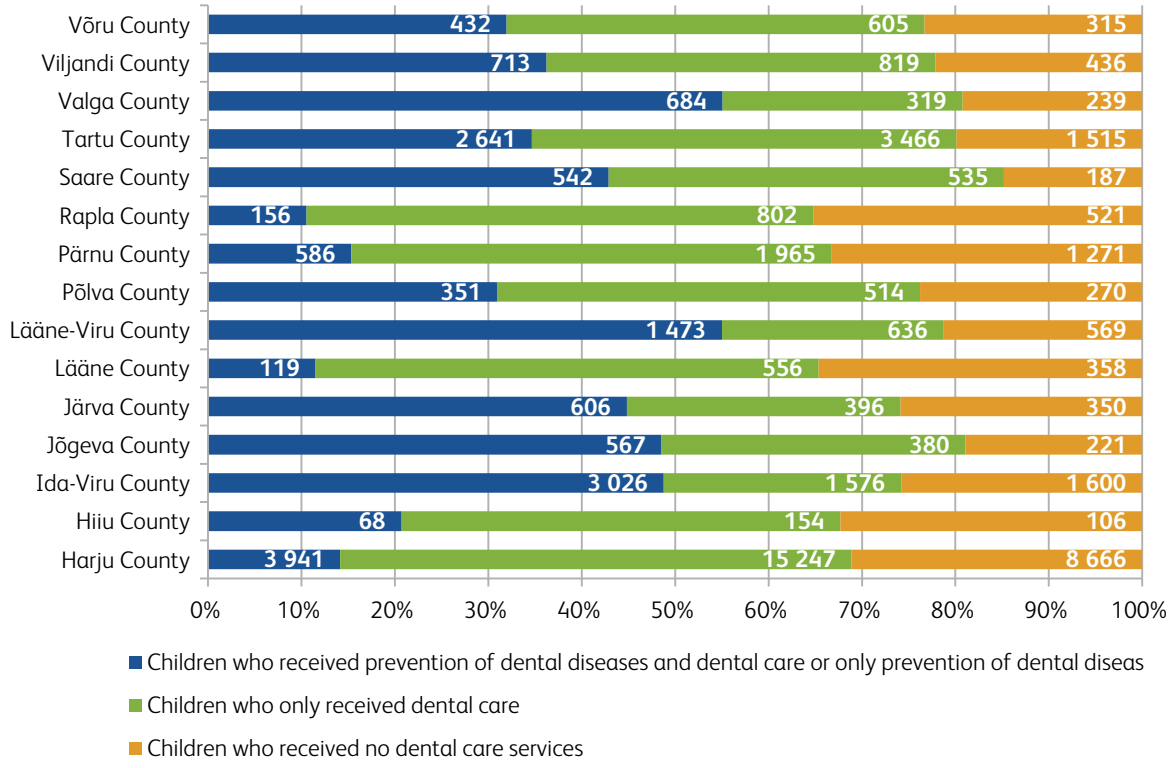


Figure 14. Participation of children up for preventive medical checks according to their year of birth under treatment contracts in preventive examinations or receipt of dental care services by these children in absolute figures and as a percentage of all children of the same year of birth – based on the county of the family physician's practice list

An increase in financing of 0.3 million euros was planned in orthodontics and an increase in the number of cases by 50. The budget was implemented in the extent of 96% in terms of the amount and in the extent of 99% in terms of cases. Compared to the year before, the financing of orthodontics increased by 0.1 million euros, with the number of cases decreasing by 360. In orthodontics, the number of cases per person who received treatment also arises from a decrease in the number of treatment invoices submitted per person. The number of persons who received treatment has increased by 1.4% or 300 children compared to the previous period, which can be deemed positive.

The amount planned in the budget for financing emergency dental care for adults remained on the level of the use in the year before, with the number of cases decreasing by 1,500. The budget was implemented in the extent of 105% in terms of the amount and in the extent of 107% in terms of cases. Compared to the year before, the financing of emergency dental care for adults increased by 41 thousand euros, the number of cases decreased by 180. In 2014 in total, the financing of the emergency dental care for adults has decreased compared to the same period in the year before in terms of cases as well as the number of persons treated. The budget was over-implemented due to the fact that faster decrease in the use was presumed in the budget.

Accessibility of dental care

The waiting times in dental care are generally within the maximum permitted limits. In case of orthodontic services, the waiting times remain within the maximum permitted limits in case of 97% of the appointments registered in the waiting lists, in case of other children's dental care services, 96% of the appointments occur within the maximum permitted waiting times. An overview of the accessibility of healthcare services (including dental care) is published on the website of the EHIF.

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. Promotion of the health and wellbeing of the population is more successful with active contributions from several authorities cooperating in the name of a common goal. In addition to the EHIF, health promotion activities are financed by the Ministry of Social Affairs and the National Institute for Heath Development.

There was one million euros planned for health promotion in the budget of the EHIF for 2014. 857 thousand euros or 85.7% of the budget was used of the resources planned for 2014. The under-implementation is mainly related to considered postponement of certain activities until 2015. Budget implementation is also influenced by economically more favourable tenders in the form of public procurements. The resources left unused in 2014 were mainly designated for patient guidelines (see Table 31).

Table 31. Health promotion expenses in thousand euros

	2013 actual	2014 budget	2014 actual	Budget implementation
Health promotion activities for children	157	170	189	111%
Prevention of home and leisure time injuries and poisoning	243	250	250	100%
Activities aimed at patient awareness	306	580	418	72%
Total	**706**	**1,000**	**857**	**86%**

Within the scope of an injury prevention project, events were organised in 17 areas, with the main aim of increasing the ability of the area to decrease the instances of home and leisure time injuries – including damage to health caused by alcohol or poisoning. Safety-related youth camps for 6th-8th form students were also held as part of the project, in the course of which the teachers received the required training as well. The project "Prevention of home and leisure time injuries" ended in 2014.

Nationwide events were held as part of the children's dental health project. The main objective of the project is shaping of the children's oral hygiene and eating habits to prevent dental caries and raising awareness of children's oral health in the parents and stakeholders. The target group of the project included 1,659 children and 161 parents. 81 trainings were organised at 44 different educational institutions within the framework of the project. 82 school nurses, 261 healthcare workers and 340 teachers/kindergarten teachers participated in the training. Information days for the stakeholders were organised in all counties. The website of the project was updated and made more user-friendly. Online guidelines entitled "Oral School" were drawn up, which are available at www.kiku.hambaarst.ee. 17 articles on oral health were published in nationwide newspapers in the course of the project, radio and television interviews were given.

Nationwide activities were organised within the scope of the children's health promotion programme "Health Promotion in Schools and Nursery Schools". The general objective of the project is development of health-supporting environments at kindergartens and schools and increasing the capability to implement activities directed to healthy development of children. Within the project, refresher courses have been organised to deepen health-promoting attitudes and to implement health-related knowledge in practice, with representatives of the total of 120 educational institutions, the total of 240 employees participating. The cooperation networks take place in 18 places through representatives of all counties, with 270 institutions counselled by coordinators. Diabetes nurses have counselled and trained employees and parents at 428 educational institutions, including 90 children/pupils from 33 institutions. Within the framework of the project, 4 diabetes guidelines have been printed and distributed in cooperation with the Estonian Children's and Youth Diabetes Association. By the end of 2014, 15 preschool educational institutions will have joined the health promotion network TEL[6] and 7 general education schools the health promotion network TEK[7], the total of 22 educational institutions. The network includes the total of 50 educational institutions, which form 41.7% of all educational institutions.

6 TEL – health-promoting kindergartens

7 TEK – health-promoting schools

For promotion of the healthcare system a national health promotion conference "Moving for the benefit of health" with the participation of 276 people took place in Pärnu on 6 June, 2014. According to the participants of the conference, the organisation, content and implementation of the conference were good. In June 2014, there was a 3-day training in Pärnu for the persons preparing clinical guidelines, the aim of which was to introduce new methods: drawing up the areas of treatment, performing searches, assessing the clinical guidelines with AGREE, assessing the evidence by applying the principles of GRADE and drawing up recommendations. 54 healthcare professionals participated in the training. Professor Holger Schünemann from Canada participated as a foreign lecturer.

To improve the awareness of the population, a primary level campaign "Finding solutions to health issues begins with your family physician and family nurse" was organised in the 1st half of 2014. The objective of the campaign was to increase the awareness of the population of the possibilities of primary level healthcare system. The campaign was organised to open the content of the service offered by the family physician and the family nurse so that people would realise that the family physician is a specialist and can diagnose and treat most diseases. The primary level campaign was repeated in the 2nd half of 2014. The visibility of the initial campaign was 84%, the visibility of the repeat campaign was equally good – 83% of the population and the initial target group. Health pages covering issues related to the EHIF have been published in the six largest daily and weekly newspapers since February, this year, extra attention is paid to the Russian-speaking readers in the Ida-Viru region with the newspaper Põhjarannik involved.

Of health-related publications for children, the publication "Diabetes in youths and children" was reprinted and a new teeth-themed calendar was put together for children. A new design has been ordered for publications the purpose of which is to ensure that all publications financed by the EHIF would clearly recognisable. Follow-up activities concerning six reprints have been postponed until the 1st half of 2015.

The objective of the pregnancy crisis counselling promotion project is to ensure the accessibility of an appropriate counselling service for pregnant women and their loved ones to enable making of informed decisions in pregnancy-related issues, increasing awareness of the potential risks and receive information about the support services and benefits ensured by the state. Pregnancy crisis counselling involves assessment of the client's condition by using a diagnostic interview, followed by making predictions and planning intervention. In 2014, 2,200 different persons were counselled on 4,500 occasions with the support of the EHIF on the basis of referrals, which makes the average of 2 appointments per client.

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. Pharmaceuticals were reimbursed to the insured persons in the total amount of 109.8 million euros in 2014, 100% of the budget was implemented (see Table 32).

