Estonian
Health Insurance
Fund

Estonian Health Insurance Fund Annual Report 2012

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Beginning of financial year	1 January 2012
End of financial year	31 December 2012
Principal activity	Public Health Insurance
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ISSN 2228-4583
ISSN 2228-4591

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Statement by the Management Board of the Estonian Health Insurance Fund – The Year 2012 in Estonian Health Insurance

The year 2012 marked the 20th anniversary of building a modern health insurance system in Estonia. The principles chosen more than two decades ago have turned out to be the right and only possible principles. Health insurance guarantees the people of Estonia effective medical care in compliance with international standards. The work we have accomplished in those years has also laid a strong foundation for future development. It is increasingly more important that the insurance package is modern and evidence-based, that the health care services are accessible in a timely manner, that treatment meets high quality standards and that health insurance is financially sustainable.

We planned to spend 779 million euros on health insurance in 2012. Family medicine was to receive 72 million euros, specialised medical care 448 million euros. Our forecast for pharmaceuticals to be reimbursed to insured persons was 102 million euros and for benefits for temporary incapacity for work - 88 million euros. By the end of the financial year we had fully implemented the health insurance budget for 2012.

Insured Persons

Improved Availability of Health Insurance

One of the main goals of the Health Insurance Fund is to guarantee the availability of medical care. A well-functioning family physician system is a precondition for that. In order to improve the availability of general medical care we increased the funding to those practice lists which contained more children, elderly persons and patients with chronic diseases. The distance allowance to motivate family physicians in rural regions was raised, as was the fee-for-service fund for examinations and tests.

The Estonian Health Insurance Fund offers the insured persons a health care services package, which is as modern as possible. To achieve this we regularly revise the List of Health Care Services. In 2012 we added 30 new services to the list, for example services related to organ transplants and those aimed at improving the quality of treating cancer and diabetes patients. With the help of orthopaedists, rehabilitation and radiotherapy specialists we updated the descriptions of the health care services and funding of those specialities.

In cooperation with professional societies and other partners we prepared the changes aimed at improving the availability of health care services that took effect in 2013. The changes include the provision of funding for a second family nurse, which allows more counselling of people in health matters. Family physicians will be able to approach specialists electronically to specify a patient's diagnosis and receive recommendations regarding treatment. Waiting times for endoprosthetic replacement of large joints, otorhinolaryngological operations and transplantation of the cornea will be shorter. Services improving the quality of the diagnostics and treatment of diabetes, neurological disease and cancer were also included in the List of Health Care Services. Group therapy was added under rehabilitation.

A more prudent use of health insurance resources has changed considerably the proportions between the types of treatment. Thus also 2012

saw an increase in the number of outpatient and day care consultations, and a reduction in inpatient consultations. In an ageing population the need for nursing care is on the rise. In order to ensure better availability of nursing care services, we added extra funding to its budget.

With the aim of improving access to health care services we restored the reference prices that had been lowered during the economic recession, to their pre-crisis levels. We launched another in-depth analysis of the waiting lists and their causes so as to ensure better and more uniform access to specialised medical care.

The number of people who received planned treatment abroad grew, as did their funding. Within the framework of a project coordinated by the Ministry of Social Affairs we started preparations for transposing the EU patients' rights directive.

In addition to securing the availability of medical care we see to it that the patients can get pharmaceuticals at affordable prices. The share of the price of prescription drugs covered by the patients themselves continued to decrease in 2012. This has been achieved with the help of a variety of national measures, among them the very successful awareness campaign on the reasonable use of pharmaceuticals, launched by the Health Insurance Fund. In 2012 the patients paid an average 6.56 euros per one reimbursed prescription. In the last couple of years the share of patient own funding has dropped 1.46 euros per prescription. This shows that patients are increasingly choosing to buy pharmaceuticals at the most favourable price. By doing so they saved an estimated 9 million euros in 2012 only.

We increased the range of medical devices reimbursed by health insurance. Like pharmaceuticals, we digitalised the prescription of medical devices. Such simplification made the acquisition of medical devices much more convenient for the insured persons.

Awareness and Prevention

Year by year the awareness of the population about their health insurance related rights and obligations has been growing, reaching the highest ever level in 2012, at 78%. Family physicians, health insurance and the ambulance service are the themes that people are best informed about. They know less about health insurance benefits and the European health insurance card. Given that the majority of people turn to the internet for information for its speed and ease of use, we have started preparations for renewing the Health Insurance Fund website.

We organised an awareness campaign on the reasonable use of pharmaceuticals. In this very successful campaign we invited the patients to request from their doctors prescriptions written by the international non-proprietary name (INN) and choose the most favourably priced among equivalent pharmaceuticals.

We continued to improve the organisation of breast cancer and cervical cancer screening, in order to achieve internationally recognised coverage levels. We promoted screening in the media, sent personal invitations, gave family physicians and hospitals feedback about the participation of women in screening. We also helped develop the cancer screening register.

To prevent dental diseases in children we started activities in schools in addition to the already on-going programmes in kindergartens, so that everyone from an early age to adulthood would acquire the correct oral hygiene skills and knowledge.

The insured persons can get information and advice in our customer service bureaux, via e-mail and telephone. For years our customer services have been performing to the highest standards. We are glad to note that we were able to keep the same high level also in 2012. The results of a survey indicate that the level of the customer services offered by the Health Insurance Fund constitutes 97% of the best possible level. Equally high ratings were given to face-to-face, telephone and e-mail communication.

Partners

Contractual Relations with Health Care Providers

In 2012 the Health Insurance Fund had a contractual partnership with 1,052 health care providers,

including 19 hospitals belonging to the Hospital Network Development Plan, and with 556 other service providers. 477 contractual partners were holders of practice lists of family physicians.

Enhancing and Harmonising the Quality of Medical Care

In order to enhance the quality of medical care the Health Insurance Fund finances the preparation of clinical guidelines. The Estonian Handbook for Guidelines Development, which was completed in 2011 served as a basis for clinical guidelines for the treatment of adult patients with hypertension, written specially for family physicians. This led to the next step - revision of the indicators of the family physicians' quality system, a process to be undertaken next year.

For the purpose of harmonising the quality of specialised medical care we give feedback to our partners about their work and disclose information related to their performance. A report containing comparable data about the hospitals belonging to the Hospital Network Development Plan was prepared for the first time in 2012. We plan to produce similar reports in the future as well.

We continued quality assessment of health care services. We commissioned five clinical audits from medical experts. We used random sampling to check some 12,000 medical files. Preparations are under way for revising the Estonian Handbook for Clinical Audits, which will be applicable from 2014. At the same time we are improving the environment that supports auditing.

Health Care Policy

Development of Health Care Policy

2012 saw a number of important changes in Estonian health care, which are bound to have a long-term effect.

The representatives of health care professionals (Estonian Medical Association, Union of Estonian Healthcare Professionals) and employers (Estonian Hospitals Association, Union of Estonian Emergency Medical Services and Estonian Association of Family Physicians), as well as other organisations involved in the process (Estonian Nurses Union, Federation of Estonian Healthcare Professionals Unions) concluded a two-year collective agreement. The minimum wage will increase from 2013. From 1 January resident physicians start to be paid for full-time work. From 1 March the minimum hourly wage will increase as follows: care-givers 23%, nurses and paramedics 17.5% and physicians 11%. During the labour dispute that led to the conclusion of the collective agreement health care professionals went on strike in October 2012. In order to facilitate a rapid solution that would satisfy all parties the Estonian Health Insurance Fund kept in constant contact with the participants during the strike and informed them about the financial resources available for health insurance, the Fund's development plan and budget. Since October 2012 the task force for a goodwill agreement for the future of Estonian health care has been meeting under the leadership of the Minister of Social Affairs. The Estonian Health Insurance Fund is a member of the task force. Constructive discussions led to the conclusion of the goodwill agreement at the end of January 2013. The agreement aims to set the directions and define the activities that will ensure the sustainability of the health care system, proceeding from the goals described in the National Health Plan 2009–2020 and in the various sectoral action plans.

IT Solutions to Develop the Health System

In 2012 we digitalised the cards for acquiring medical devices The system is analogous with the digital prescription. Medical devices that are reimbursed to the users by the Health Insurance Fund can now be obtained digitally. We hope the innovation helps enhance the quality of health data and facilitates the whole process for the patients, physicians and sellers of medical devices.

The digital prescription is one of the most important IT projects for the Health Insurance Fund. During the past two years major preparations have been under way for bringing the hosting environment of the digital prescription under the administration of the Health Insurance

Fund. The preparations for the transfer have been focused on creating new, more stable and less resource intensive data exchange software and developing the best infrastructure for the hosting environment.

The new data exchange software was ready in October 2012 and it will be launched in April 2013. In the meantime the software will undergo several functional and load tests, so as to ensure more reliable and robust performance of the digital prescription information system in the future. Integration of the hosting environment in the infrastructure of the Health Insurance Fund will also mean considerable savings in the cost of administering the digital prescription system.

We also entered into the last phase of transition to e-certificates of incapacity for work. The year 2012 saw a remarkable increase in certificates of incapacity for work being sent electronically by physicians. At the end of the year the employers started testing the system: they supplement the certificates of incapacity for work electronically and forward them to the Health Insurance Fund by using electronic means. The transition ought to accelerate the speed of data transfer and thus the insured persons would receive their benefits sooner as well.

Organisation

A Stronger Organisation: 20th Anniversary and New Management Board

The year 2012 was a festive year for the Health Insurance Fund. Our health insurance system had an anniversary. 20 years ago the foundation was laid to the Estonian health insurance system. We celebrated this important milestone with the publication of "The Story of the Estonian Health Insurance Fund. 20 Years of Treatment and Insurance". We also organised a conference, "20 years of Treatment and Insurance. Goodbye, Childhood! What Will Tomorrow Bring?" The subjects of the conference mostly focused on the patients, their expectations and the current and future possibilities of the health care system.

The visual identity of the Health Insurance Fund was also given a fresher look to mark the anniversary. We kept the symbol - the turtle - but changed the colour palette and modernised the image of our heraldic animal.

In 2012 the Supervisory Board of the Health Insurance Fund elected a new Chairman of the Management Board. From October Tanel Ross has been in charge in the Health Insurance Fund. Kuldar Kuremaa is another new member who started in the Management Board in January 2013. Mari Mathiesen continues her work in the Management Board. As the organisation of the Health Insurance Fund is aimed at development, we created the positions of development manager and information security manager last year.

In recognition of how our organisation is managed we were awarded the ISO 9001:2008 certificate in 2012. This proves that the quality management system of the Health Insurance Fund meets international standards.

The cooperation project between the Health Insurance Fund of Estonia and that of Moldova is an example of our international cooperation: with our know-how we help develop the health insurance system in Moldova.

In the summer of 2012 we organised an international summer school in Tallinn devoted to DRG, one of the methods of funding health care. Health care experts from many countries shared their experience in the history, development and future prospects of the DRG systems used by them. Even more significant was the annual conference of the budget and health experts from the Central, Eastern and South European member states of the Organisation for Economic Cooperation and Development and the World Health Organisation, which the Health Insurance Fund organised in Tallinn. The focus of the two-day meeting was on the lessons learned from the economic crisis. The discussions centred on how to restore fiscal discipline and secure the financial sustainability of the health system.

Management Report

Health Insurance System

The Ministry of Social Affairs is in charge of the Estonian health system. In cooperation with its divisions they define and carry out health care policy and exercise supervision over its implementation. As an independent public law agency in the area of administration of the ministry the Health Insurance Fund organises the activities related to health insurance.

The Estonian health system is centred round valid health insurance. The Health Insurance Fund pays for health care services and other benefits only in case these have been provided to persons who have health insurance. The Health Insurance Fund enters into contracts with service providers, e.g. family physicians and health care institutions. Services are purchased and contracts are concluded, proceeding from the needs of the insured persons and the prudent use of the health insurance money. In order to remain impartial in its funding decisions, the Health Insurance Fund does not interfere in the management of health care institutions.

The health insurance system is funded from social tax revenues. The Estonian health insurance system is built on the principle of solidarity: all insured persons are eligible to the same medical care, irrespective of their financial contribution, individual health risk or age.

The Estonian health insurance system adheres to the following internationally recognised 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 care services, which is as comprehensive, coherent and modern as possible;
- Health insurance must be as far-reaching as possible, i.e. the part a person has to cover from the total treatment costs has to be optimal and may not cause poverty risk.

The current health insurance system has been in place since 1992. Last year the Health Insurance Fund celebrated the 20th anniversary of health insurance in Estonia after independence was restored. The Estonian Health Insurance Fund in its present form as a public law agency was established in 2001.

The Role of the Health Insurance Fund

The principal aim of the Health Insurance Fund is to pay for the medical care given to insured persons. In addition we reimburse a large part of the costs of buying pharmaceuticals and medical devices, pay benefits for temporary incapacity

The Core Values of the Health Insurance Fund:

- **Innovation** – we target our activities at continuous and sustainable development, relying on competent, loyal and result-oriented employees;
- **Consideration** – we are open and friendly. 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.

for work, dental care and other benefits, engage in health promotion and develop the quality of health care services.

The mission of the Health Insurance Fund is to organise health insurance in such a manner as to ensure equal treatment of the insured persons and the timely availability of needs based, high quality and cost efficient health care services, pharmaceuticals, medical devices and financial benefits.

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 might need.

Organisation and Management

The highest body of the Health Insurance Fund is a 15-member Supervisory Board. Five members represent employer organisations, another five the organisations representing the insured persons and the remaining five are representatives of the state. The Minister of Social Affairs is the Chairman of the Supervisory Board.

A three-member Management Board manages the Health Insurance Fund. The Chairman of the Management Board is in charge of the whole organisation. The members are responsible for health care, finances and the IT sector.

As of 31 December 2012 the Health Insurance Fund had 210 employees.

In order to achieve the goals of health insurance, the main tasks of the Health Insurance Fund are to assess the needs for medical care, modernise the package of health care services, design the budget and conclude contracts for the provision of health care services with health care institutions so as to ensure the availability of the required services. The Health Insurance Fund works closely with the professional societies and health care institutions in order to better manage the available resources.

As required by law the Health Insurance Fund checks the use of the health insurance finances for their designated purpose, incl. the quality and justification of the services purchased. We review invoices and other treatment related documents, a total of 12,000 medical files in a year as part of the control. We support the preparation of clinical guidelines and commission clinical audits. We introduced the performance pay system for family physicians, in order to ensure that disease prevention and the quality of monitoring chronic diseases on the primary care level, i.e. by family physicians follows the same principles across Estonia.

The Health Insurance Fund finances projects specifically aimed at promoting health and preventing diseases with the approval of the Ministry of Social Affairs and in accordance with the priorities set by its Supervisory Board. The priorities are determined on the basis of a national health analysis. According to the analysis of loss of life years caused by disease, the biggest health loss is caused by cardiovascular diseases, cancer, injuries and poisoning. This in its turn has an impact on the costs incurred by the Health Insurance Fund with regard to health care services, pharmaceuticals and incapacity for work. Health promotion and prevention can help avoid some of these problems or reduce the harm caused by them.

Table 1 presents the key indicators of the work of the Health Insurance Fund.

Table 1 Key indicators 2008–2012

	2008	2009	2010	2011	2012	% of change against 2011
Number of insured persons at year end	1,281,718	1,276,366	1,256,240	1,245,469	1,237,104	–1
Revenue (thousand EUR)	824,452	730,501	694,438	735,112	783,131	7
Health insurance expenditure (thousand EUR)	781,189	764,336	693,377	718,418	773,575	8
Health Insurance Fund operating expenses (thousand EUR)	7,435	6,842	6,888	7,080	7,331	4
Health insurance expenditure as a percentage of GDP (%)*	4.8	5.6	4.8	4.5	4.6	0
HEALTH CARE SERVICE INDICATORS						
Number of insured persons who used specialised medical care	819,055	800,578	797,048	807,875	795,581	–2
Average length of stay (days)	6.3	6.1	6.1	6	6.1	2
Emergency care as a percentage of expenses for specialised care (%), including						
Outpatient care	17	17	18	18	17	–1
Day care	6	9	9	7	8	1
Inpatient care	63	67	67	64	66	2
Average cost per case in specialised medical care (EUR), including:						
Outpatient care	43	44	43	45	52	16
Day care	468	449	404	371	435	17
Inpatient care	1,008	1,011	982	1,008	1,124	12
Family physician consultations per 1,000 insured persons	4,039	3,895	3,831	4,228	4,364	3
Referral for treatment abroad and benefits arising from EU legislation (thousand EUR)	3,554	4,352	3,810	8,210	7,193	–12
INDICATORS OF BENEFITS FOR PHARMACEUTICALS						
Number of reimbursed prescriptions	6,636,410	6,435,700	6,689,886	6,945,735	7,438,670	7
Number of insured persons who used reimbursed pharmaceuticals	840,847	829,748	822,440	841,533	841,387	0
Average cost per reimbursed prescription for the Health Insurance Fund (EUR)	12.3	13.7	13.6	13.2	13.3	1
Average cost per reimbursed prescription per patient (EUR)	7.7	8.1	7.7	7.0	6.6	–6
INDICATORS OF BENEFITS FOR INCAPACITY FOR WORK						
Number of days for which incapacity for work benefits were paid by the Health Insurance Fund	9,182,077	7,379,379	4,600,139	4,937,836	4 954 761	0
Cost per day of incapacity for work benefits (EUR)	16.6	19.1	17.7	16.4	17.0	4

* The indicators of 2008–2011 have been revised according to the GDP as adjusted by the Statistical Office.