Table 32. Implementation of the budget of pharmaceuticals reimbursed to insured persons

	2013 actual	2014 budget	2014 actual	Budget implementation
Pharmaceuticals reimbursed 100%	50,919	54,200	53,630	99%
Pharmaceuticals reimbursed 90%	30,231	32,200	32,796	102%
Pharmaceuticals reimbursed 75%	5,738	6,100	5,973	98%
Pharmaceuticals reimbursed 50%	16,503	17,500	17,354	99%
Total	**103,391**	**110,000**	**109,753**	**100%**

The financing required for reimbursement of pharmaceuticals increased by 6.2% compared to 2013. 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% compared to the year before, which is a reflection of the increase in the use of expensive pharmaceuticals with 100% discount rate. The cost of the average reimbursed prescription for the EHIF has also increased, by 3%. The average cost of pharmaceuticals with 100% discount rate has decreased by 1%, which was largely caused by a decrease in the prices of pharmaceuticals in the segment of certain pharmaceuticals used in haematology. The increase in the average cost of a recipe was the highest in case of pharmaceuticals with 90% discount rate, which resulted from commencement of reimbursing more expensive new pharmaceuticals in the budget period than the ones used before (e.g., new anticoagulants in stroke prevention) (see Table 33).

Table 33. Number and average cost of reimbursed prescriptions for EHIF

	2013 actual		2014 actual		Change compared to 2013	
	Number of prescrip-tions	Average cost of reimbursed prescription for EHIF	Number of prescrip-tions	Average cost of reimbursed prescription for EHIF	Number of prescrip-tions	Average cost of reimbursed prescription for EHIF
Pharmaceuticals reimbursed 100%	845,903	60.19	900,451	59.56	6%	-1%
Pharmaceuticals reimbursed 90%	2,774,212	10.90	2,858,018	11.48	3%	8%
Pharmaceuticals reimbursed 75%	558,438	10.28	565,074	10.57	1%	3%
Pharmaceuticals reimbursed 50%	3,446,582	4.79	3,560,116	4.87	3%	2%
Total	**7,625,135**	**13.56**	**7,883,659**	**13.92**	**3%**	**3%**

All in all, the EHIF financed reimbursed prescriptions in the amount of 89 euros on average per insured patient in 2014 and this amount increased by 6% compared to the previous year (see Figure 15).

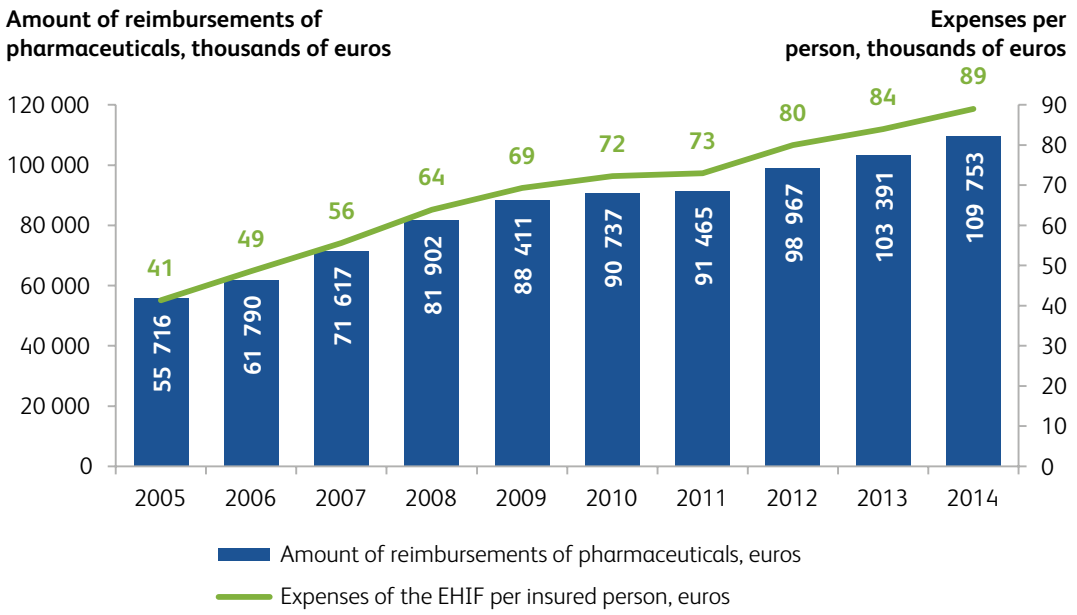
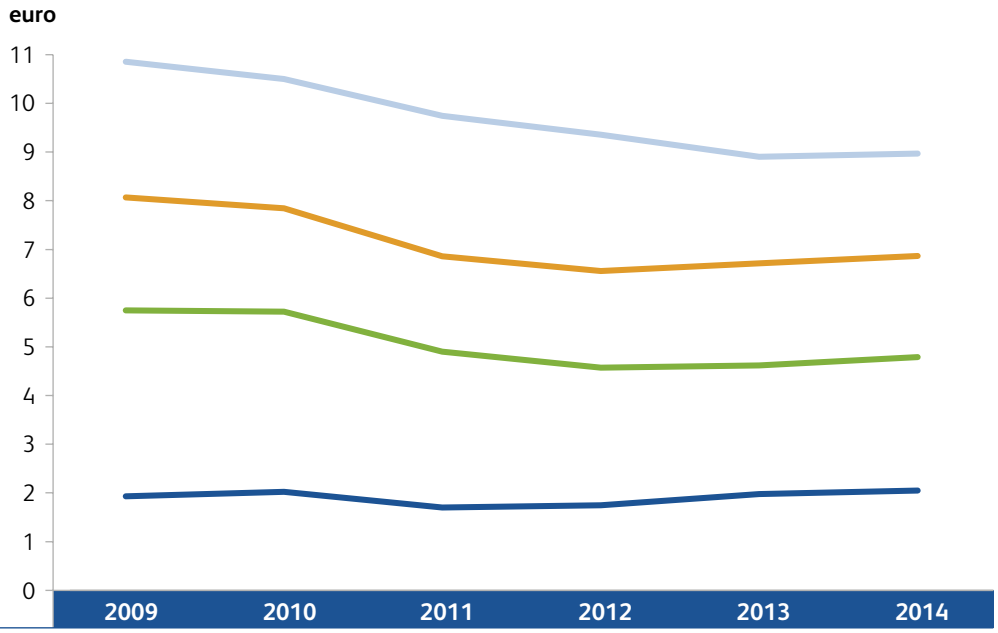


Figure 15. Total cost of reimbursed pharmaceuticals and cost per one insured person from 2005-2014

Even though increasingly innovative and more and more expensive pharmaceuticals are taken into use, the out-of-pocket expenses of insured persons when purchasing prescription pharmaceuticals have remained stable. As a ratio, it has dropped from 32s1% to 31.7% in the year and the average cost of a prescription for the patient was 6.46 euros (see Table 34 and Figure 16).

Table 34. Out-of-pocket expenses by insured person, %

	2013 actual	2014 actual	Change compared to 2013
Prescriptions with 100% discount rate	3.20	3.30	0,1%
Prescriptions with 90% discount rate	29.80	28.80	-1,0%
Prescriptions with 75% discount rate	39.50	39.40	-0,1%
Prescriptions with 50% discount rate	65.00	64.80	-0,2%
Total	**32.10**	**31.70**	**-0,4%**



	2009	2010	2011	2012	2013	2014
50% discount rate	10,85	10,50	9,74	9,36	8,91	8,97
75% discount rate	8,07	7,85	6,86	6,56	6,71	6,86
90% discount rate	5,75	5,72	4,90	4,57	4,62	4,79
100% discount rate	1,93	2,02	1,70	1,75	1,98	2,05

Figure 16. Average cost of prescription for patient, euros

86% of the prescriptions issued by doctors in 2014 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.

The reimbursement of 19 new active ingredients started in 2014. This is significantly more than the five new active ingredients in 2013. The selection of pharmaceuticals for the treatment of chronic obstructive pulmonary disease, hepatitis C, type 2 diabetes, gout and advanced forms of pancreatic, kidney and prostate cancer was expanded. The so-called new anticoagulants designed for stroke prevention, pharmaceuticals for hepatitis C and various pharmaceuticals for the treatment of prostate cancer can be considered the most important here (a significant impact on the budget and a jump in the quality of treatment).

In certain exceptional cases, the EHIF pays reimbursement for pharmaceuticals on the basis of an individual application submitted by the patient. This procedure is mostly used if the pharmaceutical required by the patient and used in outpatient use

has no marketing authorisation in Estonia and this the pharmaceutical cannot be added in the EHIF's list of pharmaceuticals. In 2014, 2,357 persons received extraordinary reimbursements in the total amount of 620 thousand euros.

The highest percentage of health insurance resources is spent on reimbursement of the diabetes pharmaceuticals sold at a discount, which in turn is mainly caused by insulin preparations. The amount spent on diabetes pharmaceuticals has increased by 9.4% in the year. The cost of the pharmaceuticals for hypertension currently in the second place have remained relatively stable. The amount of reimbursement of cancer pharmaceuticals in the budget of pharmaceuticals sold at a discount has decreased, but it must be kept in mind that many new cancer pharmaceuticals are used in hospitals and thus, in case of this diagnosis, the expenses on pharmaceuticals sold at a discount do not include reimbursement of all cancer pharmaceuticals. The reimbursement of pharmaceuticals for viral hepatitis C has increased most due to the introduction of new and more effective pharmaceuticals.

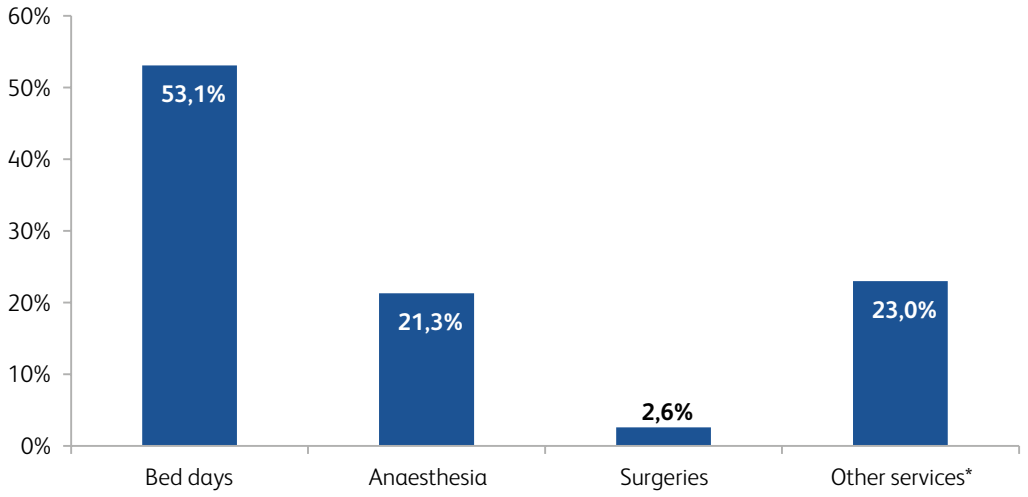
Table 35 provides an overview of the diagnoses related to the largest reimbursements of pharmaceuticals.

Table 35. Diagnoses with the biggest reimbursement of pharmaceuticals in thousand euros

	2013 actual		2014 actual	
Diagnosis	Reimbursed by the EHIF	% of total reimbursed cost	Reimbursed by the EHIF	% of total reimbursed cost
Total diabetes, incl.	16,099	16	17,609	16
insulin	10,986	11	11,455	10
orally administered preparations	5,113	5	6,154	6
Hypertension	14,675	14	14,913	14
Cancer	13,187	13	12,253	11
Bronchial asthma	6,149	6	6,343	6
Glaucoma	3,875	4	4,359	4
Chronic hepatitis C	1,964	2	3,681	3
Mental disorders	2,792	3	2,938	3
Hypercholesterolemia	2,370	2	2,343	2
Total	**61,111**	**59**	**64,439**	**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 2014 the pharmaceutical component of health services amounted to 16.2 million euros, which is 2% less than in the year before. The change in the percentage was caused by the decrease in the volume of inpatient care and the increase in the wages of healthcare workers. 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 17).



*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 17. Division of pharmaceuticals in health care services

The EHIF also assumes the obligation to pay for the so-called pharmaceutical services (so called 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 18).

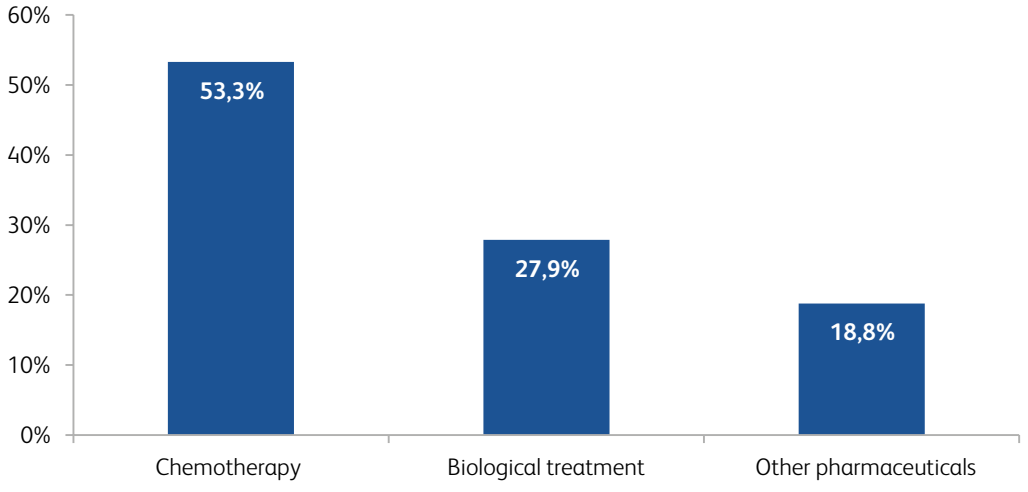


Figure 18. Share of pharmaceuticals reimbursed via the list of health services

The share of the pharmaceutical services in the list of health services was 40.9 million euros in 2014, which indicates an increase of 3% compared to the previous year.

167.1 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 18.4% of the total health insurance budget (see table 36).

Table 36. Financing of pharmaceuticals from the budget of the EHIF in thousand euros

	2013 actual	2014 actual	Change compared to 2013
Prescription pharmaceuticals reimbursed to insured persons	103,391	109,753	6%
Use of pharmaceutical codes in the list of healthcare services	39,760	40,947	3%
Pharmaceuticals in health services	16,483	16,204	-2%
Supplementary benefit for pharmaceuticals	187	199	6%
Total	**159,821**	**167,103**	**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 forgoes social-taxed income due to a temporary exemption from work.

In 2014, benefits for temporary incapacity for work totalled 103.9 million euros, which is 9.8 million euros more than the year before (see Table 37).

Table 37. Budget implementation for benefits for temporary incapacity for work, € '000

	2013 actual	2014 budget	2014 actual	Budget implementation
Sickness benefits	42,421	42,882	46,403	108%
Care allowances	15,192	15,258	16,465	108%
Maternity benefits	33,736	35,417	37,890	107%
Occupational accident benefits	2,752	2,814	3,144	112%
Total	**94,101**	**96,371**	**103,902**	**108%**

The Estonian Health Insurance Fund calculates the 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 of incapacity for work: 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 the certificate of incapacity for work and the cause of the incapacity (see website of the Health Insurance Fund).

Figure 19 shows that in 2014, sickness benefits continued to account for the largest share of all benefits for incapacity for work, i.e., 45%. Compared to the year before, the breakdown of expenses according to types of benefits has remained the same.

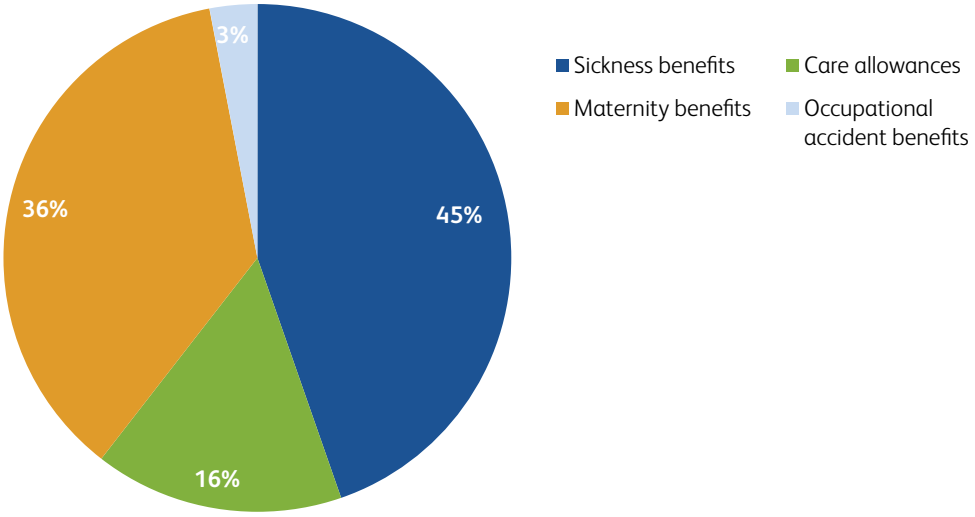


Figure 19. Distribution of benefits for temporary incapacity for work by type of benefit in 2014

Compared to the year 2013, benefits for temporary incapacity for work increased by 10%, exceeding the budget by 8%. The reason for exceeding the budget was the higher-than-expected increase in average wages[8], number of insured persons working[9] and number of certificates for maternity leave.

Looking at table 38, we can see that in 2014, the number of certificates reimbursed by the Health Insurance Fund remained on the same level it was before, but the number of days compensated increased by 3%. This change is explained by the increase in the number of certificates for maternity leave, which are significantly longer in duration than the certificates of incapacity for work.

Table 38. Comparison of benefits for incapacity for work

	2013 actual	2014 actual	Change compared to 2013
Sickness benefit			
Certificates paid for by the EHIF	220,929	217,582	-2%
Days paid for by the EHIF	2,915,972	2,997,073	3%
Total benefits paid by the EHIF (€ '000)	42,421	46,403	9%
Average benefit per day (€)	14.5	15.5	7%
Care allowance			
Certificates paid for by the EHIF	104,019	106,419	2%
Days paid for by the EHIF	846,660	855,143	1%
Total benefits paid by the EHIF (€ '000)	15,192	16,465	8%
Average benefit per day (€)	17.9	19.3	8%
Average duration of paid leave	8.1	8.0	-1%
Maternity benefit			
Certificates paid for by the EHIF	9,677	9,969	3%
Days paid for by the EHIF	1,347,845	1,385,026	3%
Total benefits paid by the EHIF (€ '000)	33,736	37,890	12%
Average benefit per day (€)	25.0	27.4	10%
Average duration of paid leave	139.3	138.9	0%
Occupational accident benefits			
Certificates paid for by the EHIF	5,469	5,752	5%
Days paid for by the EHIF	118,109	124,760	6%
Total benefits paid by the EHIF (€ '000)	2,752	3,144	14%
Average benefit per day (€)	23.3	25.2	8%
Average duration of paid leave	21.6	21.7	0%
Total benefits			
Certificates paid for by the EHIF	340,094	339,722	0%
Days paid for by the EHIF	5,228,586	5,362,002	3%
Total benefits paid by the EHIF (€ '000)	94,101	103,902	10%
Average benefit per day (€)	18.0	19.4	8%

8 Economic forecast by the Ministry of Finance in autumn 2013

9 According to the register of insured persons

Sickness benefits

Sickness benefits are benefits paid to insured persons during the period of temporary incapacity for work. In case of incapacity for work due to sickness, non-work injuries, quarantine and traffic injuries, the benefit is not paid from days 1-3 of this period; the benefit is paid by the employer from day 4 to day 8 and since day 9, the benefit is paid by the Health Insurance Fund. In other cases, the benefit is paid by the Health Insurance Fund from the second sickness day.