Health Insurance Fund: 2012 Strategic Goals and their Attainment

Scorecard 2012

Objective	Weight, %	Performance indicator	Unit	Comments	2011 performance	2012 objective	2012 performance	Performance, %
	6.0	The satisfaction of insured persons with the health care system	%	The satisfaction of insured persons with the health care system as determined in the course of a general survey conducted among insured persons	62	64	67	6.0
1. Ensure access to health care services, pharmaceuticals and financial benefits	28.5							28.1
	7.5	Satisfaction with accessibility of medical care	%	Part of the general survey	51	58	55	7.1
Ensure uniform access to health insurance benefits	7.5	The involvement of insured persons in activities leading to improved monitoring of the health status of chronic patients	%	The ratio of the number of insured persons involved against the total number of those insured	95	95	98	7.5
	7.5	Maximum waiting time for endoprosthetic replacement	Time	Keep the maximum waiting timefor endoprosthetic replacement operations at the same level as in 2010	1.5 years	1.5 years	1.5 years	7.5
	6.0	Maximum waiting time for endoprosthetic replacement	Time	Keep the maximum waiting time for endoprosthetic replacement operations at the same level as in 2010	2.5 years	2.5 years	2.5 years	6.0
2. Develop the quality of health care services in the health care system	20.0							20.0
	10.0	Satisfaction with the quality of medical care	%	Part of the general survey	72	77	78	10.0
Improve quality assessment and control	5.0	Number of clinical audits	No	Number of clinical audits conducted	5	5	5	5.0
Develop feedback to partners and disclose results of quality improvement	5.0	Partners' satisfaction regarding cooperation with the Health Insurance Fund	%	Survey results	95	95	96	5.0
3. Shape awareness and health behaviour among the population	20.0							19.8
	7.0	Noticeability of social campaigns	%	Determined in the course of a general survey conducted among the adult population	41	46	85	7.0
Increase awareness of the health system and health factors among the population	6.0	Awareness of insured persons of their rights	%	% of the responding insured persons who knew their rights in the following fields as being at least "good": general medical care, specialised medical care, incapacity for work benefits, reimbursed pharmaceuticals, health insurance coverage	76	77	78	6.0
Ensure implementation of health promotion and disease prevention projects as planned	7.0	Cancer screening coverage	%	Coverage is measured on the basis of the health insurance database, as a percentage of persons invited to screening	Breast cancer 65%; cervical cancer 73%	Breast cancer 70%; cervical cancer 70%	Breast cancer 66%; cervical cancer 71%	6.8
4. Ensure efficient use of health insurance resources and sustainable development of the health insurance system	15.0							4.8
Increase the cost-efficiency of health insurance resources	15.0	Average cost per case	%	Percentage of structural increase of the average cost of a case of inpatient specialised medical care in comparison with the previous period	2.4	1	3.1	4.8
5. Improve the operation of the organisation	10.5							10.0
Improve the operation of the organisation and develop the competence of the employees of the Health Insurance Fund	10.5	Satisfaction of the employees with the management and organisation of the work of the Health Insurance Fund	%	Percentage of satisfied employees on the basis of the results of the employee survey	90	93	89	10.0
TOTAL	100.0							88.8

Attainment of Goals in 2012

Objective		Performance indicator	Performance
		The satisfaction of insured persons with the health care system	In comparison with the previous years the satisfaction of the people of Estonia with the organisation of the health system was the highest. 67% of the population were satisfied with the organisation of health care, this is 5% more than in 2011.
1. Ensure access to health care services, pharmaceuticals and financial benefits			
		Satisfaction with accessibility of medical care	55% of the population considered accessibility of medical care good. Satisfaction has grown slightly in comparison with 2011.
	Ensure uniform access to health insurance benefits	The involvement of insured persons in activities leading to improved monitoring of the health status of chronic patients	According to the family physicians' quality system 98% of the insured persons were involved in monitoring the health status of chronic patients.
		Maximum waiting time for cataract surgery	The waiting time for cataract surgery remained within the limits approved by the Supervisory Board of the Health Insurance Fund (waiting time 1.5 years).
		Maximum waiting time for endoprosthetic replacement	The waiting time for endoprosthetic replacement remained within the limits approved by the Supervisory Board of the Health Insurance Fund (waiting time 2.5 years).
2. Develop the quality of health care services in the health care system			
		Satisfaction with the quality of medical care	The patients continue to rate highly the quality of medical care in Estonia. 78% of the people considered the quality good - a slight improvement from 2011.
	Improve quality assessment and control	Number of clinical audits	Five clinical audits were undertaken. Two audits were completed: "Assessment of the Treatment of Prostate Carcinoma" and "Assessment of Orthodontic Services". In the second half of the year the following audits were started: "Management of Patients with Myocardial Infarction in Estonian Hospitals", "Antibacterial Treatment of Children under 7 in Family Medicine", "Acute Pancreatitis - Follow-up Audit" and "The Quality of Independent Antenatal Midwifery".
	Develop feedback to partners and disclose results of quality improvement	Partners' satisfaction regarding cooperation with the Health Insurance Fund	From 25.01.2012–09.02.2012 a survey was conducted to study the satisfaction of the partners. A total of 576 contractual partners participated in the survey. The aim of the survey was to find out how the partners assessed cooperation with the Health Insurance Fund. A web-based questionnaire consisting of 47 questions was used. 96% of the partners were satisfied with the cooperation. 30% of them rated general cooperation as very good and 66% as rather good. The share of those who considered cooperation to be very good was higher among partners providing nursing care (61%). 4% were completely dissatisfied. One half of the partners (51%) thought that cooperation had improved in comparison with the previous years. Satisfaction was expressed with respect to the various aspects of cooperation. Timely settling of accounts was recognised the most. Some partners wished that the issues of health insurance were better communicated for the public - every fourth respondent expressed dissatisfaction with this. The partners were also invited to assess their contact persons in the Health Insurance Fund, in particular as regards the speed of getting into contact with them, the manner of their behaviour, their competence, problem-solving ability, and whether they forward important information in a timely and understandable fashion. Depending on their particular field, 92-95% of the respondents were satisfied with the work of the contact person.
3. Shape awareness and health behaviour among the population			
		Noticeability of social campaigns	The campaign on the reasonable use of pharmaceuticals was launched in September 2012. A noticeability study was conducted in the 4th quarter to assess the results of the campaign. According to the study the noticeability of the campaign was 84%. This and previous similar campaigns have led to a reduction of the share of patient own funding, which currently stands at 33% or 6.56 euros per reimbursed prescription.

Objective		Performance indicator	Performance
	Increase awareness of the health system and health factors among the population	Awareness of insured persons of their rights	In 2012 awareness reached the highest level ever, at 78%. Family physicians, health insurance and the ambulance service are the themes about which people are best informed. They know less about health insurance benefits and the European health insurance card. Given that many people turn to the internet for information about their rights, we have started renewing the Health Insurance Fund website.
	Ensure implementation of health promotion and disease prevention projects as planned	Cancer screening coverage	The cervical cancer screening coverage in women invited to screening in the past three years was 71% (the goal was 70%). The breast cancer screening coverage in women invited to screening in the past three years was 66% (the goal was 70%).
4. Ensure efficient use of health insurance resources and sustainable development of the health insurance system			
	Increase the cost-efficiency of health insurance resources	Average cost per case	In 2012 the structural increase of the cost of a case in specialised medical care was 3.1% (the objective was to limit the structural cost increase to 1%). The considerably higher than planned number of very expensive cases played a significant role in the increased cost, constituting 0.8% of the structural cost increase. In order to ensure the achievement of the goals in the future, the contracts for financing treatment must be monitored more closely and the impact of any potential changes assessed more regularly.
5. Improve the operation of the organisation			
	Improve the operation of the organisation and develop the competence of the employees of the Health Insurance Fund	Satisfaction of the employees with the management and organisation of the work of the Health Insurance Fund	The survey measuring the satisfaction of the employees shows that the number of those who are not satisfied has grown by 3%. The main reason is pay. Slow information exchange within a department and between departments is another cause for dissatisfaction. On a scale of five the employees gave their general satisfaction with the management and organisation of work of the Health Insurance Fund a ranking of 3.92. The employees listed as the strengths of the Health Insurance Fund its stability as an employer and the clear goals set for the organisation. Flexible organisation of work, modern tools and pleasant colleagues were also mentioned as important.

Principles of Modernising the List of Health Care Services

Physicians and Health Insurance Fund to Cooperate in Revising List of Health Care Services

The Estonian Health Insurance Fund can only pay for the health care services listed in the Regulation of the Government of the Republic establishing the List of Health Care Services of the Estonian Health Insurance Fund (hereinafter referred to as the List), subject to the conditions and limited to the prices set therein. However, the cost of the means for providing the services (i.e. equipment, instruments) changes, and the health care methods and organisation of treatment evolve, also leading to changes in costs. A situation could emerge where the actual clinical practices differ from those prescribed in the List of Health Care Services. This leads to difficulties in coding the services for the purposes of invoicing, carrying out analyses and supervision, as well as in providing evidence-based services.

Therefore the choice, structure and reference prices of health care services offered in the List must be revised regularly. The officials of the Health Insurance Fund cannot manage this task alone because they lack the relevant knowledge. This is why the revision of the List is always a joint effort by the professionals and the Health Insurance Fund. The fund's team consists of the health care specialists, economists and medical advisers.

Revision of the List

Usually the List of Health Care Services is revised once a year. Professional societies, the Estonian Hospitals Association and the Health Insurance Fund can come forward with their proposals. The process follows two paths:

1) inclusion of new evidence-based services and changing existing individual services on the basis of proposals made;
2) revision of the structure, description and reference prices of services forming a part of one medical speciality, e.g. cardiology.

The details and procedure in the first case are defined by the regulation of the Government of the Republic. Pursuant to the regulation each new service has to be assessed for its impact on the health of the patient, i.e. whether it is medically evidence-based, as well as for its cost-efficiency, and for its impact on the health insurance budget, the society and health care policy. The respective specialists shall make the required assessments. The medical specialist recommended by the University of Tartu Faculty of Medicine or the State Agency of Medicines evaluates the medical evidence base. Cost-efficiency and impact on the health insurance budget are usually assessed by experts in health economics of the Health Insurance Fund. The Ministry of Social Affairs plays a role as well, evaluating the necessity of the new service for the society and setting health care policy priorities.

In both cases the prices of the services are formed on the basis of the methodology prescribed by a regulation of the Minister of Social Affairs, establishing which funds shall be used, how costs shall be taken into account and the reference price calculated. The method is based on Activity Based Costing, which is widely used across the world. To calculate the price for each service, the activities needed for its provision shall be described first and then the activities are combined with the persons (e.g. physician, nurse etc.) and resources (e.g. equipment, disposables, premises etc.) needed to perform those activities. The descriptions are provided by the specialists of each particular field.

Thus cooperation of the parties involved is crucial for the revision of the prices of health care services, combining, on the one hand, the knowledge of the physicians about the resources available and on the other hand, the know-how of the staff of the Health Insurance Fund concerning the methods and principles of calculating the

Kersti Esnar
Head of Pricing Unit

prices. In addition the price formation process involves the Estonian Hospitals Association, whose member hospitals present the costs of their resources and of providing the services for revision. At least one regional, one central and one general hospital must be part of the price formation process. Proposals made by professional societies are also taken into account. In order to ensure that the new structure and prices of the services correspond as closely as possible to reality, the economists and medical advisers of the Health Insurance Fund visit health care institutions, study how services are provided and how work is organised and discuss how to modernise the services.

After such preliminary work the new draft service descriptions are compared with the previous year's costs and take-up of resources. Thereafter the required changes are discussed with the specialists and if necessary the descriptions of the services are amended to reflect the real situation. The prices of the services are then calculated on the basis of the new descriptions.

In addition to modifying the existing services and their prices, new services can be added to the List. To be chosen the new service has to be medically evidence-based and cost-efficient. The new service must have a greater positive impact on the health of the patient than the current service.

However, costs must be taken into account as well: does the greater positive impact on health cost more or less than the alternative, does it influence the quality of life or is it life-saving. For example, when revising the service of orthopaedic surgery in 2012, we took into account the growing number of less traumatic procedures and therefore wanted to specify those in more detail in the List. For example more operations are performed by using arthroscopy or mini-arthrotomy, which are less invasive, require shorter rehabilitation periods and thus patients can return to work sooner. The medical rehabilitation service was also modified by adding in the List physiotherapy and occupational therapy services provided simultaneously to several patients, i.e. in a group. The separation of individual and group rehabilitation services allows more efficiency in planning rehabilitation and using the services provided by occupational therapists and physiotherapists, in selecting the services that meet the needs of the patients and improving their availability.

The Supervisory Board of the Health Insurance Fund makes its own selection from the applications received, prepares a written opinion concerning the revisions in the List of Health Care Services and makes a proposal to the Minister of Social Affairs to submit the new List for approval to the Government of the Republic. The revised services and prices are included in the List of Health Care Services, adding, if necessary, implementing conditions.

Achievements in 2012

In cooperation with three professional societies the lists of orthopaedic operations and procedures, radiotherapy services and medical rehabilitation services were revised. As a rule the revision takes one year, in some exceptional cases longer. For example, we started with the descriptions of the rehabilitation services already in 2011. Usually, it is not the price formation *per se* that is the reason for the delay, but more general issues concerning the organisation of health care, which have to be specified and negotiated.

The number of health care providers involved in the process depends on the nature of the service. For example, only two health care providers participated in revising the list of radiotherapy services, since those services are only provided in two institutions. However, the revision of the list of medical rehabilitation services brought together professionals in the field and seven health care institutions, while five health care institutions participated in revising the list of orthopaedic services.

To sum up - the Health Insurance Fund can never revise the List of Health Care Services or the prices alone; cooperation is vital. Medical specialists with in-depth knowledge of their field, and medical advisers of the Health Insurance Fund are all part of the process. Cooperation does not stop at the preparation of the draft List. Guidelines are developed for those who were not participating in the price formation phase and the implementation of the new List is monitored closely. If necessary, the List can be modified or more details can be added to the List. ■

Prescription Pharmaceuticals More Affordable

Erki Laidmäe
Head of Pharmaceutical Department

Very often one can hear the opinion that pharmaceuticals are too expensive in Estonia. What is usually meant is that the share of the cost to be borne by the patient is excessive. Generally the approach to the problem is too simplistic - that the share of the Health Insurance Fund should be increased. Technically this would be the simplest and fastest solution, but in reality it would mean a reversal of the reforms in the pharmaceuticals' sector, whether it be achieved by reducing the reference prices or increasing the reimbursement level. Either way, the additional funds would have to come from the health insurance budget. As early as in 2009 the Pharmaceutical Department of the Health Insurance Fund proved that a more reasonable use of pharmaceuticals would allow the patients' out-of-pocket expenses to be considerably smaller. In the subsequent years the Health Insurance Fund and the Ministry of Social Affairs launched several activities aimed at promoting more reasonable use of pharmaceuticals.

The Ministry of Social Affairs amended legislation so as to widen the options for the patients to choose more affordable pharmaceuticals. The most important among the changes was introduced in 2010: pharmacies must offer the least expensive option to patients who have a prescription written by international non-proprietary name (INN). The obligation to monitor compliance of pharmacies with the requirement rests with the State Agency of Medicines. As another precondition the number of INN-based prescriptions had to grow significantly; thanks to the digital prescription 75% of the prescriptions prescribed in 2012 were INN-based. Given that eventually the patient makes the choice in the pharmacy, the Health Insurance Fund has been organising campaigns since 2010 aimed at increasing the self-confidence and awareness in the users. These measures have produced good results. Figure 1 shows that the upward curve indicating patients' out-of-pocket expenses has been reversed. Out-of-pocket expenses have dropped 18% from the peak in 2009.