In 2014, certificates of incapacity for work were most used due to sickness and non-work injuries by 83% and 11%, respectively (see Figure 20). Compared to the previous year, the use of certificates of incapacity for work remained unchanged with respect to reasons for the certificates.

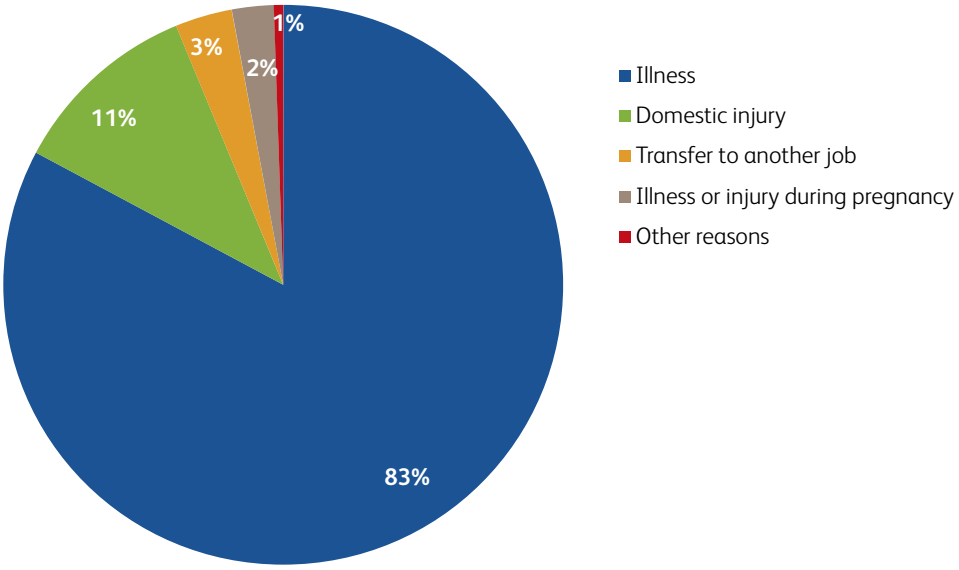


Figure 20. Breakdown of sick leave certificates by cause of leave

As regards different types of treatment, certificates for sick leave were used as follows: outpatient treatment was used in 92% and hospitalisation in 8% of the cases. Compared to the year 2013, the use of outpatient treatment increased by 2%.

By age groups, the take-up of sickness days per insured person has either decreased or remained on the same level with the year before (see Table 39).

Table 39. Number of employed insured persons and take-up of sickness days across age groups*

	Number of employed insured persons as of 31.12.2013	Number of sickness days per employed insured person	Number of employed insured persons as of 31.12.2014	Number of sickness days per employed insured person	Change in number of employed insured persons	Change in number of sickness days
... –29	112,041	6.1	115,178	6.1	3%	0%
30–39	132,827	5.3	134,610	5.2	1%	-2%
40–49	135,324	6.7	137,814	6.4	2%	-4%
50–59	131,323	9.8	133,618	9.4	2%	-4%
60–...	72,579	9.1	79,778	9.1	10%	0%

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

In 2014, the share of short-term certificates due to occurrence of viruses decreased, reflected by the decrease in the number of certificates compensated for by the EHIF by 2% together with a simultaneous increase of 3% in the number of days compensated for.

Care allowances

Care allowance is paid to an insured person who provides nursing care to a sick child or family member. The use of certificates for care leave has across the causes of leave has not changed when compared to the previous year. Certificates for care leave for nursing a child under 12 years of age made up 98% of all care leave certificates. Certificates for care leave for nursing a child under 3 years of age, a disabled child under 16 years of age or a sick family member made up 2% of the certificates for care leave.

Maternity benefits

Maternity benefits are benefits paid to employed insured women in case of maternity leave.

In 2014, the use of certificates for maternity increased by 3% compared to the same period last year. At the same time, according to the statistics by Statistics Estonia, the number of births dropped by 1%. Looking at the use of certificates for maternity leave across counties (see Figure 21), Harju County stands out with 5% more certificates than in the same period last year.

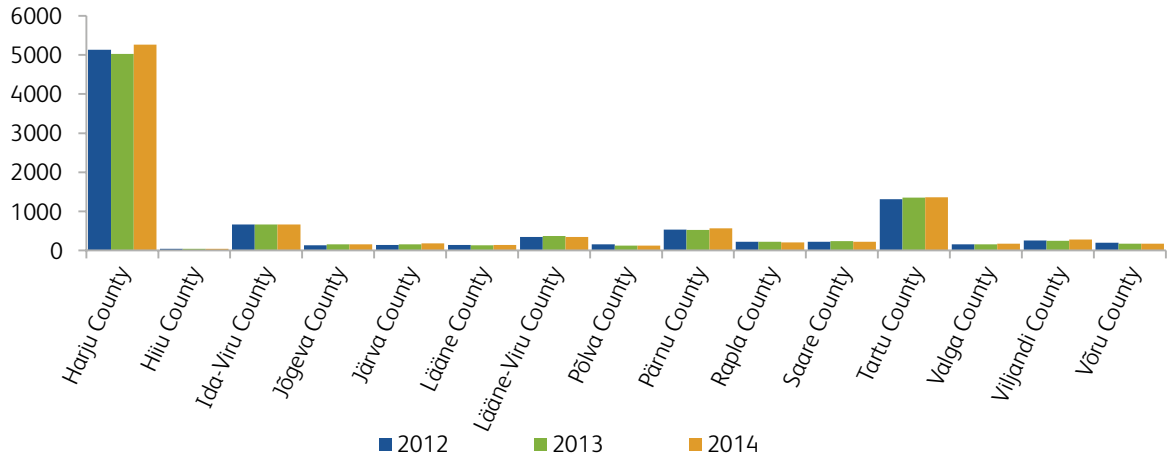


Figure 21. Number of certificates for maternity leave in counties in 2012-2014

In analysing the use of certificates for maternity leave in Harju County by age groups, it appeared that 30-39 year-old women with higher income and women aged 40-49 have started to give births more. The daily average maternity benefit in these age groups amounts to 35 and 40 euros, respectively, significantly impacting the daily average cost of maternity benefits.

Occupational accident benefits

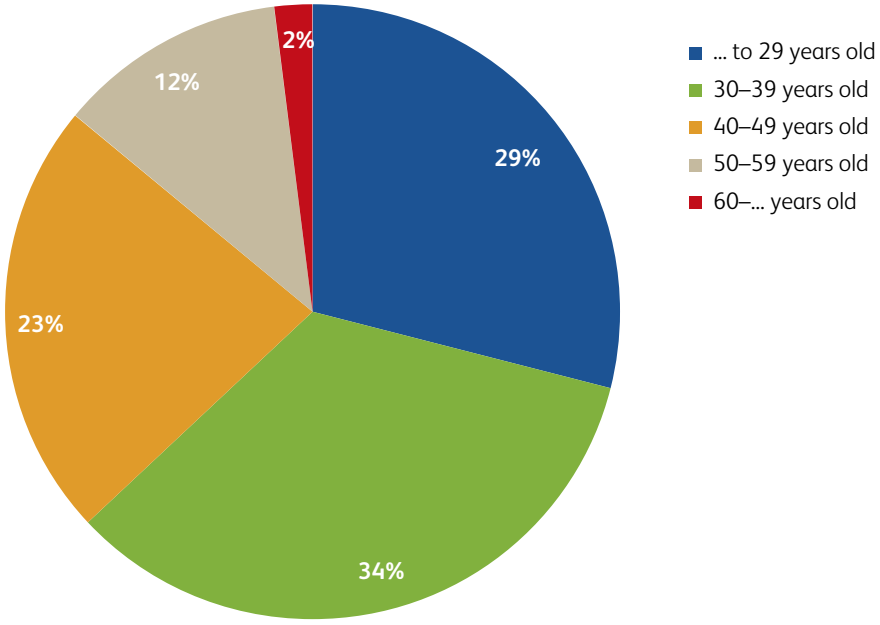
Occupational accident benefits are paid starting from day 2 of the certificate of incapacity for work.

In the breakdown of causes of certificates of incapacity for work issued due to occupational accidents, a slight shift has occurred compared to last year. Even though in 2014, the number of employed insured people increased by 3% compared to the same period last year (see Table 3), the number of certificates of incapacity for work issued due to occupational accidents decreased by 1%. 2014. On the certificates of incapacity for work submitted to the EHIF, the causes of the exemption from work were as follows: occupational accidents made up 94%, complications resulting from occupational accidents 4% and work injuries 2%.

Benefits paid on the basis of certificates from foreign physicians

The EHIF also pays benefits for temporary incapacity for work to insured persons on the basis of certificates for incapacity of work issued by physicians in foreign countries. In 2014, foreign physicians issued 559 initial leave certificates Estonian insured

persons. Compared to the year before, the number of the certificates remained the same, but a total of 3% less benefits were paid. The decrease in the amount of benefits paid was probably caused by an increase in the number of low-income insured people as benefits are calculated on the same grounds for both foreign and domestic certificates of incapacity for work. Certificates issued by foreign physicians accounted for 64% of sickness benefits, 30% of care allowances, 4% of maternity benefits and 2% of occupational accident benefits. The share of benefits in the types of certificates of incapacity for work has significantly changed. On Figure 22, we can see that the issue of certificates of incapacity for work has significantly changed by age groups as well. If in 2013, people aged 30-49 took up 60% of the certificates of incapacity for work, then in 2014, most of the certificates (63%) were taken up by the age group of people up to the age of 39.



Joonis 22. Välisriigi arstitõendid vanusegruppide lõikes

5. Other financial benefits

Other financial benefits cover

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

Table 40. Budget implementation for other financial benefits, € '000

	2013 actual	2014 budget	2014 actual	Budget execution
Financial benefits for dental care services	9,140	9,827	9,159	93%
Supplementary benefit for pharmaceuticals	187	121	199	164%
Total	**9,327**	**9,948**	**9,358**	**94%**

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 regulation of the Minister of Social Affairs in to improve the availability of dental care services.

Financial benefits for dental care services are divided into two:

- denture benefits;
- dental care benefits.

In 2014, financial benefits for dental care services totalled 9.2 million euros, which is 19 thousand euros more than the year before (see Table 41). The main reason for the under-implementation of the budget is lower use of dentures than expected.

Table 41. Budget implementation for benefits for dental care services, € '000, and number of applications

	2013 actual		2014 budget		2014 actual		Budget implementation	
	Amount	Number of applications	Amount	Number of applications	Amount	Number of applications	Amount	Number of applications
Denture benefits	7,228	39,181	7,795	47,514	7,275	39,633	93%	83%
Dental care benefits	1,912	96,095	2,032	102,527	1,884	97,138	93%	95%
Total	**9,140**	**135,276**	**9,827**	**150,041**	**9,159**	**136,771**	**93%**	**91%**

Every year, the EHIF reimburses the cost of dental care services to insured persons as follows:

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

The EHIF reimburses the cost of dentures to insured persons who have been granted pension for incapacity for work or old-age pension pursuant to the State Pension Insurance Act, and persons who are 63 years old and older, in the amount of up to 255.65 euros within a three-year period.

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. By submitting the application directly to the dentist, a person can request that the price of the service be lowered 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 rest is paid by the EHIF. Compared to the year 2013, in 2014, the share of insured people who applied for the benefit through the service provider increased by 8%, making up 85% of all applications for the benefit for dentures. Pensioners prefer to apply for the benefit through the service provider as this way, they are saved the journey to the EHIF and the invoice payable is smaller by the amount of the benefit.

When comparing the use of dental care benefits in 2013 according to types, we can see an increase only in the number of applications submitted by old-age pensioners and persons receiving pension for incapacity for work (see Table 42). One of the reasons for the increase in the number of applications submitted is the increase in the number of old-age pensioners[10]. Use of benefits by pregnant women and mothers of children under one year of age continues to decrease, probably due to lower birth rates[11].

Table 42. Applications for benefits for dental care services by type of benefit

	2013 actual	2014 actual	Change compared to 2013.
Pregnant women	5,027	4,985	-1%
Mothers of children under one year of age	5,807	5,432	-6%
Persons with an increased need for dental care	129	126	-2%
Persons entitled to a pension for incapacity for work or an old-age pension	85,132	86,595	2%
Total	**96,095**	**97,138**	**1%**

5.2 Supplementary benefits for pharmaceuticals

Up to the present, an insured person was eligible for supplementary benefits for pharmaceuticals if their expenses on listed pharmaceuticals exceeded 384 euros in a calendar year (the mandatory own contribution or prescription fee and any amounts exceeding the reference price were not taken into account). In 2014, the number of insured people who received the benefit decreased by 2%, but the average amount paid out to a person increased by 8%. In addition to the discount received in the pharmacy, a total of 1,333 patients received supplementary benefits in the amount of 199,000 euros (see Table 43).

Table 43. Budget implementation for supplementary benefits for pharmaceuticals

	2013 actual	2014 budget	2014 actual	Budget implementation
Amount of benefit (€ '000)	187	121	199	164%
Number of beneficiaries	1,357	1,420	1,333	94%
Average amount paid to a beneficiary (€)	138	85	149	175%

10 According to Statistics Estonia, the number of old-age pensioners has been increasing year by year for the past 5 years.

11 According to Statistics Estonia, birth rate has been falling year by year since 2011.

6. Other expenses

Other expenses include

- planned treatment abroad;
- benefits arising from European Union legislation;
- benefits for medical devices;
- health insurance expenses covered by government grants;
- miscellaneous health insurance benefits.

Table 44. Budget implementation for other expenses, € '000

	2013 actual	2014 budget	2014 actual	Budget implementation
Planned treatment abroad	2,168	1,760	3,882	221%
Benefits arising from European Union legislation	5,679	6,464	6,140	95%
Benefits for medical devices	8,325	9,066	8,770	97%
Health insurance expenses covered by government grants	1,465	1,740	1,446	83%
Miscellaneous health insurance benefits	0	0	35	-
Total	**17,637**	**19,030**	**20,273**	**107%**

6.1 Planned treatment abroad

The cross-border free movement of insured persons is regulated by European Union legislation and the agreement between the Estonian Health Insurance Fund and the Finnish Red Cross for finding unrelated bone marrow donors. An insured person can be referred for planned treatment or tests abroad if the health care service sought for cannot be provided to insured person in Estonia, nor are there any alternatives to that service available to that person in Estonia. The health care service must be indicated for the insured person, its medical effectiveness must be proven and the average probability of achieving the expected outcome must be at least 50%. The decision on the compliance with these criteria is assessed by a council of at least two medical specialists.

Compared to last year, both the number of treatment events and the average cost of a treatment event have increased. If in 2013, the average cost of a treatment event in 2013 amounted to 8,600 euros and the budget implementation to 2.2 million euros, then in 2014, the average cost of a treatment event was 14,000 euros and the budget was implemented in the amount of 3.9 million euros (see Table 45). The budget was overimplemented due to the fact that in 2014, the number of more expensive treatment events was higher than in earlier years.

Table 45. Budget implementation for planned treatment abroad, € '000

	2011 actual	2012 actual	2013 actual	2014 budget	2014 actual	Budget implementation
Planned treatment abroad	1,745	2,035	2,168	1,760	3,882	221%

During 2014, the EHIF assumed the obligation to pay for planned health services abroad in 248 cases. Of these, 58 decisions were made on planned treatment abroad, 166 on conduct of tests abroad and in case of 24 insured people, unrelated bone

marrow donors were sought through the Blood Services of the Finnish Red Cross. For 8 cases, reimbursement of planned treatment abroad was denied, that is, the share of satisfied applications is 97%. In 2014, the largest number of patients was referred for treatment or tests to Finland and Germany. Most of the gene tests were performed in the Netherlands and in Belgium (see Table 46).

Table 46. Countries where insured persons received treatment or underwent tests in 2014*

Countries	Total	Treatment	Tests
Germany	76	17	59
Belgium	39	0	39
Finland	38	21	17
The Netherlands	28	0	28
Denmark	9	0	9
Sweden	7	2	5
Latvia	7	7	0
United Kingdom	6	1	5
Russia	4	4	0
USA	3	1	2
Italy	2	1	1
Switzerland	1	1	0
Poland	1	1	0
Ireland	1	1	0
Spain	1	0	1
Austria	1	1	0
Total	**224**	**58**	**166**

*The number of affirmative decisions taken during the year is not compatible with the number of people who went abroad as with regard to some persons, several decisions on treatment or tests have been made.

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 do not coincide fully in any one year.

In 2014, treatment invoices received from other countries for 272 persons. Of these, 85 persons were treated and 153 tested abroad and 33 persons incurred expenses related to finding a bone marrow donor; in addition, one person received invoices for both treatment and for finding a bone marrow donor. In 2013, treatment invoices were received from other countries for 252 persons. Of these, 63 were treated and 161 tested abroad 28 persons' invoices concerned searches for bone marrow donors.

6.2 Benefits arising from EU legislation

The provision of and payment for health services is governed by a regulation of the European Parliament and of the Council coordinating the social insurance systems of the European Union, 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;
- receive any type of health care when they reside in another Member State.

Persons insured in other EU Member States are entitled to:

- receive the necessary health care while staying temporarily in Estonia;
- receive 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 these costs.

Financing of cross-border health care is an open commitment for the EHIF. A sum of 6.5 million euros was planned for this purpose in the 2014 budget. The actual expenditure was somewhat lower – 6.1 million euros. Compared to the year 2013, expenses have gone up by 8% (see Table 47).

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 planned treatment there, pay for it 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. In 2014, the EHIF satisfied 69 applications and reimbursed 101,000 euros to insured persons for the healthcare services received abroad. According to the estimates of the EHIF, the implementation of the patients' rights directive has not had a negative impact on the availability of the services financed by the EHIF in Estonia.

Table 47. Budget implementation for health care services under the Directive and Regulation of the European Parliament and the Council, € '000

	2011 actual	2012 actual	2013 actual	2014 budget	2014 actual	Budget implementation
Expenses of Estonian insured persons abroad on health care services	5,266	3,930	4,480	4,665	4,781	102%
Expenses of other Member States' insured persons in Estonia on health care services and discount pharmaceuticals	1,199	1,228	1,199	1,319	1,258	95%
Costs according to European Parliament and Council directive	0	0	0	480	101	21%
Total	**6,465**	**5,158**	**5,679**	**6,464**	**6,140**	**95%**

Providers were paid 1.2 million euros for the health care services provided in Estonia to patients from other EU Member States and pharmacies were paid 44,000 euros for pharmaceuticals sold to such patients at a discount.

The EHIF paid 4.8 million euros to other Member States for health care services provided to persons temporarily staying in other EU Member States and employees seconded to and retired persons living in other Member States. Of this amount, 712,000 euros was capitation fee paid on behalf of the people who receive a pension from Estonia. Health care services of people living or staying in other countries were financed for 4 million euros. A total of 46,000 euros was reimbursed to people.

Reimbursements were made to insured people who did not have their European health insurance card on them during their stay in another Member State and were thus rendered an invoice.

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 Health and Labour.

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.