In addition to increasing awareness in the general population, the optimal use of pharmaceuticals by physicians needs constant attention as well, for this is key to the reasonable level of the patients' out-of-pocket expenses, but equally important for the efficiency of using health insurance funds. A case in point is the clinical guidelines for the treatment of adult patients with hypertension,

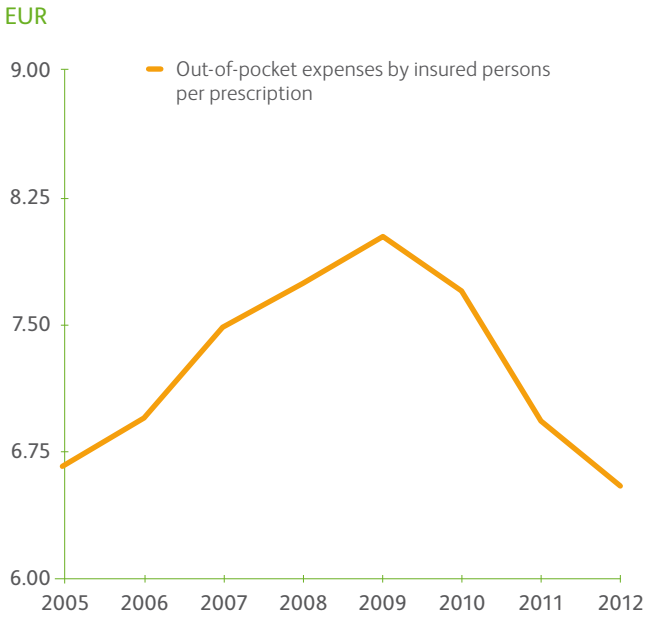


Figure 1 Out-of-pocket expenses by insured persons per prescription in 2005–2012, EUR

written specially for family physicians in 2011, which followed the new approach. Side by side with medical aspects the guidelines laid out economic arguments before proceeding with treatment recommendations. For example, cheaper alternatives are suggested for treatment, provided no significant clinical differences have been detected between alternative ingredients. Based on the recommendations of the clinical guidelines the Health Insurance Fund and the Estonian Association of Family Physicians agreed on some indicators, which will be monitored as part of the family physicians' quality system from 2013. One of the indicators is to promote reasonable use of pharmaceuticals, to this effect the number of INN-based prescriptions issued by a family physician is monitored. During the coming years we plan to work on feedback to physicians, which would make them consider aspects leading to a more reasonable use of pharmaceuticals when issuing prescriptions.

Consequently, changing the patients' attitudes in using pharmaceuticals is a complex matter that cannot be solved with the help of the seemingly simple methods described in the introduction above. We have learned from the experience of our Nordic colleagues that even considerably more prosperous countries are facing the same challenges and resort to similar methods in meeting the challenges. Even in welfare states the optimal use of pharmaceuticals helps keep down the costs for patients and find resources for new drugs for the health insurance systems. Hence we see here another area where we are about to catch up with our Nordic neighbours. ■

Medical Advisers Contribute to Better Treatment Results

Medical advisers play a crucial role in the Estonian Health Insurance Fund. They have in-depth knowledge of medicine and help service providers make decisions in the health care system, which are the best for the insured persons' health.

The work of medical advisers falls into three broad areas.

One of the areas is consulting work. Every hospital, health centre and family physician has a medical adviser to contact if necessary. The problems can concern the price list of the Health Insurance Fund or difficulties in executing invoices for treatment etc. If needed, medical advisers can also give advice to patients, pharmacies and employers. We hope to focus more on the latter area in the future, so as to offer comprehensive support to our contractual partners.

The second major area involves checking invoices, certificates of incapacity for work and reimbursed prescriptions for correctness and justification. The checks are conducted on the basis of medical files. Partners are notified of any errors discovered in order to prevent future mistakes and if necessary, claims shall be processed.

Last but not least is work with contracts concluded with health care institutions. It is the task of the medical advisor to participate in drafting the contracts and to check their implementation, ensuring that beside numbers the needs of insured persons and medical considerations are taken on board as well. They also have to monitor compliance with other contract terms and conditions, e.g. waiting lists and organisation of work in the institutions etc.

Medical advisers take part in conducting expert analyses of new services, e.g. they cooperate with professional societies in the working groups for processing amendments of the price list of health care services.

The year 2012 saw sweeping changes in the work of medical advisers. In its capacity of checking the implementation of the terms and conditions of contracts concluded between the Health Insurance Fund and service providers, the medical adviser has to supervise the family health centres, incl. for availability of services. In earlier years on-site visits to family physicians focused on their compliance with the contract terms and conditions, now more attention is paid to information and advice. The new approach for on-site visits involves discussing issues that could help increase the awareness of the family physicians, in order to ensure the best possible medical care. The medical adviser prepares some themes prior to the meeting with the family physician, e.g. the use of the fee-for-service fund for examinations and tests or the results of random sampling. Other themes include cooperation of family physicians and specialists, availability of specialised medical care and nursing care, participation of the women in the family physician's practice list in breast and cervical cancer screening, organisation of school health services, issuing INN-based prescriptions and clinical guidelines. There is no doubt that such discussions have been useful for both parties. Together they have come to solutions that should benefit the patients and ensure more efficient use of the health insurance resources. The family physicians have received feedback about their work, the Health Insurance Fund has learned about problems in providing specialised medical care and nursing care. This

Maivi Parv
Director of Tartu Department

Sirje Saarma
Head of Health Insurance Benefits Bureau

in turn has led to involving professional societies and hospitals in those discussions, so that the solutions can be worked out together.

From this year medical advisers assumed more responsibility in checking medical files. Some of the medical advisers act as coordinators for thematic control of the medical files across Estonia, they are responsible for carrying out the checks both as regards its form and content, and for submitting a summary report. The aim of coordination is to carry out the revisions in different regional departments based on the same criteria in order to improve the assessment of medical activities reflected in the medical files and promote discussions between medical advisers when resolving more complicated situations. This year medical advisers of the Harju, Tartu and Pärnu regional departments coordinated the checks of medical files in the following fields: vascular surgery, treatment using a continuous positive airway pressure (CPAP) device and the treatment council or cancer patients.

In conclusion, our medical advisers are working together with health care institutions every day in order to ensure quality medical care to insured persons. The stronger role of medical advisers contributes towards achieving this aim even more.

Innovations in Waiting Time Monitoring

Triin Habicht
Head of Health Care Department

According to the survey, "Assessment of Health and Health Care by the Population, 2012" more than one half of the population (55%) were satisfied with the availability of medical care. The result is 4% better than last year. Every person hopes to get a quick solution to his or her health problem, but there is no health care system in the world that can provide immediate access to a doctor's office to everyone who so wishes.

Patients must be able to see a doctor within reasonable time, depending on the condition of their health. There is no doubt that the severity of the case must be established swiftly and patients with a life-threatening condition must get immediate help.

For example, acute cases must be seen by a family physician on the same day, whereas other cases (e.g. a regular check-up of a patient with a chronic disease) must be seen in five working days. In specialised medical care the waiting time for outpatient visits is six weeks and for planned inpatient treatment - eight months. These are the maximum allowable waiting times. The medical indications determine the actual waiting time for any individual patient.

The Health Insurance Fund must have an overview of the waiting times, as this allows us to monitor access to medical care. Once a month hospitals submit reports about waiting lists, setting out the actual waiting times and stating how many patients have to wait longer than allowed and why.

Figure 2 shows that the total number of people waiting for specialised outpatient care has more than doubled over time. However are many different reasons for being included in a waiting list.

The number of persons included in the waiting lists depends on several factors. For example in cases where it is possible to sign up several months in advance, the waiting list seems to extend artificially. In addition to first time visits the statistics include patients invited to follow-up visits, as well as those who have registered but fail to turn up. According to health care institutions the share of patients who sign up but do not show up could be as high as 10%. The figure shows that as of 1 January 2013 43% of the patients listed

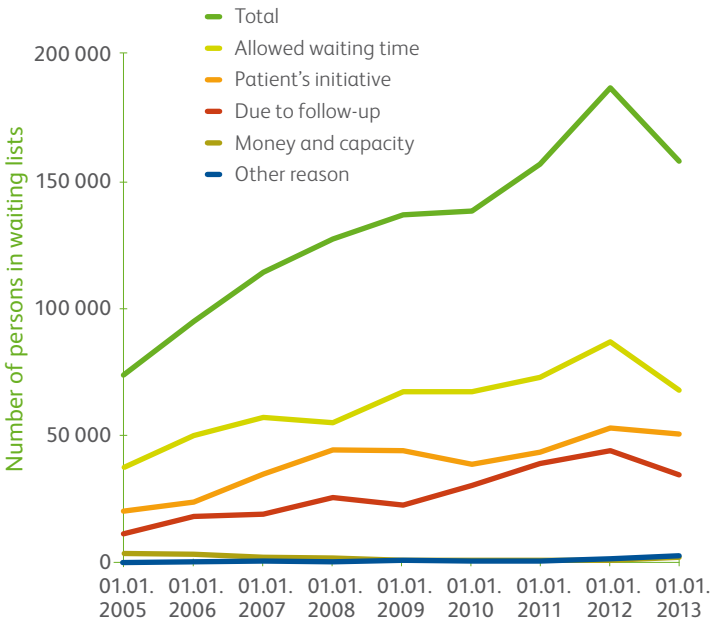


Figure 2 Number of patients in waiting lists in hospitals belonging to the Hospital Network Development Plan, by reason

could see a doctor within the allowable waiting time (cf. 50% in 2005). However, this should not lead to the conclusion that the remaining 57% had problems. 39% of those who had to wait longer than permitted were follow-up visits and 56% waited longer voluntarily. About 3% (i.e. 2 500 persons) had to wait more than six weeks to see a doctor because of the lack of staff, availability of operating rooms or equipment or scarcity of financial or other resources. The latter group also includes those who were not aware of the possibility of seeing another specialist in the same health care institution or choosing a different institution..

Activities in 2012

It is very important for the Health Insurance Fund that patients can see a doctor in a timely manner. Therefore we involved all our regional departments in the review of the current reporting concerning waiting lists and the procedures related to monitoring and improving access to services.

In cooperation with the hospitals we developed a new reporting form for outpatient waiting lists, which allows us to see, on a monthly basis, the actual waiting times of patients who visited a doctor. The new report will be applicable from 2013. The first months will be devoted to analysing the quality of data together with the hospitals, in order to be sure of the correctness of such data. The previous report was looking ahead, providing information about the persons still waiting to visit a doctor. Some of them never went, some could jump the line because of the nature of their illness. A comparative analysis of the two report formats helps the Health Insurance Fund discover the shortcomings and seek solutions together with hospitals. In addition to regular reporting, we have carried out on-the-spot checks in the health care institutions to establish the reasons of long waiting times and to find ways to resolve the situation[1]. The checks will continue in 2013.

There can be several reasons for long waiting times: the organisation of work at a hospital, the cooperation between family physicians and specialists, scarcity of budgetary funds. If money were the only reason, the Health Insurance Fund could review and change the volumes agreed with the health care institutions. However, usually it is not the money and therefore the other two factors have to be changed as well. The Health Insurance Fund cannot do this, but we can discuss the problems and bring together the heads of hospitals, specialists and family physicians and seek solutions. The introduction of the national digital registration system would contribute towards unifying the waiting times across the country. For we all share one and the same goal: the patient must have the necessary help when needed. ■

[1]Please visit our website for reports concerning the checks http://www.haigekassa.ee/kindlustatule/jarjekorrad

Launch of E-certificates of Incapacity for Work (E-TVL)

Certificates of incapacity for work always used to be processed on paper. This is why it took a long time to exchange the data necessary for calculating the benefits, and the extended procedure ate up the resources of the health care institutions, employers and the Health Insurance Fund. First, the physician issued the patient a paper certificate of incapacity for work, the patient handed the certificate to the employer, who forwarded it to the Health Insurance Fund. As a rule the employers did not take every individual certificate immediately to the Health Insurance Fund, since it would have taken up more resources by way of staff and mailing costs in bigger firms. Therefore they forwarded the certificates only once a week. During peak times of sickness the Health Insurance Fund received very many certificates at the same time. The backlog in entering the data and computing the benefits was often up to three weeks. As a result the people had to wait longer for their sick pay. The Health Insurance Fund decided to simplify the process and digitalised the data exchange necessary for paying incapacity for work benefits.

Transition to e-certificates of incapacity for work or the E-TVL has been a step-by-step process. First, in 2006–2008 the whole software for processing the financial benefits was moved to a new platform, more suited to electronic data exchange. As a next step an electronic data exchange system was created for health care institutions, since as a precondition for the full-fledged introduction of the E-TVL data exchange, the traffic of e-certificates from physicians to the Health Insurance Fund had to become possible.

The expectations of the employers and any shortcomings that have gone unnoticed so far will be best revealed during piloting the new system. At the end of 2012 the employers could start piloting the service of forwarding the certificates electronically. Our major partners North Estonia Medical Centre and East Tallinn Central Hospital were among the first to join the system, and Stoneridge Electronics was the first enterprise to come aboard. By now all the main chains and banks have started using the system. Despite occasional problems employees using the E-TVL have been satisfied as well: the new system is user friendly, simple and performs well.

The Health Insurance Fund plans to make the E-TVL service available to all enterprises by the beginning of 2014 at the latest, once the legal provisions necessary for the E-TVL data exchange have entered into force. Until then every entity who wishes to forward electronically the data contained in the certificate of incapacity for work, must conclude a data exchange agreement with the Health Insurance Fund.

The E-TVL is scheduled to be fully operational for employers in 2015. From then on the health care institutions would not have to issue paper certificates any longer and all the relevant information would be transferred electronically.

The new system would mean a win-win situation for all concerned: the health care institutions would not have to issue certificates on paper, the employers would save time and resources with respect to data exchange and the employees would receive their sick pay sooner. ■

Lii Pärg
Head of Customer Service Department

Ado Viik
Director of Harju Department

Clinical and Patient Guidelines Focus on Patients and Build Partnerships

Sirje Vaask
Head of Quality Division

The provision of patient-centred health care is a process that is based on the partnership between the health care professional and the patient. Trust and cooperation are not built in a day. To achieve this both parties need to have information about the various possibilities available.

As regards knowledge, the health care professionals have an advantage, but they also need time and skills to process the wealth of information out there. Modern clinical and patient guidelines are very useful here, helping both the health care professionals and the patients to make the best treatment and care decisions. The purpose of clinical guidelines is to point to interventions whose effectiveness has been proved by evidence and which reduce morbidity and mortality, and improve the quality of life of the patient. Improved health status of the patient is the best result. The guidelines help harmonise the management and the possibilities of the treatment of patients irrespective of where the treatment is carried out.

Patient guidelines raise the awareness of patients and serve as a precondition for them to actively participate in the process of treatment. This also means that the individual assumes responsibility for what was agreed, e.g. to do physical exercises or take pharmaceuticals. We have noticed that people have become more and more active in seeking information concerning their own health problems or their family members and want to know if guidelines exist in Estonia for a particular condition. It is important to remember though, that clinical guidelines are not applicable to every case and the condition of every patient is unique, therefore the patients and their relatives have to place their trust in the experience of health care professionals when making decisions. And what's more, not every area or health condition has its own clinical or patient guidelines. Clinical guidelines are useful in cases where the health care professionals have no comprehensive information about best practices and thus evidence-based sources can provide the required answers. In 2012 the first clinical guidelines for the treatment of adult patients with hypertension were written specially for family physicians in Estonia[2]. The analysis conducted by the Health Insurance Fund revealed a great variation in the management of patients with hypertension. Cardiovascular diseases are the number one cause of morbidity and mortality in Estonia; hypertension is widely spread, with up to 60% of the elderly suffering from the condition. Early detection - when it is not too late yet to modify risk factors and start taking medication - can significantly reduce the prevalence of future complications of hypertension. This was the reasoning behind the decision to pick hypertension as the first subject for the guidelines. Initial feedback from family physicians and medical students has been excellent. Finally they have at their disposal a succinct, clear, understandable and convenient tool for dealing with hypertension.

At the same time we also came out with the blood pressure diary designed for patients,

[2]The clinical guidelines can be found at: www.ravijuhend.ee

[3]The web based salt calculator can be found at: http://www.toitumine.ee/kampaania/sool/

which became so popular that has run out of print already. The Health Insurance Fund has funded the following patient guidelines on the same subject: "High Blood Pressure. How to Protect Your Heart?", "Keep Healthy, Protect Your Heart", "Health Diary for Patients with Hypertension" and "Healthy Exercise. It's Easy to Start". The web based salt calculator developed by the National Institute for Health Development is also available for all[3].