Compared to the year 2013, the benefits paid for medical devices have increased by more than 5%. This could be expected because at the end of 2014, a new category was added to the list of medical devices, a few categories were supplemented with new articles and the conditions of reimbursement were revised. The number of people who use medical devices has also increased (see Table 48).

Table 48. Budget implementation for benefits for medical devices, € '000, and number of persons

	2013 actual		2014 budget	2014 actual		Budget implementation
	Amount	Number of persons	Amount	Amount	Number of persons	Amount
Primary prostheses and orthoses	1,710	12,877	1,710	2,058	16,179	120%
Glucometer test strips	4,216	38,528	4,500	3,751	40,998	83%
Stoma appliances	1,145	1,756	1,160	1,221	1,762	105%
Insulin pumps	59	62	63	53	55	84%
Accessories for insulin pumps	382	247	387	441	286	114%
Wound dressings and patches	52	1,128	80	49	1,571	61%
CPAP device	352	704	362	557	1,112	154%
CPAP device masks	152	1,171	154	257	1,577	167%
Other medical devices	40	248	37	41	271	111%
Disposable needles for insulin injection devices	217	7,569	400	292	10,600	73%
Lancets	0	0	213	50	5,505	23%
Total	**8,325**	**64 290**	**9,066**	**8,770**	**79 916**	**97%**

Compared to what was entered in the budget, the actual use of medical devices fell short of the budget in 2014. This can be explained with the fact that since the beginning of 2014, a reference price system is applied to the calculation of the benefits in insulin needles, lancets and wound dressings categories and from 1 July, in the glucometer test strip category. Above all, the application of the reference price system significantly reduced the amounts to be reimbursed in the test strip category regardless of the continuous rapid rise in user numbers. As a result of the implementation of the reference price, compared to

the previous year, the reimbursement costs of glucometer test strips went down by 11%. At the same time, the number of users of the test strips increased by 6%.

Compared to what was planned, lancets (disposable implement for obtaining blood samples from the finger) were used the least. As this is a new medical device group that was added to the list at the beginning of 2014 only, it took time for the information to reach doctors and insured persons. Also, patients must be made more aware of the importance of the use of disposable lancets. In 2014, the EHIF paid more attention than before to raising patients' awareness about the medical devices reimbursed to them, publishing information booklets and articles for diabetics in various publications.

Compared to what was planned, the greatest increase occurred in the group of CPAP (continuous positive airways pressure device) devices and masks. The user numbers of both the device and the mask have increased more than expected. This shows a rapid increase in the number of patients who need the device.

In 2014, 49 proposals were submitted for additions to or amendments in the EHIF's list of medical devices, of which 21 were granted. A total of 160 new articles of medical devices were added to the list. Also, the availability of medical devices reimbursed for diabetics and patients who need daily self-catheterisation was improved. So, in 2015, several new options were added to the list and additional resources came from the reference price system successfully applied in 2014 in the calculation of the benefits in various medical devices, primarily glucometer test strips.

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.

A total of 1.4 million euros was provided from the state budget, of which pharmaceuticals were reimbursed in the amount of 825,000 euros and health care services for 620,000 euros. In 2013, infertility treatment procedures were provided in the amount of 1.5 million euros.

Income from government grants is recorded in the structure of the budget of the EHIF under other income (see the chapter on Income).

6.5 Miscellaneous health insurance benefits

In June 2014, an amendment to the regulation "Procedure for the assumption of a payment obligation of an insured person by the Estonian Health Insurance Fund and the methods for calculation of the payments to be made to health care providers" came into force, aimed at correcting a technical inaccuracy which had occurred during the preparation of the EHIF's list of health services at establishing the implementation conditions of the health service under the code 365R (Anti-VEGF intravitreal injection treatment). The amendment in the methods retroactively granted to the EHIF the right to pay, starting on 1.1.2014, for the health service under the code 365R even if besides the regional and central hospital, this service has been provided to the insured person by another health service provider which has entered into an agreement with the EHIF for provision of such health service.

The EHIF identified that insured persons have paid to other contractual partners of the EHIF as well for such service received in the first half-year of 2014 before the entry into force of the amendment to the methods. Based on the principle of equal treatment of insured persons, the management board of the EHIF decided to reimburse, starting from 1.1.2014, to the insured persons who have paid for their own treatment the cost of the service under the code 365R as an exception.

In 2014, 290 insured persons were reimbursed in the amount of 35,000 euros for the expenses groundlessly incurred.

Operating expenses of EHIF

The EHIF's operating expenses planned on the administration of health insurance benefits amounted to 8.9 million euros in 2014, of which 8.5 million euros was used up (see Table 49).

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.

The EHIF's operating expenses account for 0.98% of its total budget for 2014. In 2004 and 2005, operating expenses formed nearly 1.3% of the budget and decreased to 1.08% in 2006; since 2007, the EHIF's operating expenses have not exceeded 1% of its budget.

Table 49. Budget implementation for EHIF's operating expenses, € '000

	2013 actual*	2014 budget	2014 actual	Budget implementation
Personnel and management expenses	4,947	5,346	5,261	98%
Administrative expenses	1,337	1,571	1,450	92%
IT costs	976	1,080	962	89%
Development expenses	223	339	278	82%
Other operating expenses	454	562	551	98%
Total	**7,937**	**8,898**	**8,502**	**96%**

*Comparative data for 2013 have been adjusted by budget lines according to the new structure of operating expenses implemented from the beginning of 2014.

Personnel and management expenses

The basis for planning the resource need of the EHIF's personnel is an activity-based matrix of needs, in which, through measurable activities based on statistical key figures, and through estimated activities based on assessments, the number of positions that must be filled to achieve the goals set for the budget period is calculated. During budgeting for 2014, the activity-based resource needs were estimated to be 219.3 positions. Within the year, the activity-based matrix of needs was supplemented to achieve the goals and based on this, 2.0 positions were additionally established in the second half-year. At the end of 2014, there were 221.3 positions in the structure of the EHIF, of which 208.6 were filled.

Administrative expenses

In 2014, the structure of operating expenses changed with regard to budget lines. Administrative expenses cover the expenses related to daily activities and starting from 2014, this includes the training expenses of the employees of the EHIF, consultation (including auditing) expenses, expenses on research and internal communication.

At the beginning of 2014, the EHIF announced the selection of additional partners for entering into agreements to provide insured persons with health services in specialised medical care, nursing care and disease prevention. As at 31.12.2014, in relation to the selection, 12 complaints had been filed with an administrative court; three of these have been terminated (two petitioners have withdrawn the complaint, one complaint was dismissed).

In the first half-year, the EHIF in cooperation with FranklinCovey xQ® conducted a strategy awareness survey, the results of which provide the management with objective and systematic ground to decide what to do to improve performance on each level of the organisation. The survey resulted in 66 points, which was 5 points higher than the average result in Estonia.

Administrative expenses also cover the expenses on the analysis by the University of Tartu on the management of dental care and disease prevention in Latvia, Lithuania, Hungary, Slovenia, the Netherlands, France, the United Kingdom, Denmark, Sweden and Finland, aimed at getting input for the better management and financing of dental care and dental disease prevention in Estonia.

In the third quarter of the year, the web applications of the EHIF were security tested. The main objective of this work was to assess the security level of the applications and test the source code of the application according to best practices by performing a semi-automatic code audit.

In the third quarter of 2014, we started a quarterly image survey to establish the reliability and public image of the EHIF. The survey is aimed at mapping the contacts between the population and the EHIF, awareness of the activities of the EHIF and assessments to various aspects of the service such as reliability, availability and quality. According to the fresh image survey, the EHIF is ranked in top ten in the list of reliable public sector companies, but at the same time, 30% of the people of Estonia do not know what exactly the EHIF does. We are aimed at improving the awareness of the people of Estonia of the role and responsibility of the EHIF.

Quality management has been implemented at the EHIF since 2012. Ensuring quality entails both the external and internal aspect where the external result ensures trust between the client and the cooperation partner and the internal result with regard to ensuring quality is the management's belief that the client's needs are constantly kept in mind and the structure is ready to meet these needs. In the years 2012-2014, the quality management system of the EHIF was audited by Bureau Veritas Estonia and starting from

2015, it is being audited by DNW Business Assurance. The auditors have not identified any deviations and non-compliances with respect to the requirements in the standard ISO 9001:2008.

The job satisfaction of the employees has been examined by the EHIF in cooperation with Tripod Grupp since 2009. The job satisfaction survey assesses significance and satisfaction on a five-point scale. The average level of satisfaction in the entire organisation in 2014 was 4.0 points, which is a good result. Compared to 2013, average satisfaction in the organisation as a whole has

increased by 0.1 points. Looking at the changes in the level of satisfaction over a longer period of time, we can see that in 2009-2013, the results had been slowly, but steadily falling, but since 2014, have been on a rise.

The aspects the employees regarded very important and were very satisfied with:

- working conditions and environment (satisfaction 4.1);
- relations with colleagues (satisfaction 4.1);
- work supervision by an immediate superior (satisfaction 4.0).

In the fourth quarter of 2014, the EHIF participated in the Estonian Service Index survey conducted by TNS Emor, according to which our customer service is the best in the public sector. In addition to us, the Unemployment Insurance Fund, the Tax and Customs Board and the Police and Border Guard Board also participated. The survey assessed the level of the service provided by companies in three service channels: direct service, phone service and e-mail service.

IT costs

In 2014, 89% of the budget for IT costs was implemented. The budget was under-implemented because an investment planned in the budget was postponed to 2015. Of the IT costs for 2014, 28% is made up by the depreciation of the non-current assets acquired in previous years. To have the technical systems in working order and corresponding to needs for provision of health insurance to insured persons and partners, 495,000 euros was used from the annual budget for the development and maintenance of these systems and for licence fees.

Development expenses

Starting from 2014, development expenses will cover development expenses on health care services, for example, expenses related to the preparation and publication of clinical guidelines and the expenses on auditing health insurance benefits and

consultations. In addition, development expenses cover expenses on external communication – publishing of information booklets and printed materials and updating the website of the EHIF.

Under-implementation of the budget for developing health care services is caused by lower-than-expected expenses on clinical audits in 2014 in relation to the temporal shift in the audits. Five clinical audits have been planned for 2014: oncogynaecological treatment, sepsis treatment, atrial fibrillation treatment and follow-up audits for acute abdomen diagnostics and prostate cancer audits. These clinical audits will be completed in the first half-year of 2015.

In 2014, two clinical guidelines were approved: "Treatment of generalised anxiety disorder and panic disorder (with or without agoraphobia) in family medical care" and "Primary treatment of adult asthma" together with implementation plans which contain agreed activities for introducing the clinical guidelines and for later evaluation. In addition, in the accounting period, recommendations for and work drafts of five clinical guidelines were prepared ("Prevention and care of bedsores", "Treatment of bariatric patient before and after surgical intervention", "Use of surgical safety checklist in operating rooms", "Perioperative treatment of acute pain",

"Treatment of patients with alcohol use disorder"). In 2014, the scopes of four selected clinical guidelines were approved: "Post-stroke rehabilitation guidelines", "Treatment of chronic venous ulcers", "Prevention and treatment of chronic kidney disease" and "Treatment of premature birth and perinatal period of premature infants". The first patient guidelines for patients with arterial hypertension were also approved. A focus group of patients was involved in the improvement of the contents of the guidelines. Four new patient guidelines are being prepared (anxiety disorders, asthma, bedsores and bariatry). In June, a three-day training EBM2014 was held for 55 compilers of the clinical guidelines, providing participants with knowledge and skills to help them out in the entire process of preparing clinical guidelines starting from identifying the scope, making queries, evaluating clinical guidelines and evidence materials up to preparing recommendations. The preparation and coordination of clinical guidelines has been labour-intensive, but the participants have acquired valuable experience and knowledge of how to assess the evidence. In October, a training on research methods was held for the compilers of clinical guidelines, with 30 participants.

The implementation of the clinical guidelines has been evaluated with the audit "Quality of counselling patients with primary arterial hypertension at family health centres" and as a result, new implementation trainings (incl. e-training) for family physicians and nurses have been planned. The Guideline Advisory Board has been operating for three years now and a new composition was elected. The first three years of service of the Board have been the period for the preparation and introduction of the new evidence-based methods. The subjects selected by the Board for the preparation of the clinical guidelines have been relevant and important, allowing to significantly harmonise the diagnostics and treatment and thereby presumably improve the results for patients as well.

In 2014, the website of the EHIF has been updated, being the information channel for insured persons and partners and providing information about the activities of the EHIF and the options of the national health insurance system.

Other operating expenses

Other operating expenses in the budget cover, starting with the year 2014, VAT cost on the operating expenses, expenses related to the issue of the European health insurance card, state fees, notary's and bailiff's fees, exchange losses related to operating expenses and health insurance expenses, doubtful receivables and government grants.

The government grants in the accounting period comprised of the expenses related to development of the Moldovan health insurance system in the amount of 23,000 euros and writing off a study loan in the amount of 6,000 euros on the basis of a regulation by the Government of the Republic.

The general aim of the cooperation with Moldova is the development of a sustainable health insurance system in Moldova. For this purpose, sufficient knowledge is required to ensure sustainable development and implementation of the Moldovan health insurance system by training the key persons involved. The activities planned in the organisational strategy of the Moldovan health insurance fund for 2013-2017 have been efficiently developed and implemented by now. Since 2013, there have been 7 visits, in the course of which subjects such as DRG implementation, entry into agreements with hospitals, surveillance, budget planning, compensation for pharmaceuticals, IT solutions and organisational development have been covered. The EHIF has also supported the development of the family physician information phone system in Moldova, explaining to the contracting

party the backstage of the development of the system and encouraging Moldova to take a step towards this system, based on its own experience and the current situation in the Moldovan health care system.

On 6 October 2014, the health insurance funds of Estonia and Moldova signed a new termless cooperation agreement which will come into force on 12 November 2015. To ensure continuous cooperation, a Joint Committee was formed, which will assemble once a year either in Estonia or Moldova to monitor the progress made in the activities planned, discuss the problems in the Moldovan health insurance system and provide solutions to these.

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 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.

By the end of 2013, the legal reserve of the EHIF was 5.1 million euros. According to article 38 of the Estonian Health Insurance Fund Act, the legal reserve was required in 2014 to reach 54.4 million euros. In order to reach the amount required by law, the legal reserve was increased by 3.2 million euros in 2014.

In 2015, the legal reserve is required to reach 57.2 million euros. In order to reach the amount required by law, the legal reserve has to be increased by 2.8 million euros in 2015.

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 EHIF is the reserve formed from the budgetary funds of the health insurance fund in order to minimise the risks arising for the health insurance system from the obligations assumed.
- The size of the risk reserve shall be 2% of the health insurance budget of the health insurance fund.
- The funds of the risk reserve may be used upon a decision of the Supervisory Board of the Health Insurance Fund.

At the end of 2013, the risk reserve of the EHIF was 16.7 million euros. According to article 39[1] of the Estonian Health Insurance Fund Act, the risk reserve was required in 2014 to reach 18.0 million euros. In order to reach the amount required by law, the risk reserve was increased by 1.3 million euros in 2014.

In 2015, the risk reserve is required to reach 18.9 million euros. In order to reach the amount required by law, the risk reserve has to be increased by 900,000 euros in 2015.

Retained earnings

At the beginning of 2014, the retained earnings of the EHIF amounted to 162.2 million euros.

A sum of 3.2 million euros was transferred from retained earnings to the legal reserve in 2014 and 1.3 million euros to the risk reserve in order to reach the amount of reserve required by law.

The net loss of the EHIF for 2014 was initially estimated to be 3 million euros. As the EHIF's income fell below the budget by 3.6 million euros and budget resources were used to a greater extent than planned, the year's eventual outcome was a loss of 16.5 million euros.

As of 31 December 2014 the retained earnings of the EHIF were 141.2 million euros.

The EHIF's management board proposes the supervisory board to transfer 2.8 million euros of retained earnings to the legal reserve and 0.9 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	31.12.2014	31.12.2013	Note
Current assets			
Cash and cash equivalents	176,346	199,641	2
Receivables and prepayments	90,504	83,740	3
Inventories	5	3	4
Total current assets	**266,855**	**283,384**	
Non-current assets			
Long-term receivables	348	450	5
Property, plant and equipment	309	509	6
Intangible assets	119	199	6
Total non-current assets	**776**	**1,158**	
Total assets	**267,631**	**284,542**	

Liabilities and net assets

€ '000	31.12.2014	31.12.2013	Note
Liabilities			
Current liabilities			
Payables and deferred income	54,098	54,503	8
Total current liabilities	54,098	54,503	
Total liabilities	**54,098**	**54,503**	
Net assets			
Reserves	72,337	67,808	9
Accumulated surpluses for prior years	157,702	163,695	
Surplus for the year	-16,506	-1,464	
Total net assets	**213,533**	**230,039**	
Total liabilities and net assets	**267,631**	**284,542**	

Statement of financial performance

€ '000	2014	2013	Note
Health insurance component of social security tax and recoveries from other persons	894,821	830,625	10
Income from government grants	1,503	1,744	17
Expenses related to government grants	-1,475	-1,472	17
Expenses related to health insurance	-906,767	-828,954	13
Gross surplus	**-11,918**	**1,943**	
Administrative expenses	-7,951	-7,237	14
Other operating income	3,233	3,910	11
Other operating expenses	-522	-693	15
Operating surplus	**-17,158**	**-2,077**	
Interest and other finance income	652	613	12
Surplus for the year	**-16,506**	**-1,464**	

Statement of cash flows

€ '000	2014	2013	Note
Cash flows from operating activities			
Social security tax received	887,167	826,632	
Cash paid to suppliers	-911,088	-832,572	
Cash paid to employees	-4,234	-3,648	
Taxes paid on personnel expenses	-1,420	-1,237	
Other receipts	6,313	6,337	
Net cash from operating activities	**-23,262**	**-4,488**	
Cash flows from investing activities			
Paid for non-current assets	-33	-171	
Net cash used in/from investing activities	**-33**	**-171**	
Net change in cash and cash equivalents	**-23,295**	**-4,659**	
Cash and cash equivalents at beginning of year	199,641	204,300	2
Increase in cash and cash equivalents	-23,295	-4,659	
Cash and cash equivalents at end of year	176,346	199,641	2

Statement of changes in net assets

€ '000	2014	2013	Note
Reserves			
Reserves at beginning of year	**67,808**	**66,730**	
Transfer to the reserves	4,529	1,078	
Reserves at end of year	**72,337**	**67,808**	**9**
Accumulated surpluses for prior years			
At beginning of year	**162,231**	**164,773**	
Transfer to the reserves	-4,529	-1,078	
Surplus for the year	-16,506	-1,464	
At end of year	**141,196**	**162,231**	
Net assets at beginning of year	**230,039**	**231,503**	
Net assets at end of year	**213,533**	**230,039**	

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 2014 have been prepared in accordance with the 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 2014 and ended on 31 December 2014. The numeric data in the financial statements are presented in thousands of euros.

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 the 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 and under the principle 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 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 EHIF is the reserve formed from the budgetary funds of the health insurance fund in order to minimise the risks arising for the health insurance system from the obligations assumed.
- The size of the risk reserve shall be 2% of the health insurance budget of the health insurance fund.
- The funds of the risk reserve may be used upon a decision of the Supervisory Board of the Health Insurance Fund.

The EHIF has 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 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. 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 EHIF.

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 2014) 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	31.12.2014	31.12.2013
Cash at bank	176 346	199 641

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 2014.