The Clinical Guideline Advisory Board led by the University of Tartu Faculty of Medicine has been offered 12 new themes for guidelines. The Clinical Guideline Advisory Board chose the following themes for new clinical guidelines, to be completed by the end of 2013: "Prevention and Care of Pressure Ulcers", "Management of Adult Patients with Asthma in Family Medicine" and "Management of Anxiety Disorders in Family Medicine". Later patient guidelines will be written on the same subjects.

Patient guidelines empower individuals to take informed decisions and make the best choices, by taking into account evidence-based information on the one hand and the individual needs and preferences of the patient on the other hand. This helps the patient to adhere to what has been agreed and to monitor his or her condition for any changes. We think it is important to involve the patients more in the drafting of the guidelines, so as to take into account their needs and preferences even more. ■

Feedback to Hospitals – New Report from Health Insurance Fund

Jane Alop
Chief Health Care Specialist of Health Care Department

Health Care Management Decisions Must Be Based on Facts

A report containing indicators about the availability of treatment, the efficiency of the treatment process and activities for all the 19 hospitals belonging to the Hospital Network Development Plan[4] was prepared by the Health Insurance Fund for the first time in 2012. The indicators were agreed after several years of joint efforts by the hospitals, professional societies and the Health Insurance Fund.

The purpose of the new report is to give feedback to hospitals about their activities on the basis of the same methodology, so that they can compare themselves with other hospitals in Estonia. Several years of working together with the hospital specialists showed that such information makes the exchange of best practices and learning from others easier. Presentation of comparative data in this manner is a widespread international practice. The main problems lie with access to and the quality of data, given the different motives of health care providers in forwarding the data. The fact that the Estonian health insurance system is mostly funded by a single entity and the invoices are issued electronically, presents a unique opportunity for multiple analyses of the data so gathered.

Invoices Are Valuable Sources of Information

Payment for health care services is effected on the basis of invoices issued by the health care institutions to the Health Insurance Fund. The invoice is a financial document, setting out who has provided services to whom. The invoice also contains a coded description of the service provided and the cost. The quality of data in the invoices can be relied upon, because on the one hand, the service providers are motivated themselves to issue correct invoices and on the other hand, the Health Insurance Fund constantly checks the invoices for accuracy.

In a year the Health Insurance Fund processes close to 7.6 million invoices. Almost one half of the invoices are from providers of specialised medical care, mainly hospitals. Nowadays such volumes of data are processed routinely, but it is important to be able to analyse the data as best as possible and shape one's activities accordingly.

Feedback to Hospitals

There are 19 hospitals in Estonia whose services the Health Insurance Fund is obliged to purchase under law. The prices of the services are fixed in the List of Health Care Services. The volumes and structure of services are negotiated annually between the service providers and the Health

[4]The hospitals belonging to the Hospital Network Development Plan have been confirmed by Regulation No 105 of the Minister of Social Affairs of 2 April 2003

Insurance Fund. By using a specific method to process and analyse the invoices issued for the services, it is possible to draw conclusions about the way hospitals have organised their work. The following examples show how this is done.

Thanks to modern methods of treatment the patients no longer have to stay overnight at the hospital after a number of operations. Day surgery is more convenient and safer for the patient (the patient is less likely to catch hospital infection) and more efficient for the hospital (the hospital resources can be used for treatment and not for providing accommodation). 26% of the inguinal hernia operations were performed in day care in the hospitals belonging to the Hospital Network Development Plan in 2012. The share of day care varies greatly in hospitals, ranging from 1% to 81%.

Long waiting times are always in the spotlight and cause dissatisfaction among insured persons. Under the contract the hospitals have the obligation to file regular reports about waiting lists. On 1 January 2012 38% of the people in the waiting lists in the hospitals belonging to the Hospital Network Development Plan had to wait longer than allowed, but only very seldom (1% of the cases) this was caused by the limited capacity of the hospitals. The average waiting time varies by hospital, this is what should give some fruit for thought for the people in charge of the hospitals.

Firm Decision to Continue

The 2012 report was the first step in disclosing indicators comparing the work of the hospitals. The promising reception by the hospital encourages us to carry on with the work.

We are glad to note that the report also caught the attention of the general public. The main coverage came from local newspapers. This allowed the hospitals to offer their comments as well. The insured persons were given an exhaustive overview of the activities of the hospitals and were assured that the activities met the expectations of the public.

In cooperation with the hospitals and specialists the Health Insurance Fund is working on new indicators to be included in the next reports. The 2012 report is available on the website of the Health Insurance Fund[5]. The yearly reports years will be made available at the Health Insurance Fund website by May 15 of the following year. We believe that giving feedback to the general public is important for ensuring transparency of the health care system and it helps improve the organisation of work in the health care institutions and the quality of health care offered to the patients. ■

[5]The 2012 feedback report can be found at: http://www.haigekassa.ee/raviasutusele/kvaliteet/tagasiside

Family Medicine and Digital Prescription Most Recognised in Health Care in Estonia

Evelin Koppel
Head of Public Relations Department

Since 2001 the Health Insurance Fund and the Ministry of Social Affairs have been commissioning a national opinion poll, "Assessment of Health and Health Care by the Population", which aims to measure the satisfaction of the people with the health system and availability of medical care.

The survey is conducted every autumn among 1,500 persons aged 15–74. The results are used by the Health Insurance Fund for preparing the development plan, getting feedback and assessing performance.

Strike Had No Significant Impact on Satisfaction with Health System

Last year's survey shows that the people had slightly fewer contacts with the health system than in 2011 but their satisfaction with the system grew a little, despite fewer contacts and despite the strike. Almost 75% of the population went to see a doctor. The biggest number of people (61%) visited a family physician, 38% went to a specialist and 33% visited a dentist.

Doctors' services are more used by women. The age of the patient plays a significant role in the frequency of contacts with the health system. As could be expected, people in the age group 60-74 had more contacts with all services (except with dentists). Those between 50 and 59 are also fairly frequent visitors of family physicians and specialists. However, members of this group see a dentist less often than others. Residents of Northern Estonia pay the most visits to doctors, whereas those of North East Estonia are the least frequent visitors of a doctor's office.

Quality of Medical Care Highly Rated

The following is most liked by people about the organisation of health care: the family medicine system, the good and friendly attitudes of doctors, the existence and availability of medical care, the digital prescription and the electronic system in general.

83% of the population are satisfied with the family medicine system in general, and almost 90% are happy about their own family physician and nurse. The results have always been positive, but this year saw the highest satisfaction rates in recent years. Most patients can see a family physician within the permitted waiting time, i.e. five working days.

The patients continue to rate highly the quality of medical care in Estonia: 78% of the population considered the quality good (see figure 3). In comparison with last year the opinions have become more positive. People living in Central and Western Estonia are the most satisfied with the quality of medical care. Students have a higher estimation of the quality, whereas the unemployed are less satisfied. Contacts with family physicians are rated more positively, those with the ambulance service - more negatively.

More Affordable Ways to Buy Pharmaceuticals

Last year 64% of the population purchased prescription drugs. 90% of those who had purchased pharmaceuticals and used the digital prescription system were satisfied with their experience. Over the years the level of satisfaction with the system of buying pharmaceuticals has remained high.

The Health Insurance Fund continued the campaign on the reasonable use of pharmaceuticals in 2012. We invited the patients to request INN-based prescriptions from their doctors and choose the most favourably priced among equivalent pharmaceuticals in the pharmacy.

Among the people who had purchased prescription drugs last year 61% could buy the most favourably priced option in the pharmacy. In comparison with 2011 the share of such persons has gone up by 20%. The awareness levels have grown significantly among patients, physicians and pharmacists. In Northern Estonia the pharmacists offered or the patients asked for the choice of pharmaceuticals in more instances than the average. The residents of Western Estonia and North East Estonia were less often able to choose or knew less often how to ask for a more favourably priced pharmaceutical.

Availability is Important

Quite clearly people are the most concerned about the time they have to wait in order to see a specialist. Roughly one third of those who visited a specialist considered the waiting time too long.

The availability of medical care is rated as good by 55% and as bad by 44% of the respondents. In comparison with last year the satisfaction levels have increased slightly (see figure 4). The residents of Tallinn and the unemployed gave a lower rating to availability, whereas students and residents of Central Estonia had a higher opinion of it. Somewhat more positive about the availability of medical care are those who themselves have had no contact with the system. More than half the patients could see a specialist within the permitted waiting time, i.e. six weeks. However, there is a slight increase in those patients who had to wait six weeks or longer.

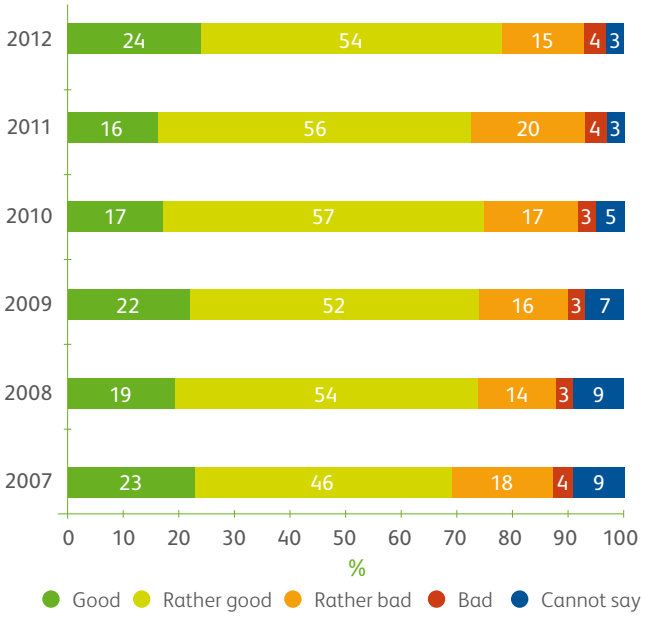


Figure 3 Assessment of quality of medical care, %

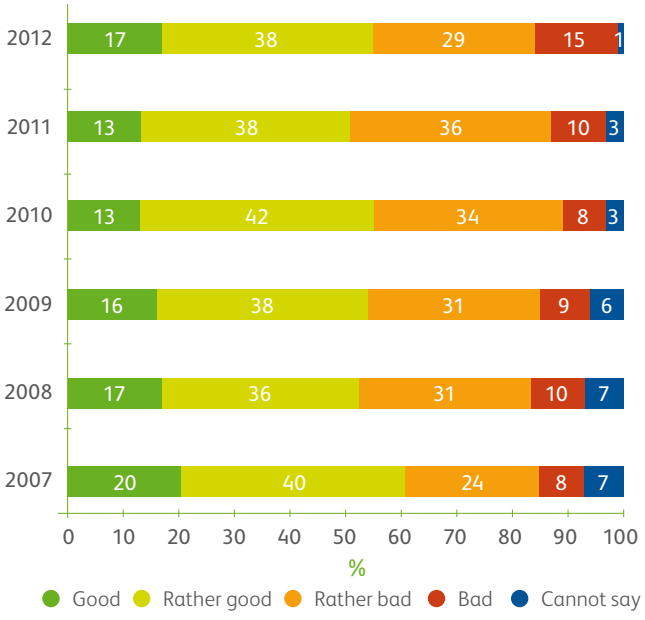


Figure 4 Assessment of availability of medical care, %

The introduction of the national digital registration system would contribute towards unifying the waiting times across the country. 80% of the respondents would like to be able to monitor the waiting lists of providers of specialised medical care via the internet. This indicator has not changed in comparison with last year.

Despite concern over long waiting times 63% of the population still prefer the current system of funding health care, in which health insurance covers all services even if the waiting times can sometimes be exceedingly long. The share of those who prefer this system has grown over the years.

The satisfaction of the people with the health system is vital for the Health Insurance Fund. We take their opinion into account when planning the activities and making decisions. The priorities of the Health Insurance Fund for the coming years are the following: shorter waiting times, stronger family medicine system, support to enhanced quality of treatment, continued efforts to inform the patients about their rights and obligations in the health insurance system.

2012 Budget Execution Report

Table 2 Budget (in thousands of euros)

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
HEALTH INSURANCE FUND REVENUE					
Health insurance component of social tax	725,580	771,884	776,919	100.7	7.1
Revenue from contracts for persons considered equal to insured persons	3,040	3,000	1,318	43.9	–56.6
Recoveries from other persons	890	700	607	86.7	–31.8
Finance income	2,760	2,200	1,241	56.4	–55.0
Other income	2,842	2,840	3,046	107.3	7.2
Government grants	1,542	1,476	1,625	110.1	5.4
Other income	1,300	1,364	1,421	104.2	9.3
TOTAL BUDGET REVENUE	**735,112**	**780,624**	**783,131**	**100.3**	**6.5**
EXPENSES RELATED TO HEALTH INSURANCE					
Health care service expenses	**522,525**	**562,718**	**563,944**	**100.2**	**7.9**
Disease prevention	6,528	7,330	6,854	93.5	5.0
General medical care	66,108	71,538	70,212	98.1	6.2
Specialised medical care	417,017	448,105	450,472	100.5	8.0
Nursing care	14,816	16,502	17,538	106.3	18.4
Dental care	18,056	19,243	18,868	98.1	4.4
Health promotion expenses	**806**	**968**	**814**	**84.1**	**1.0**
Expenses for pharmaceuticals reimbursed to insured persons	**91,465**	**101,841**	**98,967**	**97.2**	**8.2**
Expenses for benefits for temporary incapacity for work	**80,770**	**88,468**	**84,265**	**95.2**	**4.3**
Expenses for other financial benefits	**8,295**	**8,975**	**9,136**	**101.8**	**10.1**
Other expenses	**14,557**	**16,174**	**16,449**	**101.7**	**13.0**
Expenses covered by targeted financing from the state budget	1,461	1,476	1,572	106.5	7.6
Other expenses for health insurance benefits	13,096	14,698	14,877	101.2	13.6
TOTAL HEALTH INSURANCE EXPENSES	**718,418**	**779,144**	**773,575**	**99.3**	**7.7**
HEALTH INSURANCE FUND OPERATING EXPENSES					
Personnel and management expenses	**4,380**	**4,792**	**4,645**	**96.9**	**6.1**
Wages and salaries	3,262	3,567	3,460	97.0	6.1
Incl. remuneration of management board members	139	138	153	110.9	10.1
Unemployment insurance contributions	44	48	45	93.8	2.3
Social tax	1,074	1,177	1,140	96.9	6.1
Administrative expenses	**1,011**	**1,131**	**1,012**	**89.5**	**0.1**
IT expenses	**834**	**964**	**773**	**80.2**	**–7.3**
Development expenses	**159**	**225**	**151**	**67.1**	**–5.0**
Training	76	113	86	76.1	13.2
Consultations	83	112	65	58.0	–21.7
Finance expenses	**87**	**87**	**0**	**0.0**	**–**
Other operating expenses	**609**	**841**	**750**	**89.2**	**23.2**
Supervision over health insurance system	53	102	75	72.8	41.5
Public relations/communication	68	114	108	94.7	58.8
Other expenses	488	625	567	90.9	16.2
Total Health Insurance Fund operating expenses	**7,080**	**8,040**	**7,331**	**91.2**	**3.5**
TOTAL BUDGET EXPENSES	**725,498**	**787,184**	**780,906**	**99.2**	**7.6**
Earnings of the budget year	**9,614**	**–6,560**	**2,225**	**–**	**–**
RESERVES					
Change in legal reserve	0	0	0	–	–
Change in risk reserve	0	854	857	–	–
Change in retained earnings	9,614	–7,414	1,368	–	–
Total change in reserves	**9,614**	**–6,560**	**2,225**	**–**	**–**

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 pays social tax for himself or herself. Persons considered equal to such persons on the basis of the Health Insurance Act or on the basis of a contract are also insured persons.

For the purposes of health insurance statistics the persons with health insurance fall into five categories, based on the grounds for their insurance:

- Employed insured persons – persons insured by an employer, sole proprietors (incl. their spouses who are participating in their activities), members of management bodies, persons who have entered into a contract 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 – the unemployed, persons on parental leave, caregivers of disabled persons, conscripts;
- Persons insured under international agreements – pensioners coming to reside in Estonia from another EU member state, employees seconded to Estonia from another EU member state, Estonian pensioners going to reside in another EU member state, military pensioners of the Russian Federation;
- Persons considered equal to insured persons under voluntary agreement – insured persons who have concluded a voluntary agreement.

For statistical purposes the leading principle is that the category of employed insured persons is the most important. Thus a person whose insurance is valid on multiple grounds only appears under one category and a working pensioner is just included under employed insured persons.

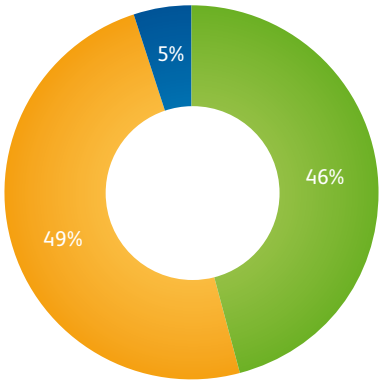
Table 3 Number of insured persons

	31.12.2010	31.12.2011	31.12.2012	Change 31.12.2012–31.12.2011 (persons)	% of change from 2011
Persons considered equal to insured persons	609,467	608,708	602,249	–6,459	–1
Employed insured persons	565,933	568,434	575,277	6,843	1
Other insured persons	80,840	68,327	59,578	–8,749	–13
Persons insured by the state	77,038	65,463	57,619	–7,844	–12
Persons insured under international agreements	3,586	2,600	1,642	–958	–37
Persons considered equal to insured persons under voluntary agreement	216	264	317	53	20
TOTAL	1,256,240	1,245,469	1,237,104	–8,365	–1

The changes in the number of insured persons in 2012 show an increase in the number of employed insured persons, resulting from improved employment and a decrease in the number of persons insured by the state, because the unemployed re-entered the labour market (see table 3).

The share of persons insured under international agreements is declining as well, for many of the military pensioners of the Russian Federation opt for the right to apply for the Estonian old age pension.

The number of persons who have concluded a voluntary insurance agreement has grown at the average rate of 50 per year since 2010. Conclusion of an insurance agreement secures health insurance for those persons who would not be deemed insured persons under the Health Insurance Act. To be insured on the basis of a voluntary agreement one has to pay a contribution, which constitutes 13% of his or her average gross salary of the previous calendar year.



- Employed insured persons
  - share of total number of insured persons 46%
  - average social tax paid per each insured person 1,286 euros
- Persons considered equal to insured persons
  - share of total number of insured persons 49%
  - average social tax paid per each insured person 0 euros
- Other insured persons
  - share of total number of insured persons 5%
  - average social tax paid per each insured person 643 euros

Figure 5 The breakdown of insured persons by category and their social tax contribution

In general the number of insured persons has been dwindling, caused mainly by people leaving Estonia for other countries and also by the fact that in 2012 the number of deaths exceeded that of births[6].

The breakdown of insured persons by category and their contribution towards the payment of the health insurance component of social tax are shown in Figure 5.

Table 4 shows the average health insurance expenses per each insured person.

Table 4 Average expenses per insured person in 2012

Age of insured persons	Number of insured persons as on 31.12.2012	Expenses on general medical care, EUR	Expenses on specialised medical care, EUR	Expenses on pharmaceuticals, EUR	Total expenses, EUR
0–9	148,235	61	241	29	331
10–19	126,839	44	238	27	309
20–29	160,883	45	245	37	327
30–39	158,465	47	273	49	369
40–49	156,176	50	281	61	392
50–59	165,824	63	419	104	586
60–69	142,048	65	606	167	838
70–79	115,170	76	817	210	1,103
80–89	56,880	71	836	173	1,080
90–99	6,431	64	730	100	894
100–109	153	60	610	50	720

[6]According to the Statistical Office in 2012 10,871 persons emigrated from Estonia, while 4,416 persons moved to Estonia. Thus emigration exceeded immigration by 6,455 persons. The reduction in births and increase in deaths has turned natural increase negative as well, with deaths exceeding births by 1,460.

Revenues

Table 5 provides an overview of the Health Insurance Fund revenues in 2012.

Table 5 Revenues in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Health insurance component of social tax	725,580	771,884	776,919	101	7
Revenue from contracts for persons considered equal to insured persons	3,040	3,000	1,318	44	–57
Recoveries from other persons	890	700	607	87	–32
Finance income	2,760	2,200	1,241	56	–55
Other income	2,842	2,840	3,046	107	7
Incl. government grants	1,542	1,476	1,625	110	5
Other income	1,300	1,364	1,421	104	9
TOTAL	735,112	780,624	783,131	100	7

Most of the Health Insurance Fund revenues are made up of the health insurance component of social tax: in 2012 99.2% of the total revenues. Social tax revenues constituted 776.9 million euros, which was more than budgeted for 2012 (the budget was executed at 100.7%). Employers account for 95.2% of the social tax revenues. The remaining 4.8% is paid by the state on behalf of the unemployed and persons receiving social benefits (see figure 6).

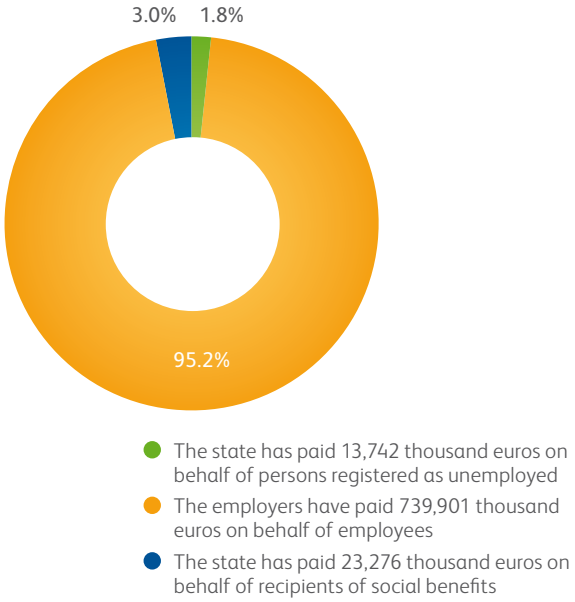


Figure 6 Breakdown of social tax revenues

Figure 7 provides an overview of the dynamics of the revenues from the health insurance component of social tax.

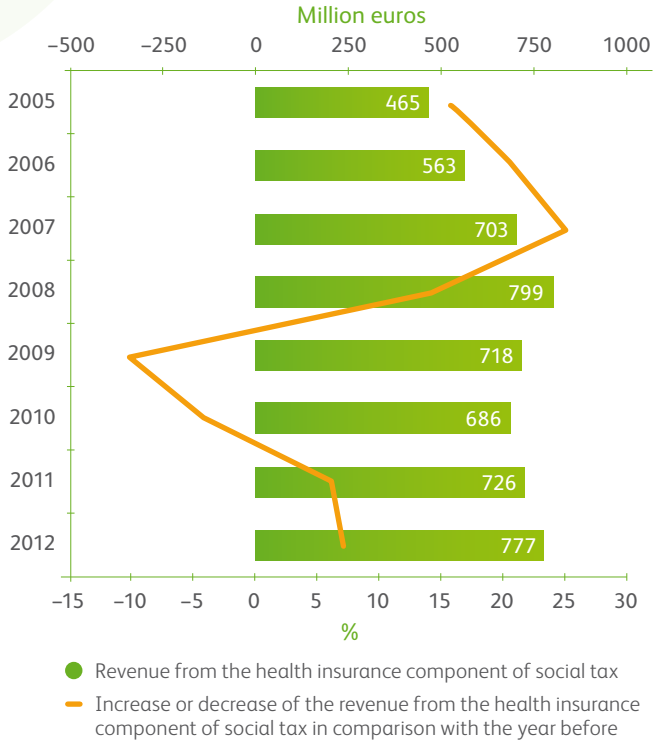


Figure 7 Dynamics of the revenues from the health insurance component of social tax, 2005–2012

Revenue from contracts for persons considered equal to insured persons constituted 1,317.8 thousand euros in the period under review, incl. 386.0 thousand euros in contributions paid under voluntary agreements and 931.8 thousand euros in contributions for non-working pensioners of the armed forces of the Russian Federation.

Recoveries from other persons amounted to 607.2 thousand euros. These include the claims submitted to health care providers, pharmacies, insured persons and employers as a result of various controls.

1.2 million euros were earned as finance income in the financial year. The income was earned from investing reserves.

From 2012 the funds (legal reserve, risk reserve, retained earnings) of the Health Insurance Fund are kept in the group account of the State Treasury. Based on a deposit agreement concluded with the Ministry of Finance the Health Insurance Fund earns interest on the balance of the moneys held on the accounts, at the rate which equals the profitability of the state cash reserve. An overview of the investments made in 2011 is provided in Table 6. Other income includes government grants, income from medical services provided in Estonia to insured persons from other EU member states and other income.

The Health Insurance Fund received 1,572.0 thousand euros in government grants to pay for pharmaceuticals and health care services on the basis of the Artificial Insemination and Embryo Protection Act. The Ministry of Foreign Affairs gave 22.8 thousand euros in support of the development of the health insurance system in Moldova and the National Institute for Health Development made available 29.8 thousand euros for covering the expenses relating to the national cancer prevention strategy. ■

Expenses

The Health Insurance Fund expenses consist of health insurance expenses and operating expenses.

Health Insurance Expenses

1. Health Care Services

The funds for health care services were used as budgeted in 2012 (see table 6). The expenses grew 8% in comparison with 2011. The abolition from 1 January 2012 of the 0.95 coefficient that was applied to reference prices of the services in the List of Health Care Services accounted for 5.3% of the increase in expenses.

There was some variation between the budgeted and actual use of the funds in the case of individual health care services. For example the expenses incurred on specialised medical care exceeded the budget by 1% and those on nursing care by 6%, whereas 6% of the funds allocated for disease prevention remained unused. The following chapters explain expenditure by services and benefit types.

Table 6 Expenses for health care services in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Disease prevention	6,528	7,330	6,854	94	5
General medical care	66,108	71,538	70,212	98	6
Specialised medical care	417,017	448,105	450,472	101	8
Nursing care	14,816	16,502	17,538	106	18
Dental care	18,056	19,243	18,868	98	4
TOTAL	522,525	562,718	563,944	100	8

1.1. Disease Prevention

The objective of disease prevention is early detection of the disease in order to take measures to avoid illness. In 2012 6.9 million euros were invested on disease prevention, constituting 94% of the budgeted amount (see table 7).

Compared to the same period in 2011, disease prevention expenses have increased 5%, mainly due to the growing reference prices of health care services. Less than before has been spent on perinatal diagnostics, this has resulted from more effective pretesting (see for details below). Spending has also been lower than budgeted for the projects aimed at early detection of cardiac diseases and osteoporosis. Table 8 provides an overview of the number of persons participating in the disease prevention projects.

Table 7 Disease prevention expenses in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
School health	3,198	3,499	3,342	96	5
Youth reproductive health	833	895	882	99	6
Breast cancer screening	817	960	916	95	12
Cervical cancer screening	178	212	209	99	17
Prevention of cardiovascular diseases in risk groups	149	188	120	64	–19
Early detection of osteoporosis	42	48	40	83	–5
Screening for phenylketonuria and hypothyroidism	179	201	180	90	1
Perinatal diagnostics for hereditary diseases	325	408	319	78	–2
New-born hearing screening	257	302	283	94	10
Health checks of young athletes	550	617	563	91	2
TOTAL	6,528	7,330	6,854	94	5

Table 8 Participants in disease prevention projects

	Actual number of participants in 2011	Planned number of participants in 2012	Actual number of participants in 2012	Performance, %
School health	155,476	156,289	148,504	95
Youth reproductive health	32,929	32,800	32,680	100
Breast cancer screening	31,287	34,000	33,079	97
Cervical cancer screening	13,111	15,000	13,518	90
Prevention of cardiovascular diseases in risk groups	3,943	4,800	2,647	55
Early detection of osteoporosis	947	1,000	866	87
Screening for phenylketonuria and hypothyroidism	14,459	15,600	14,039	90
Perinatal diagnostics for hereditary diseases	1,406	1,800	1,432	80
New-born hearing screening	13,324	14,000	13,915	99
Health checks of young athletes	10,026	11,500	9,750	85

School health services constituted one half of the disease prevention expenses (48.8%). From 2012, schools for students with special educational and health needs employ one full-time nurse for every 200 students; the total number of students in such schools is approximately 3,600. Preventive medical examinations show that the main health problems in schoolchildren are visual disorders (31%), posture problems (21%) and being overweight (10.3%). In the course of the year the quality of service provision was assessed in twenty schools for students with special needs. Primarily there were problems in schools where nurses had more than one employer (i.e. the nurse was employed both at a health care institution and a school). The assessment led to the following conclusions: teaching first aid has to be improved,

a health questionnaire has to be introduced, which will accompany the medical examination of students and nursing plans have to be developed for planning the activities aimed at dealing with the health problems of individual students.

Last year 31,907 young persons (6% of them young men) had counselling concerning the reproductive health of young people and used services related to the prevention of sexually transmitted diseases. About 20% of the young people turned to the youth centres for the first time in 2012. Sexually transmitted diseases were discovered in 2% of the visitors. 2% of the young women of up to nineteen years of age visited the youth centres because of pregnancy: half of them decided to proceed with the pregnancy and the other half decided to undergo an abortion.

The objective of the screening process for early detection of breast and cervical cancer was to increase participation rate. In January the women were informed of the prevention measures against cervical cancer by means of articles and posters. In May, during the Breast Cancer Week posters and TV spots were used to increase awareness. In autumn the women were once more reminded of the need to participate in screening. In addition to media communication, 117,000 invitations to screening were sent to women by regular mail in the course of the year. More than 50% of the cervical cytology tests are performed during regular health checks. In the course of the screening 135 breast cancer cases were discovered, of them 72% were early-stage cases. Precancerous conditions were found in 3% of the women screened for cervical cancer and 4 cases of cervical cancer were diagnosed.

The project for the prevention of cardiovascular diseases was focused on county-wide counselling centres for the prevention of cardiovascular diseases to which family physicians could refer their patients with higher risk factors, including for the purposes of secondary prevention. The actual number of referrals turned out to be smaller than originally planned. This is an indication that the service stands ready to be integrated into the family medicine system.

The project for early detection of osteoporosis is targeted only at patients of the risk group (mainly the patients receiving corticosteroid treatment). Due to the improved availability of biological treatments the number of persons receiving such treatment has decreased. At the same time the possibilities for diagnosing and treating osteoporosis in the whole population have significantly improved. As a result the target group of the project for osteoporosis and the costs have decreased.

From 2013 the projects for early detection of cardiac diseases and osteoporosis will be integrated into the general and specialised medical care systems.

The target group for the projects of screening new-borns for phenylketonuria and hypothyroidism and new-born hearing screening depends on the number of births. The screening enabled the detection of phenylketonuria in one and hypothyroidism in two cases. 34 parents refused to take the test. Hearing screenings detected a hearing disorder in 13 children born in 2012; the final diagnosis was also confirmed in nine children born in 2011. Fewer additional tests have been needed after screening new-borns for hearing disorders and the share of false-positives in the health care institutions has been lower than expected.

The project of perinatal diagnostics for hereditary diseases is needed because of the number of pregnant women who have found to have a risk for such diseases on the basis of prior maternal serum screening tests. The need for diagnostics was actually lower than expected and only 885 invasive procedures were carried out. In other cases the consultation of a geneticist was sufficient. A fetal chromosomal anomaly was discovered in 54 cases (including Down Syndrome in 27 cases).

Health checks of young athletes is a project targeted at young people between the ages of nine and nineteen who regularly engage in sports for at least five hours a week in addition to the physical education classes. In 2012 the number of young people who engaged in sports for more than eight hours a week was higher than planned. More tests are indicated for this particular group and therefore the cost per case is higher. The reason for fewer tests than in 2011 did not lie in the decreasing need but rather in the capacity of the health care institutions. The waiting time for preventive tests was one month on the average. In order to increase availability the East Tallinn Central Hospital will join the project in 2013.

1.2. General Medical Care

In 2012 general medical care cost 70.2 million euros. The increase in comparison with 2011 came mostly on account of growing spending on the fee-for-service fund for examinations and tests and the basic allowance.

The structure of expenses for general medical care is similar to 2011: the capitation fee was again the biggest spending article (64%). The share of the fee-for-service fund for examinations and tests grew 1% and that of the basic allowance 2% (see table 9). The share of the cost of the fee-for-service fund in capitation fees increased from 29% to 31% (see below for more detail).

Table 9 General medical care services in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Basic allowance	7,375	9,016	8,981	100	22
Distance allowance	329	502	492	98	50
Total capitation cost*	44,225	45,257	44,878	99	1
Capitation fee for insured persons of up to 3 years of age	–	2,744	2,674	97	–
Capitation fee for insured persons aged 3-6	–	2,804	2,843	101	–
Capitation fee for insured persons aged 7-49	–	19,314	18,983	98	–
Capitation fee for insured persons aged 50-69	–	11,974	11,927	100	–
Capitation fee for insured persons over 70	–	8,421	8,451	100	–
Fee-for-service fund for examinations and tests	12,787	14,980	14,050	94	10
Family physician performance pay**	813	1,064	1,192	112	47
Family physician's advisory line	579	623	619	99	7
General medical care reserve***	0	96	0	–	–
TOTAL	66,108	71,538	70,212	98	6

*Comparison with 2011 by age groups is not possible, since in 2012 the principles of grouping the insured persons for capitation fees were modified.
**Performance pay is budgeted for and paid on the basis of the results of the preceding calendar year(s) as a single payment in the third quarter.
***Funds for monitoring pregnancies and for conducting autopsies are budgeted for under the general medical care reserve. In the budget execution report these expenses are included in the line "Fee-for-service fund".