Note 3. Receivables and prepayments

€ '000	31.12.2014	31.12.2013
Trade receivables	3,159	2,997
Allowance for doubtful receivables	-91	-45
Government grant receivable*	57	60
Operating expense recoveries receivable	1	1
Contractual receivables from insured persons	28	23
Interest receivable	17	32
Social tax receivable**	87,086	80,395
Prepaid expenses	247	277
Total	**90,504**	**83,740**

* The government grant receivable comprises a receivable from the Ministry of Social Affairs for funding artificial insemination treatment.
** Social tax receivable of 87,086 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 31.12.2014, the EHIF's inventories consisted of unused prescription forms of 5 thousand euros (31.12.2013: 3 thousand euros).

Note 5. Long-term receivables

Miscellaneous long-term receivables

€ '000	31.12.2014	31.12.2013
Long-term deferred tax receivable from the Tax and Customs Board	0	100
Non-current portion of amount paid to the National Social Insurance Board for renovation of the premises of Pärnu department and Rapla office	348	350
Total	**348**	**450**

Note 6. Non-current assets

6.1. Property, plant and equipment

€ '000			
Cost	**Land and buildings**	**Other fixtures and fittings**	**Total property, plant and equipment**
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**
Acquisitions	0	31	31
Write-off	0	-212	-212
31.12.2014	**412**	**1,465**	**1,877**
Accumulated depreciation			
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**
Depreciation charge	22	209	231
Write-off	0	-212	-212
31.12.2014	**297**	**1,271**	**1,568**
Carrying amount			
31.12.2013	**137**	**372**	**509**
31.12.2014	**115**	**194**	**309**

6.2. Intangible assets

€ '000	
Cost	**Licenses purchased**
31.12.2012	**377**
Acquisitions	239
Write-off	0
31.12.2013	**616**
Acquisitions	0
Write-off	0
31.12.2014	**616**
Accumulated depreciation	
31.12.2012	**377**
Depreciation charge	40
Write-off	0
31.12.2013	**417**
Depreciation charge	80
Write-off	0
31.12.2014	**497**
Carrying amount	
31.12.2013	**199**
31.12.2014	**119**

Note 7. Leases

Operating leases

Reporting entity as a lessee

The statement of financial performance for 2014 recognises operating lease payments totalling 329 thousand euros. Of this, 26 thousand euros was expensed as lease payments for vehicles and 303 thousand euros was expensed under lease contracts on premises.

In 2013, operating lease payments totalled 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.

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	31.12.2014	31.12.2013
Payable to medical institutions for services	41,314	42,426
Payable to pharmacies for medicines distributed at a discount	6,229	5,965
Other payables for health insurance benefits	3,724	3,340
Other trade payables	206	204
Total	**51,473**	**51,935**

Trade payables include related party transactions of 2,899 thousand euros (2,595 thousand euros as of 31 December 2013), see Note 16.

8.2. Taxes payable

€ '000	31.12.2014	31.12.2013
Personal income tax	1,903	1,599
Social tax	216	268
Income tax on fringe benefits	5	3
Unemployment insurance contributions	11	13
Statutory pension insurance contribution	5	4
VAT	1	6
Total	**2,141**	**1,893**

Personal income tax liability includes personal income tax of 1,840 thousand euros (31.12.2013: 1,540 thousand euros) withheld from incapacity benefits paid by the EHIF to insured persons.

Social security tax liability includes social security tax of 55 thousand euros (31.12.2013: 52 thousand euros) accrued on the holiday pay liability.

8.3. Other payables

€ '000	31.12.2014	31.12.2013
Payables to employees	290	515
Other payables	150	133
Advances received	44	27
Total	**484**	**675**

Advances received comprise the balance of an advance payment in the amount of 32,000 euros for the Moldova project funded by the Ministry of Foreign Affairs and the advance payment made by the National Institute for Health Development for posting invitations to participate in cancer screening in the amount of 12,000 euros.

In 2014, payables and deferred income amounted to 54,098 thousand euros and in 2013, to 54,503 thousand euros.

Note 9. Reserves

€ '000	31.12.2014	31.12.2013
Legal reserve	54,386	51,147
Risk reserve	17,951	16,661
Total reserves	**72,337**	**67,808**

At the end of 2013, the EHIF's legal reserve amounted to 51,147 thousand euros. According to article 38 of the Estonian EHIF Act, the legal reserve was required in 2014 to reach 54,386 thousand euros. In order to reach the amount required by law, the legal reserve was increased by 3,239 thousand euros in 2014.

At the end of 2013, the risk reserve of the EHIF was 16,661 thousand euros. According to article 39^1 of the Estonian Health Insurance Fund Act, the risk reserve was required in 2014 to reach 17,951 thousand euros. In order to reach the amount required by law, the risk reserve was increased by 1,290 thousand euros in 2014.

Note 10. Revenue from operating activities

€ '000	2014	2013
Health insurance component of social security tax	893,759	829,699
Recoveries from other persons	1,062	926
Total	**894,821**	**830,625**

Recoveries from other persons include related party transactions of 12 thousand euros (3 thousand euros as in 2013), see Note 16.

Note 11. Other operating income

€ '000	2014	2013
Voluntary insurance agreements	628	520
Insurance agreements with other countries	568	618
Services provided to European Union citizens	1,974	2,714
Fees for processing health care invoices	55	44
Foreign exchange gains	8	14
Total other operating income	**3,233**	**3,910**

Note 12. Interest and other finance income

The Ministry of Finance calculates for the EHIF an interest on the balance of the moneys in current accounts that are part of the group account of the state, at the rate which equals the profitability of the state cash reserve, see Note 2.

In 2014, the interest on the balance of the moneys held on the accounts amounted to 652 thousand euros (613 thousand euros in 2013).

Note 13. Expenses related to health insurance

€ '000	2014	2013
Health service benefits	664,070,	605,257,
Of which: disease prevention	7,591,	7,230,
primary medical care	82,248,	76,088,
specialised medical care	529,044,	481,561,
nursing care	24,537,	20,607,
dental care	20,650,	19,771,
Health promotion expenses	857,	706,
Expenses related to benefits for medicines	109,753,	103,391,
Expenses related to temporary incapacity benefits	103,902,	94,101,
Other financial benefits	9,358,	9,327,
Other expenses related to health insurance benefits*	18,827,	16,172,
Of which: health service benefits arising from international agreements	10,022,	7,847,
benefits for medical devices	8,805,	8,325,
Total expenses related to health insurance	**906,767,**	**828,954,**

** Expenses for 2014 differ from the corresponding figure in the budget implementation report since in the budget, government grants of 1,446 thousand euros allocated from the state budget have also been recorded as expenses (difference in 2013: 1,465 thousand euros).

Expenses related to health insurance include related party transactions of 39,000 thousand euros (34,574 thousand euros as in 2013), see Note 16.

Note 14. Administrative expens

€ '000	2014	2013
Personnel and management expenses	5,261,	4,947,
Wages and salaries	3,929,	3,695,
Incl. remuneration of management board members	162,	172,
Unemployment insurance contributions	37,	35,
Social tax	1,295,	1,217,
Administrative expenses	1,450,	1,069,
including operating lease payments*	329,	318,
IT costs	962,	990,
Development expenses	278,	231,
Total administrative expenses	**7,951,**	**7,237,**

*See Note 7

Administrative expenses include related party transactions of one thousand euros (35 thousand euros as in 2013), see Note 16.

The remuneration of the members of the management board for 2014 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	2014	2013
Management board members	3	3
Managers	16	17
Senior specialists	39	39
Mid-level specialists	151	147
Support staff	5	5
Total number of employees	**214**	**211**

Note 15. Other operating expenses

€ '000	2014	2013
Supervision over health insurance system	0	70
Public relations/communication	0	86
Management board's liability insurance	0	5
Foreign exchange loss	18	14
Expensed receivables	95	42
Internal communication and information days	0	15
Fringe benefits and taxes	0	110
VAT on operating expenses	352	351
Health insurance forms	46	0
State fees	1	0
Extraordinary compensation for health services	10	0
Total other operating expenses	**522**	**693**

In 2014, the structure of operating expenses changed with regard to budget lines. Supervision over health insurance and expenses on public relations/communications in the amount of 60 thousand euros are covered by development expenses. Management board's liability insurance in the amount of 5 thousand euros, expenses on internal communication and information days in the amount of 38 thousand euros and fringe benefits and taxes in the amount of 179 thousand euros are covered by administrative expenses.

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.

Transactions with related parties in 2014

€ '000	Amount	Lisa
Purchase of services	39,001	13, 14
Sale of services	12	10
Payable at 31.12.2014	2,899	8
Receivable at 31.12.2014	0	

No write-downs of receivables from related parties were made in 2014.

Purchase of services primarily covers the health services purchased from providers of health care services, in which the related party of the institution is a member of the supervisory board.

Transactions with related parties in 2013

€ '000	Amount	Lisa
Purchase of services	34,609	13, 14
Sale of services	3	10
Payable at 31.12.13	2,595	8
Receivable at 31.12.13	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	2014	2013
Compensation to insured persons for medicine costs incurred on artificial insemination	621	660
Compensation of expenses incurred on infertility treatment based on health services provided	825	805
Moldova project	23	7
Compensation for study loan	6	0
Total	**1 475**	**1 472**

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 and compensation for study loans are recognised within the EHIF's operating expenses.

Income from government grants:

€ '000	2014	2013
Compensation to insured persons for medicine costs incurred on artificial insemination	621	660
Compensation of expenses incurred on infertility treatment based on health services provided	825	805
National cancer prevention strategy funds	28	33
Moldova project	23	7
Compensation for study loan	6	0
Prescription Centre	0	239
Total	**1,503**	**1,744**

Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the 2014 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
01.04.2015

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 2014, 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 120 to 136.

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 2014, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 01.04.2015

/signed/

Taivo Epner
Authorized Public Accountant No 169

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Estonian Health Insurance Fund Yearbook 2014