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

	2011 actual	2012 actual	% of change from 2011
NUMBER OF PRACTICE LISTS			
Number of practice lists	802	800	0
Number of lists receiving distance allowance	198	195	–2
Average size of practice list (number of insured persons)	1,566	1,559	0
NUMBER OF PERSONS*			
Insured persons up to 3 years of age	–	43,185	–
Insured persons aged 3-6	–	61,219	–
Insured persons aged 7-49	–	659,132	–
Insured persons aged 50-69	–	305,846	–
Insured persons over 70	–	177,841	–
TOTAL NUMBER OF PERSONS FOR WHOM CAPITATION FEE WAS PAID	1,255,971	1,247,223	–1

*Comparison with 2011 by age groups is not possible, since in 2012 the principles of grouping the insured persons for capitation fees were modified.

As of December 2012 there were 800 practice lists of family physicians in Estonia (see table 10). In 2012 a basic allowance at a coefficient of 1.5 was paid to 53 family physicians who provided services at several locations.

The abolition of the general coefficient of 0.97 applicable to capitation fees ought to have increased the expenses on capitation fees by 3.1%. But a 0.7% reduction in the number of insured persons caused the expenses on capitation fees to increase only by 1.5%.

The expenses of the fee-for-service fund for examinations and tests grew by 10% in comparison with 2011. In 2011 family physicians for the first time received reimbursement for additional examinations and tests, which exceeded the sum allocated for the fee-for-service fund for the calendar year at a coefficient of 0.3,

in total 16,000 euros. In 2012 this amount shrank to 13,185 euros. The total expense of the fee-for-service fund is bigger because of the maximum allowable share of the cost of the fee-for-service fund in capitation fees was increased. In 2011 the allowable share for family physicians not participating in the family physicians' quality system was 27%, in 2012 it was raised to 29%. The share for family physicians participating in the family physicians' quality system grew from 32% to 34% and for those who achieved a positive result in the quality system - from 32% to 37%.

The 22% increase in the basic allowance results from the change in reference price from 1 January 2012. The increase in distance allowances also has influenced the total to some extent.

The total number of practice lists has decreased by two and the number of insured persons on the lists by 1%.

Like in 2011, there were fifteen small practice lists with the service area of less than 1,200 residents, which received capitation fees for a total of 1,200 insured persons.

Table 11 Participation in and performance of family physicians' quality system, 2010-2011

	2010	2011
Number of family physicians who applied for performance pay	718	755
Number of family physicians who received performance pay for successful preventive activities and monitoring of chronic illnesses	282	397
Incl. with the coefficient of 1.0	182	311
with the coefficient of 0.8	100	86
Performance pay for professional competence (valid certification, performing the required number of gynaecological examinations and minor operations)	155	106

Of the budgeted amounts designated for the general medical care reserve, 11,739 euros were spent on monitoring normal pregnancies and 31,368 euros on conducting autopsies.

The number of family physicians participating in the family physicians' quality system has constantly increased since 2007. The participation rate in 2011 was 95% and in 2012 already 98%.

The insured persons on the practice lists of family physicians who participate in the family physicians' quality system are better covered by preventive activities and systematic monitoring of chronic diseases.

The results of family physicians who participate in the quality system are reviewed annually. Thus the expenses for 2012 reflect the performance pay for 2011.

In 2011, all family physicians of Hiiu, Jõgeva, Ida-Viru and Põlva counties participated in the quality system (see figure 8). The percentage of family physicians of these counties, who achieved

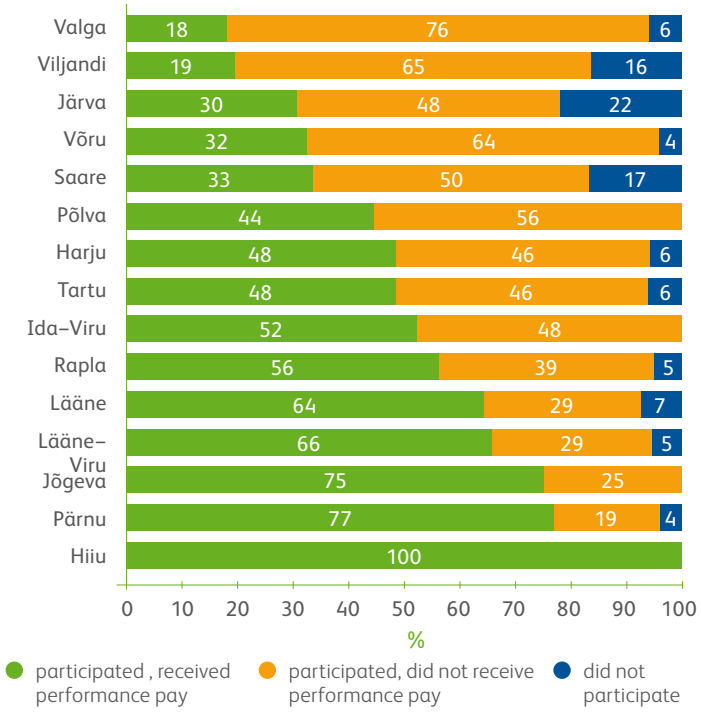


Figure 8 Participation of family physicians in the quality system by county, 2011

excellent results, was respectively 100%, 75%, 52% and 44%. Performance pay for professional competence was paid to 13% of the family physicians. The change in comparison with last year resulted from the modification of the indicator used for assessing the competence of family nurses.

The total number of visits by a family nurse has increased 1.6 times in 2008–2012, proving that the role of family nurses in patient counselling has increased (see table 12).

The family physician's advisory line 1220 operates 24/7 in Estonia in order to provide prompt medical advice in case of health problems. Also information can be asked about the organisation of health care. The use of the line has increased: in 2012 the physicians and nurses answered a total of 222,287 calls, with an average of 609 calls in 24 hours (in 2011, 216,984 calls were answered with an average of 595 calls in 24 hours). The majority of the callers required consultation about a health problem and 1% needed advice on the organisation of health care.

Table 12 Number of visits to family physicians and family nurses, 2008–2012

	2008	2009	2010	2011	2012
Consultations by family physicians	4,368,668	4,182,361	3,994,334	4,411,214	4,523,318
Consultations by family nurses	370,853	418,305	480,269	535,240	592,690
Prophylactic consultations	450,309	387,782	394,360	363,182	326,747
Consultations	5,189,830	4,988,448	4,868,963	5,309,636	5,442,755
Persons consulted	983,466	973,129	957,090	981,575	973,882
Number of persons in practice lists	1,286,597	1,280,795	1,271,082	1,255,971	1,247,223
Share of persons consulted by family physicians of the number of persons in the practice lists (%)	76	76	75	78	78

1.3. Specialised Medical Care

In 2012 specialised medical care cost a total of 450.5 million euros. This expenditure was divided between outpatient, day and inpatient specialised medical care, preparedness fee for hospitals and centrally contracted health care services. The latter expenditure amounted to 4.5 million euros.

The expenses grew by 8% in comparison with 2011 (see figure 6). The abolition of the coefficient that was applied to reference prices mostly accounted for the increase (the impact was 5.3%). The structural increase of the cost of a case also fuelled the increase (the impact was 3.1%, of which 0.8% went on very expensive, unplanned treatment). Modification of the List of Health Care Services was also behind the increase in expenses. The health care professionals' strike first and foremost influenced planned outpatient treatment. The failure to meet the planned number of cases was caused by an unexpectedly high number of very expensive cases (see below for details).

Execution of the budget for centrally contracted health care services is analysed separately. The expenses on that constitute about 1% of the total expenses on specialised medical care.

1.3.1. Specialised Medical Care, Except Centrally Contracted Health Care Services

Treatment Expenses and Cases by Type of Care

The money for specialised medical care, except centrally contracted health care services was used as planned in the budget (see table 13). The execution of the budget was mainly influenced by the number of cases in the hospitals belonging to the Hospital Network Development Plan, which exceeded the agreed volumes. Given the special situation that emerged in the health care sector as a result of the health care professionals' strike in 2012 and taking into account the state of the 2012 budget, the Health Insurance Fund decided, by way of exception, to make a one-off payment to all hospitals belonging to the Hospital Network Development Plan for the health care services which exceeded the agreed financial amounts for 2012, using the coefficient of 0.3. In total additional payment was made for 23,000 cases (incl. 17,000 outpatient and 5000 inpatient cases). The sum constituted 0.7% of the execution of the total budget for specialised medical care. The expenses on inpatient care were used as budgeted, day care expenses exceeded the budget and the expenses on outpatient care turned out to be smaller than budgeted. The

Table 13 Expenses on specialised medical care (thousands of euros) and cases by type of care

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
EXPENSES ON SPECIALISED MEDICAL CARE					
Total (except preparedness fee)	395,025	434,816	436,696	100	11
Outpatient care	130,233	149,110	148,291	99	14
Day care	24,061	26,288	28,322	108	18
Inpatient care	240,731	259,418	260,083	100	8
Preparedness fee	8,423	9,250	9,250	100	10
TOTAL SPECIALISED MEDICAL CARE	403,448	444,066	445,946	100	11
CASES					
Total (except preparedness fee)	3,207,049	3,209,917	3,162,267	99	–1
Outpatient care	2,903,380	2,905,556	2,865,870	99	–1
Day care	64,899	66,254	65,092	98	0
Inpatient care	238,770	238,107	231,305	97	–3
Preparedness fee	380	382	382	100	1
TOTAL SPECIALISED MEDICAL CARE	3,207,429	3,210,299	3,162,649	99	–1

number of cases did not reach the budgeted levels in any of the types of care.

The budgeted targets were most closely met by outpatient care: 99% for both expenses and the number of cases. The lower than budgeted number of cases in day care and inpatient care was caused by the increase in the average cost of a case. Part of the reason lies in the transfer of certain services from inpatient care to day care.

In comparison with previous years the share of cases and expenses in outpatient and day care has been constantly rising. This ties in with the general trend to provide services without having to resort to inpatient care, if possible.

The Health Insurance Fund has paid the hospitals belonging to the Hospital Network Development Plan a fee for preparedness, in the amounts as planned in the 2012 budget for the total expenses on specialised medical care.

Annexes 1 and 2 of the Budget Execution Report present the actual and budgeted expenses and numbers of cases and changes thereof in comparison with 2011 broken down by specialties.

The main changes by specialties:

- Surgery and orthopaedics, which to a great extent is a surgical specialty are both characterised by the trend described in the introduction - transfer from inpatient care to day care. The trend ought to continue in the coming years, resulting from the revision of the chapter of surgery in the List of Health Care Services. The newly added, modern, less invasive possibilities for treatment are a precondition for treating such patients in day surgery. The failure to meet the planned target for inpatient surgery cases was caused by the considerably higher number of expensive cases, which could not be foreseen.

  In orthopaedics fewer than planned endoprosthetic replacements were performed. As a result the planned number of inpatient cases was not reached by the entire specialty. The Health Insurance Fund reckons that the strike played a role here, because never before have the contracts for endoprosthetic replacements remained unfulfilled to such an extent. Despite the fact that the waiting list for endoprosthetic replacements keeps growing slowly but steadily (e.g. by 100 persons in the 4th quarter of 2012) a person has to wait an average 1.5 years to get the replacement.

- The figures for the three quarters of 2012 already pointed to the failure to meet the targets in otorhinolaryngology. The fact that neither the contracted costs nor the number of cases is met shows problems with capacity of the health care providers. In September the Health Insurance Fund carried out an analysis of the reasons for long waiting times. In North Estonia Medical Centre the waiting times were longer than permitted primarily because of the lack of staff. The health care professionals' strike was main reason why the contract with Tartu University Hospital remained unfulfilled.

- The steady increase in neurological cases is in line with the structural changes in morbidity in general, caused by the ageing of the population. In previous years the actual cases always exceeded the budgeted numbers, but last year, for the first time in many years, the actual number of cases was considerably smaller than planned. On the one hand service providers lack capacity, for example there are not enough specialists in North Estonia Medical Centre, on the other hand more expensive health care technologies are used, causing an increase in the average cost of a case.

- Ophthalmology is another specialty where the cost of cases has risen due to funding new expensive health care technologies. The general budgeted number of cases for ophthalmology was not met, but there were more inpatient cases than planned. The good news is that the number of cases of cataract day surgery has started to stabilise. After a steady increase in these cases over the past years, the 2012 budget was executed as planned. In the second half of 2012 the waiting list for cataract surgery has shortened by a thousand persons. The average waiting time is 1-1.5 years.

- From 2012 the expenses budgeted for dermatovenereology include biological treatment of severe cases of psoriasis, previously funded as part of centrally contracted health care services. According to the budget the additional funds

for biological treatment were meant for outpatient care, but the relatively expensive treatment was mostly administered in day care. On the whole the spending met the budget, although there were variations by type of care. The generally smaller number of cases in outpatient care resulted from the higher than planned average cost of an outpatient case.

- The increased cost of specialised day care in paediatrics, pulmonology and internal medicine can also be explained by the inclusion of biological treatment in the contracts for specialised medical, which earlier was funded as part of centrally contracted health care services.

- There were more day care cases in psychiatry than planned. The increase mostly came on account of patients who were placed under observation, with no direct treatment given. According to the opinion of the Health Insurance Fund the indications and manner of using day care need to be agreed with the psychiatrists in clearer terms. This is scheduled for 2012. The transition of cases from inpatient care to outpatient and day care has reduced the number of inpatient cases. Over the years the use of outpatient services has remained relatively stable, with only a slight increase.

- The number of cases and costs in oncology have grown in all types of care. The constantly improving diagnostic and treatment possibilities of tumours are the main reason for the increase. With more options available the number of treatments per patient grows. From the 2nd quarter of 2012 East Tallinn Central Hospital was given permission to start providing inpatient health care services in oncology, which also caused the budget to be exceeded.

- The number of outpatient cases and costs have grown in pulmonology. One of the reasons is the inclusion of new services in the List (tests for sleep apnoea).

- The changes in infectious diseases go hand in hand with the changing numbers of people with HIV and AIDS and their treatment needs. It is a good thing that the actual number of persons who needed treatment was lower than forecast. The statistics on communicable diseases from the Health Board show decreasing incidence as well. However, the average cost of inpatient care has been higher than budgeted.

- The number of cases and costs in primary follow-up care were smaller than budgeted. The reasons lie in increasing options for nursing care. The average cost per case has also decreased.

- The number of medical rehabilitation cases keeps growing, exceeding the budget, mostly on account of outpatient cases. As more and more rehabilitation services are needed, the Health Insurance Fund has been constantly supporting its development and availability. This is partly the result of diseases related to the ageing population (joint disorders, strokes, fractures), which require medical rehabilitation, partly caused by the general increase of the importance of rehabilitation treatment.

Budget Execution by Major Diagnosis Categories (MDC)

In addition to the traditional monitoring of the execution of the budget on the basis of specialties, MDCs can also be used for the same purpose. The analysis is based on the principal diagnosis coded according to ICD-10 code[8] and set out in the invoice for treatment. In comparison with the specialty-based approach the MDCs allow a more in-depth assessment of the use of the budget on the basis of the treated diseases or disease groups.

Invoices are classified into MDCs on the basis of their ICD codes, usually grouped by organ systems (e.g. the nervous system, respiratory system, female/male reproductive system etc.). Altogether there are 25 MDCs. In this report four

[8]ICD-10 - International Statistical Classification of Diseases and Related Health Problems, 10th Revision

MDCs are reviewed for the use of treatment costs and five for the number of cases.

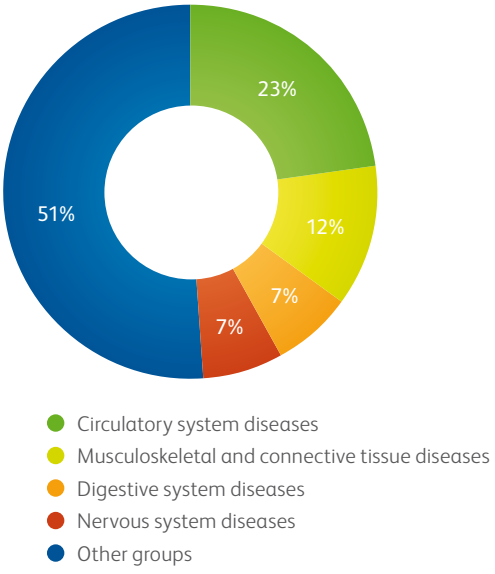


Figure 9 Distribution of inpatient treatment costs by major diagnosis categories

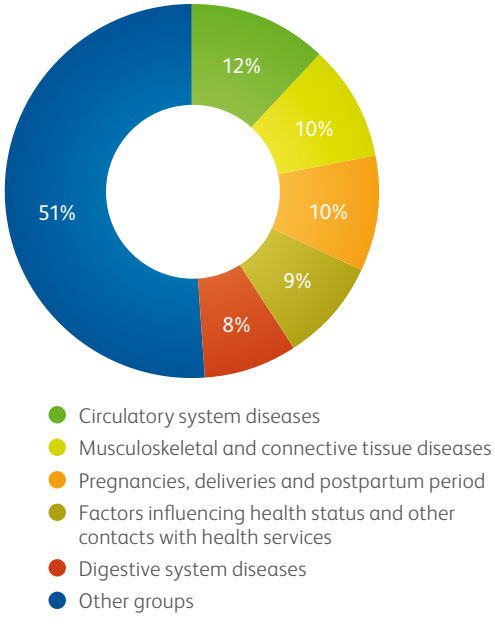


Figure 10 Distribution of inpatient cases by major diagnosis categories

All in all the Health Insurance Fund paid about 260 million euros for inpatient care in 2012. Figure 9 shows the distribution of the money by MDCs.

The four major MDCs take up 50% of the budget for inpatient care. Among these, diseases of the circulatory system account for the largest share, roughly 25% of the total cost of inpatient care.

Figure 10 shows the distribution of cases between the five major MDCs. The numbers are slightly different from the distribution of costs, since some diagnosis related groups contain relatively more cases, which are cheaper than the average. These are generally related to pregnancies, deliveries and the postpartum period, as well as to contacts with health services, which usually constitute invoices for the person accompanying a child in the hospital.

The greatest share of diseases of the circulatory system both as regards the costs and cases is an indication of the burden of disease borne by the population, for chronic diseases of the circulatory system occur the most frequently.

Budget Execution by Diagnosis Related Groups in hospitals belonging to the Hospital Network Development Plan

DRGs[9] are used for the purpose of analysing the execution of the budget. On the basis of the DRGs, invoices for treatment of insured persons are divided into clinically meaningful groups with homogenous resource use, thus enabling us to assess and analyse the performance and expenses of hospitals. DRGs as payment method has been used in Estonia since 2004. Below is an overview of inpatient and day care costs and cases in hospitals belonging to the Hospital Network Development Plan, based on DRGs. The most widely used 5-6 DRGs are presented.

Treatment Costs

The top six DGRs with the highest treatment costs in inpatient care constitute one-fifth (ca 50 million euros) and in day care two-thirds (ca 9 million euros) of all costs covered on the basis of DRGs in the corresponding type of care.

[9]DRG – (diagnoses related groups) is the case-based payment system used in Estonia in which patients with similar clinical problems and similar resource use are assigned into one group.

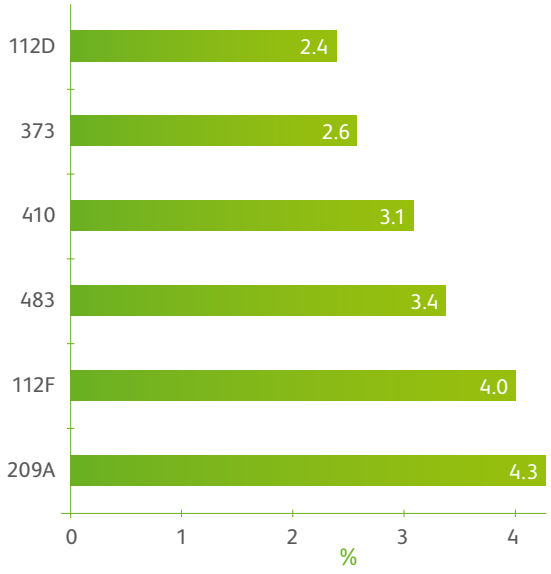


Figure 11 Distribution of costs in inpatient care by DRGs

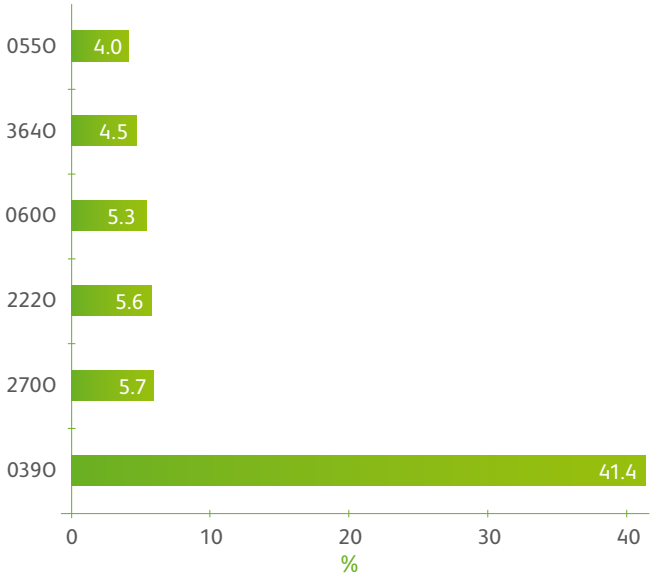


Figure 12 Distribution of costs in day care by DRGs

The most expensive DRG in inpatient care is related to the major joint and limb re-attachment procedure of the lower extremity (209A), followed by DRGs related to various invasive cardiology procedures (112F and 112D), tracheostomy (483), chemotherapy (410), and vaginal delivery (373) (see figure 11). There have been no major changes in the distribution of costs in inpatient care in recent years.

In day care the DRG based costs are predominantly related to cataract surgery (039O, ca 5 million euros) making up more than 40% of all DRG based costs covered in day care. Skin and subcutaneous tissue related procedures (270O), otorhinolaryngological (060O and 055O), orthopaedic (222O) and gynaecological procedures have a considerably smaller share in costs (see figure 12).

Cases

In 2012, as in previous years, DRG 467 had the greatest share of cases, this is the group for invoices for persons accompanying sick children in the hospital. This DRG made up ca 8% of all invoices for inpatient care in 2012. Given that DRG 467 does not have a direct link to the actual performance of hospitals, it has been left out of the six top DRGs used in the report.

The distribution of costs and cases in inpatient care does not coincide entirely, there are certain differences, as usually it is the relatively cheaper cases that make up DRGs with the highest share of cases. DRG 373 has the highest share of inpatient cases grouped by DRGs, ca 9000 or 4%. Vaginal deliveries come under DRG 373. Chronic diseases (DRG 127 and 014A), chemotherapy (410) and diseases of the digestive system (184B) have the lowest share of cases (see figure 13).

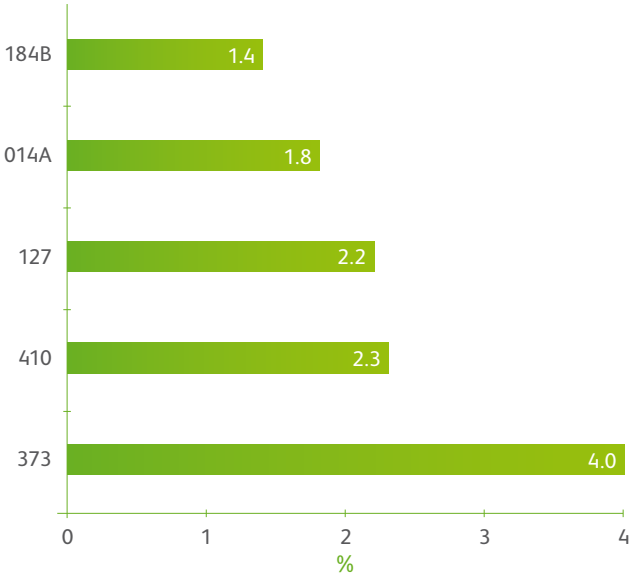


Figure 13 Distribution of cases in inpatient care by DRGs

Cataract surgery (DRG 039O) has the highest share of cases in day care, similarly to costs. (see figure 14). Other DRGs are related to gynaecology (361O and 381O), otorhinolaryngology (060O and 055O) and general surgery (270O) and their share in comparison with cataract surgery is considerably lower.

Depending on the type of hospital the use of DRGs with the highest number of inpatient and day care cases differs, given the structure of services and patients in the specific hospitals. Annexes 3 and 4 of the Budget Execution Report present the distribution of the use of DRGs by hospital type.

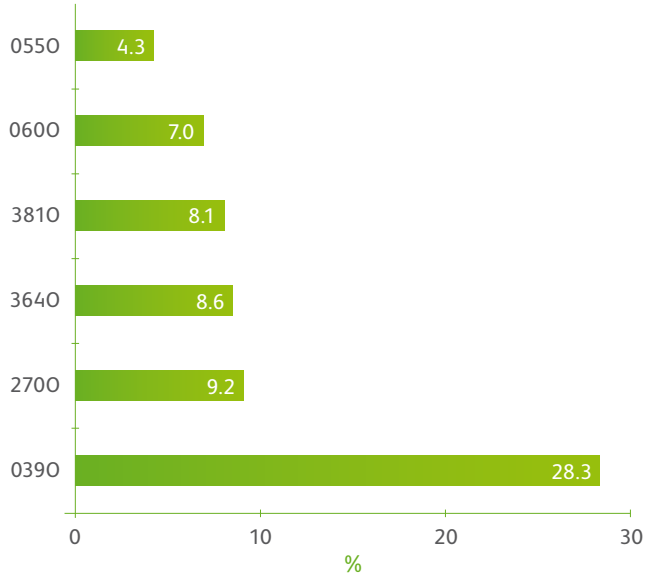


Figure 14 Distribution of cases in day care by DRGs

Special Cases of Specialised Medical Care

For the purposes of planning the budget and monitoring its execution the Health Insurance Fund considers certain services separately. These are services for which centralised waiting lists exist or which are difficult to forecast. The aim of keeping a close eye on the special cases is to ensure the availability of and equal access to these services for insured persons.

Table 14 Cost of special cases in thousands of euros

	Cost					Change, %			
	2008	2009	2010	2011	2012	2009/ 2008	2010/ 2009	2011/ 2010	2012/ 2011
Endoprosthetic replacements	10,667	10,263	10,291	10,735	11,257	–4	0	4	5
Cataract surgery	6,583	6,454	6,342	6,551	6,998	–2	–2	3	7
Cardiac surgery	10,439	9,479	9,313	9,131	8,635	–9	–2	–2	–5
Deliveries	12,616	12,284	11,808	11,027	11,005	–3	–4	–7	0
Cardioverters*	–	217	1,324	1,633	2,140	–	–	23	31
Organ transplants **	–	–	483	622	1,103	–	–	29	77
TOTAL	40,305	38,697	39,561	39,699	41,138	–4	2	0	4

*The funding of cardioverters under special cases commenced in 2009.
**The funding of organ transplants under special cases commenced in 2010.

Table 15 Number of special cases

	Number of special cases, actual					Change, %			
	2008	2009	2010	2011	2012	2009/ 2008	2010/ 2009	2011/ 2010	2012/ 2011
Endoprosthetic replacements	2,870	2,734	2,851	2,851	2,852	–5	4	0	0
Cataract surgery	11,211	11,320	12,867	13,484	13,652	1	14	5	1
Cardiac surgery	1,115	995	993	997	866	–11	0	0	–13
Deliveries	15,627	15,338	15,503	14,339	13,704	–2	1	–8	–4
Cardioverters*	–	21	105	132	171	–	–	26	30
Organ transplants **	–	–	48	62	107	–	–	29	73

*The funding of cardioverters under special cases commenced in 2009.
** The funding of organ transplants under special cases commenced in 2010.

The following are deemed special cases: endoprosthetic replacements, deliveries, cardiac surgery, cataract surgery, implantation of cardioverters and organ transplants. Tables 14 and 15 provide overviews of the costs and of the number of cases regarding these services, from 2008 to 2012.

Every year more and more cardioverters (devices to restore cardiac rhythm) are implanted and organs are transplanted. This has led to an increase in the related costs. The organ transplant costs include both direct costs and the costs of subsequent monitoring of the patients.

In 2012 71 organs were transplanted: 61 kidney transplants, 9 liver transplants and 1 bilateral lung transplant.

It is not possible to forecast the exact treatment needs for deliveries and emergency cardiac surgery, therefore the Health Insurance Fund pays for those services on the basis of the actual needs.

The number of endoprosthetic replacements has been stable in the years 2010–2012. The number of cataract operations has been growing slightly every year during the same period.

1.3.2. Centrally Contracted Health Care Services

Centrally contracted health care services cost 4.5 million euros, 12% more than budgeted.

Centrally contracted health care services are expensive services whose volume is relatively small. The execution of the budget for these services has been quite hectic during the year, resulting in unpredictable over- or under-use of the budget for the individual services (see tables 16 and 17). Based on an analysis of the previous years a decision was taken to stop contracting some health care services centrally, as their use had expanded and the volumes had grown. This led to modifying the principles of contracting health care services centrally for the purposes of the 2012 budget. Services that used to be contracted centrally are now included in the specialised care budgets and budget execution reports of the individual specialties. The following services are no longer contracted centrally: bone marrow transplants, peritoneal dialysis, antidotes and serums, cochlear implants and certain pharmaceuticals, e.g. biological treatments. The budget of the services, which continued to be contracted centrally, was exceeded considerably because of the long-term and expensive treatment of a single patient with a haematological disease. The number of autopsies was slightly higher than planned.

Table 16 Cost of centrally contracted health care services in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Emergency transport of insured persons (aircraft)	214	176	173	98	–19
Haematological treatments	1,673	1,771	2,519	142	51
Autopsies	49	63	76	121	55
Centrally contracted pharmaceuticals*	8,742	2,029	1,758	87	–80
Bone marrow transplants **	1,142	–	–	–	–
Peritoneal dialysis**	1,391	–	–	–	–
Antidotes and serums **	12	–	–	–	–
Artificial urinary sphincters **	46	–	–	–	–
Cochlear implants **	300	–	–	–	–
TOTAL	13,569	4,039	4,526	112	–67

*From 2012 some of the services are included in the budget line for the respective specialty of specialised medical care.
**From 2012 the services are included in the budget line for the respective specialty of specialised medical care.

Table 17 Cases of centrally contracted health care services and the average cost per case in euros

	2011 actual		2012 actual		% of change from 2011	
	Case	Average cost per case	Case	Average cost per case	Case	Average cost per case
Emergency transport of insured persons (aircraft)	131	1,634	103	1,680	–21	3
Haematological treatments	365	4,584	381	6,612	4	44
Autopsies	355	138	532	143	50	4
Centrally contracted pharmaceuticals*	5,376	1,626	972	1,809	–82	11
Bone marrow transplants **	181	6,309	–	–	–	–
Peritoneal dialysis**	837	1,662	–	–	–	–
Antidotes and serums **	2	6,000	–	–	–	–
Artificial urinary sphincters **	8	5,750	–	–	–	–
Cochlear implants **	18	16,667	–	–	–	–

*From 2012 some of the services are included in the budget line for the respective specialty of specialised medical care.
**From 2012 the services are included in the budget line for the respective specialty of specialised medical care.

1.3.3. Comparison of Main Indicators in Specialised Medical Care

Table 18 provides an overview of the indicators in specialised medical care in 2008–2012.

Table 18 Main indicators of inpatient and outpatient specialised medical care

	2008 tegelik	2009 tegelik	2010 tegelik	2011 tegelik	2012 tegelik	Change, % 2009/ 2008	2010/ 2009	2011/ 2010	2012/ 2011
Average cost per case (EUR)									
Outpatient care	43	44	43	45	52	2	–2	5	16
Day care	468	449	404	371	435	–4	–10	–8	17
Inpatient care	1,008	1,011	982	1,008	1,124	0	–3	3	12
Number of inpatient bed days	1,560,768	1,449,960	1,458,555	1,436,100	1,412,328	–7	1	–2	–2
Average length of inpatient stay (days)	6.3	6.1	6.1	6.0	6.1	–3	0	–2	2
Number of outpatient consultations	3,797,861	3,647,303	3,671,655	3,801,950	3,785,111	–4	1	4	0
Outpatient care	3,722,259	3,573,286	3,609,613	3,732,239	3,714,476	–4	1	3	0
Day care	75,602	74,017	62,042	69,711	70,635	–2	–16	12	1
Number of outpatient consultations per case	1.34	1.32	1.18	1.28	1.29	–1	–11	8	1
Outpatient care	1.34	1.31	1.29	1.29	1.30	–2	–2	0	1
Day care	1.35	1.34	1.07	1.07	1.09	–1	–20	0	2
Number of persons using specialised medical care services	819,055	800,578	797,048	807,875	795,581	–2	0	1	–2
Outpatient care	795,791	777,144	774,589	786,099	774,661	–2	0	1	–1
Day care	45,911	44,474	47,063	52,230	51,549	–3	6	11	–1
Inpatient care	169,755	163,911	162,514	161,550	155,653	–3	–1	–1	–4
Number of cases per person	3.78	3.76	3.89	3.97	3.97	–1	3	2	0
Outpatient care	3.50	3.50	3.62	3.69	3.70	0	3	2	0
Day care	1.22	1.24	1.23	1.24	1.26	2	–1	1	2
Inpatient care	1.47	1.47	1.48	1.48	1.49	0	1	0	1
Share of emergency care expenses of treatment costs (%)									
Outpatient care	17	17	18	18	17	0	1	0	–1
Day care	6	9	9	7	8	3	0	–2	1
Inpatient care	63	67	67	64	66	4	0	–3	2
Share of emergency care of all cases (%)									
Outpatient care	16	17	17	17	17	1	0	0	0
Day care	13	15	12	9	10	2	–3	–3	1
Inpatient care	57	61	62	62	64	4	1	0	2
Number of operations	164,819	155,010	160,403	163,718	154,969	–6	3	2	–5
Outpatient care	19,517	20,302	21,154	19,808	18,346	4	4	–6	–7
Day care	45,838	42,620	46,911	52,507	50,479	–7	10	12	–4
Inpatient care	99,464	92,088	92,338	91,403	86,145	–7	0	–1	–6

- The average cost per case increased in all types of care in 2012, most of all in day care. The main reason was the abolition of the coefficient that was applied to the reference prices of health care services; the impact was 5.3%. Transferring some centrally contracted health care services to specialised medical care was another factor to influence the cost of a case by 2.4%. Other changes in the reference prices in the List of Health Care Services had an impact of 1.3%. The structural increase of specialised medical care services in general amounted

to 3.1%, of which 0.8% was the result of the increase in the volume of extremely expensive cases, i.e. those that cost more than 65,000 euros. In 2011 there were 12 very expensive cases on which a total of 946 thousand euros were spent. In 2012 the number of very expensive cases was 30, and the total cost was 2.9 million euros. The cases are very expensive in the following specialties: oncology (improved possibilities of treating malignant tumours), cardiology (technologically complex and thus more expensive cardiovascular surgery) and paediatrics (modern, but expensive ways of treating preterm new-borns). Had the number of extremely expensive cases remained on the 2011 level the Health Insurance Fund would have been able pay for about 20 thousand outpatient cases of average cost – this example illustrates the impact of very expensive cases.

- The number of inpatient bed days has dropped along with the reduction in the number of inpatient cases by 3% in comparison with 2011. At the same time the average duration of inpatient treatment has increased, as the share of more complex inpatient cases is higher.

- The number of persons using specialised medical care services has shrunk in all types of care. This is partly the result of the health care professionals' strike. However, the number of persons with health insurance has decreased as well. Therefore the share of insured persons who received specialised medical care (64%) has remained the same, i.e. the availability of specialised medical care has not changed in comparison with 2011.

- The share of emergency care expenses of treatment costs was smaller in outpatient care, but increased slightly in day care and inpatient care. The share of emergency care of all cases remained the same in outpatient care, but grew in inpatient care. The Health Insurance Fund constantly monitors the share of emergency care in both the treatment costs and in the number of cases.

- The number of operations decreased by 5% in all types of care. One of the reasons was the modification of the definition of the term "operation" in the List of Health Care Services, applicable from 2012: general surgery procedures started to be coded as procedures not as operations as was the case before. Cancellation of planned operations during the health care professionals' strike could be another reason why the number of persons who underwent surgery decreased.

1.4. Nursing Care

In 2012, the Health Insurance Fund spent 18% more for nursing care provided to insured persons than in 2011 (see Table 19). The costs for outpatient and inpatient nursing care grew at almost the same pace, 19% and 18% respectively. The increase is in line with the objective of the Health Insurance Fund to improve the availability of nursing care. The higher expenses incurred for inpatient nursing care are related to the investment from the European Regional Development Fund aimed at increasing the capacity in nursing care. Therefore the Health Insurance Fund added another 7% to the funds planned in the budget for inpatient nursing care in 2012.

The number of cases in inpatient nursing care grew 14% and in outpatient care 13% in comparison with 2011. The reason lies in the increase of cases of home nursing, which has been growing at the rate similar to the previous years.

The average cost of a case has also gone up: 4% in inpatient nursing care and 5% in outpatient nursing care. The abolition in 2012 of the general coefficient applied to reference prices has caused the price hike (see table 20).

The higher number of home nursing visits and of people who were provided such care is also proof of better availability of outpatient nursing care (see table 21). The increase in the number of home nursing visits outpaced the increase in the number persons receiving nursing care, thus the average number of visits per person is higher. This is also one of the reasons why the average cost of a home nursing case has gone up. The number of home care visits for cancer patients has grown, but the number of persons offered the service has dropped.

Table 19 Nursing care expenses in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Inpatient nursing care	11,670	12,908	13,796	107	18
Outpatient nursing care, incl.	3,146	3,594	3,742	104	19
Home nursing	2,705	3,082	3,258	106	20
Home care for cancer patients	363	421	397	94	9
Geriatric assessment	78	91	87	96	12
TOTAL	14,816	16,502	17,538	106	18

Table 20 Nursing care cases and average cost in euros

	2011 actual		2012 actual		% of change from 2011	
	Cases	Average cost per case	Cases	Average cost per case	Cases	Average cost per case
Inpatient nursing care	14,831	787	16,848	819	14	4
Outpatient nursing care, incl.	28,359	111	32,146	116	13	5
Home nursing	22,994	118	26,470	123	15	4
Home care for cancer patients	4,023	90	4,249	93	6	6
Geriatric assessment	1,342	58	1,427	61	6	6
TOTAL	43,190	343	48,994	358	13	4

Table 21 Visits of outpatient nursing care

	2011 actual		2012 actual		% of change from 2011	
	Number of visits	Persons visited	Number of visits	Persons visited	Number of visits	Persons visited
Home nursing	169,920	5,951	197,707	6,497	16	9
Home care for cancer patients	16,587	1030	17,337	1019	5	–1

1.5. Dental Care

Ravikindlustuse seaduse alusel tasub haigekassa Pursuant to the Health Insurance Act, the Health Insurance Fund shall pay for dental care services for insured persons of up to nineteen years of age. In the case of dental care for adults, the Health Insurance Fund shall only pay for emergency services.

In 2012 dental care cost 18.9 million euros, constituting 98% of the budgeted amount. There are variations as to the execution of the budget by different cost items. Fewer than planned preventive dental care services and dental care services for children were provided; this applies both to the costs and the number of cases.

The cases in orthodontics exceeded the plan by 2% and therefore the costs were higher than forecast as well. The demand for orthodontic services continues to be high. Availability has improved as the number of service providers grew. Emergency dental care for adults was also in higher demand than foreseen and thus the costs and number of cases exceeded the budget. (see tables 22 and 23).

Table 22 Expenses for dental care in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Dental care for children	13,963	14,831	14,402	97	3
Orthodontics	3,033	3,333	3,393	102	12
Preventive dental care	328	332	292	88	–11
Emergency dental care for adults	732	747	781	105	7
TOTAL	18,056	19,243	18,868	98	4

Table 23 Dental care cases

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Dental care for children	311,786	311,513	301,247	97	–3
Orthodontics	41,809	43,997	44,864	102	7
Preventive dental care	23,359	22,295	19,778	89	–15
Emergency dental care for adults	19,031	18,458	19,252	104	1
TOTAL	395,985	396,263	385,141	97	–3

2. Health Promotion

The Health Insurance Fund finances health promotion through health promotion projects, based on its development plan. The activities are coordinated with the Ministry of Social Affairs, in line with the goals of the National Health Plan. The budget for health promotion was 968 thousand euros. All the scheduled projects were implemented. The total cost was 814 thousand euros or 84% of the budgeted amount. The funds were not used up entirely due to savings in the implementation costs. The selection of the partners through public procurement contributed to the savings. All 30 projects met the objectives set and implemented the planned activities, and for less money than planned (see tables 24 and 25).

Table 24 Health promotion expenses in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Health promotion activities for children	262	280	220	79	–16
Prevention of cardiovascular diseases	27	40	25	63	–7
Early detection of cancer	18	69	44	64	144
Prevention of home and leisure time injuries	337	300	284	95	–16
Activities aimed at patient awareness	162	279	241	86	49
TOTAL	806	968	814	84	1

Table 25 Annual quantitative indicators of project activities

	2008 actual	2009 actual	2010 actual	2011 actual	2012 actual
The number of participants in training, sports and other events aimed at the general public	53,890	60,250	70,400	44,368	56,894
Number of persons who received individual counselling	8,967	11,051	12,687	7,285	2,296
Number of participants in training events for health care professionals	427	193	229	367	818
Number of participants in training events for teachers	1,227	2,136	1,961	2,493	1,495
Number of participants in training events for other stakeholders (social workers, managers, task forces)	1,605	1,354	1,368	1,423	1,106
Number of printed publications	18	18	25	20	18
Total print run of publications	362,600	415,512	702,450	606,400	590,000
Number of radio and TV programmes/spots	8	15	8	4	4

In 2012, a largest part of the funds was spent on regional projects aimed at the prevention of injuries in 15 counties and 2 major cities. More activities were aimed at increasing patient awareness. In addition to campaigns and the publication of patient guidelines several training events were organised for stakeholders, e.g. on how to implement clinical guidelines. The budget for health promotion activities for children was not used up entirely. Patient guidelines were issued and articles were placed in the media within the framework of projects aimed at early detection of cardiovascular diseases and cancer.

More than 55 thousand persons in Estonia participated in health promotion activities and training events in 2012. The participants ranged from pre-school children and students to the elderly. Although the general number of participants grew, there were fewer teachers and other specialists among the participants, since the project funds have not increased in the past two years. However, more health care professionals are now involved in communicating health promotion issues to the general public. The number of persons who received individual counselling dropped, as the projects focused more on training

stakeholders. Information concerning childbirth and infant health continues to be provided by health care professionals at the primary level. There were no changes in the number of media activities and publications in comparison with the previous years.

Activities aimed at patient awareness

Improved patient awareness is important for the Health Insurance Fund, so as to make the insured persons better informed about their rights and obligations, which in turn contributes to their better health status. Sufficient evidence-based information must be disseminated through a variety of channels in order to engage the people in these activities. A revised awareness campaign on the reasonable use of pharmaceuticals was launched in 2012. The campaign was successful, as noticeability in the target group was as high as 85%. Another measure of the usefulness of the campaign is the reduction of the share of cost that patients have to cover when purchasing pharmaceuticals. The patients' own funding has significantly dropped.

All major daily and weekly newspapers published health pages, altogether on 48 occasions. Five new patient guidelines were prepared. Nine publications were re-printed. All materials can also be found at the following website: www.ravijuhend.ee. Training events aimed at the introduction of new clinical and patient guidelines were organised for health care professionals.

Health promotion activities for children

Three on-going health promotion activities for children were continued. In addition patient guidelines for parents were published.

The aim of the children's dental health project is to reduce dental diseases in children. The project involved more than 1,390 children and more than 400 parents. In 2011 800 children were covered by the project. Within the framework of the 2012 projects specialists were offered training, and 48 child care institutions were visited, where the children, their parents and staff were taught. Cooperation involved health care professionals as well. Work was undertaken to develop the homepage, as the internet is a popular information channel for the target group.

1,811 persons received pregnancy crisis counselling. In comparison with last year twice as many men sought counselling: 138 men in 2011 and 311 men in 2012. The number of instances of counselling was smaller than in previous years, but the number of centres where counselling was provided remained the same.

Estonian Midwives Association implemented a project for assessing the family schools operating at health care institutions and helped them in the acquisition of visual aids. According to feedback the competence of the family school lecturers increased and they were highly motivated to teach the future parents.

Prevention of home and leisure time injuries

Projects aimed at preventing injuries are run on a regional basis, taking into account the conditions in a county or city. In 2012 the projects were more focused on risk groups, incl. students and the elderly. The students participated in discussions concerning prevention of accidents and alcohol abuse. In cooperation with the Rescue Services, the Police, the Red Cross and the Defence Forces accident prevention training events and training camps were organised for 6th year students, where they could improve their skills on how to remain safe and behave properly in case of accidents.

Municipal specialists also received training; they were taught how to notice dangers in their town or rural municipality or risk behaviour in the local people. Prevention of injuries was the subject of the 2012 Health Promotion Conference. More than 250 specialists participated in the conference and discussed best practices.

3. Pharmaceuticals Reimbursed to Insured Persons

The cost of pharmaceuticals for outpatient use reimbursed to insured persons is an open commitment for the Health Insurance Fund. This means that the Health Insurance Fund has the obligation to reimburse the needs-based costs to the extent prescribed by law and cannot refuse payment on the grounds of lack of funds. Neither is the execution of the budget entirely under the control of the Health Insurance Fund, as it also depends on the inclusion of new pharmaceuticals into the list of pharmaceuticals subject to reimbursement, changes in prices etc. The Ministry of Social Affairs and the Government of the Republic develop and impose measures for managing the costs.

In 2012 99 million euros were reimbursed to insured persons for pharmaceuticals, amounting to 97% of the budgeted sum (see table 26).

Table 26 Cost of pharmaceuticals reimbursed to insured persons in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	Share of costs by type of reimbursement, % 2011	2012
Reimbursement of 100% of cost	45,755	50,921	49,358	97	50	50
Reimbursement of 90% of cost	26,294	28,515	29,259	103	29	29
Reimbursement of 75% of cost	5,306	6,110	5,609	92	6	6
Reimbursement of 50% of cost	14,110	16,295	14,741	90	15	15
TOTAL	91,465	101,841	98,967	97	100	100

Expenses on the reimbursement of pharmaceuticals skyrocketed after a period of relative stability during the years of economic recession (see figure 15). The average cost per insured person increased together with increasing consumption. The average cost of a reimbursed prescription does not seem to be decreasing any longer for the Health Insurance Fund. Pharmaceuticals with twelve new active substances were added to the list of pharmaceuticals subject to reimbursement. In some cases the restrictions on prescribing pharmaceuticals subject to reimbursement were lifted. New pharmaceuticals subject to reimbursement are used in the case of cancer related pain, tromboprophylaxis after cardiac surgery, chronic obstructive pulmonary disease, type II diabetes, thrombocytopenia, cystic fibrosis, amyotrophic lateral sclerosis, renal cancer, epilepsy and glaucoma.

The increase in costs was mostly divided between the pharmaceuticals whose cost is reimbursed 90% or 100%. In the former case the average cost of a prescription decreased in comparison with the year before, but the number of prescriptions increased by 12%. Both the number of prescriptions and the cost for the Health Insurance Fund

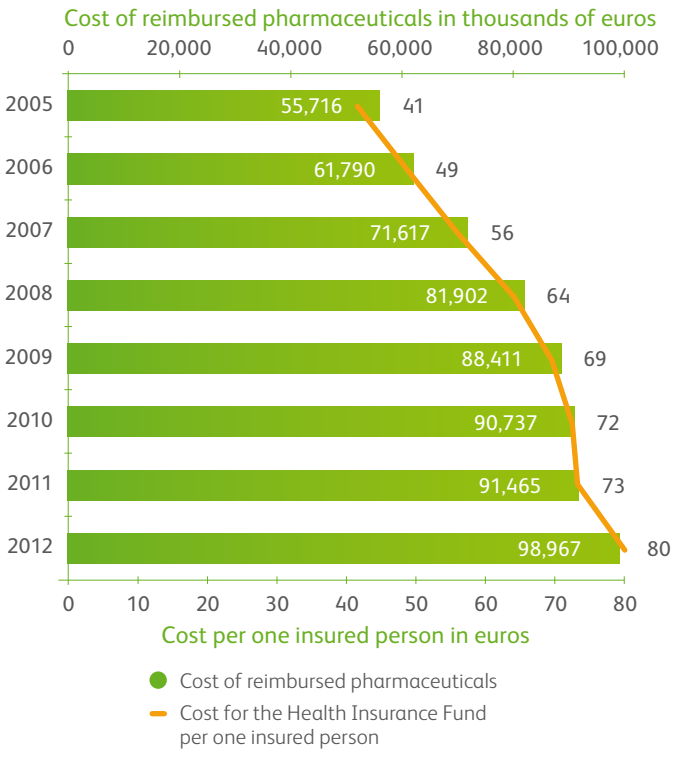


Figure 15 Total cost of reimbursed pharmaceuticals and cost per one insured person

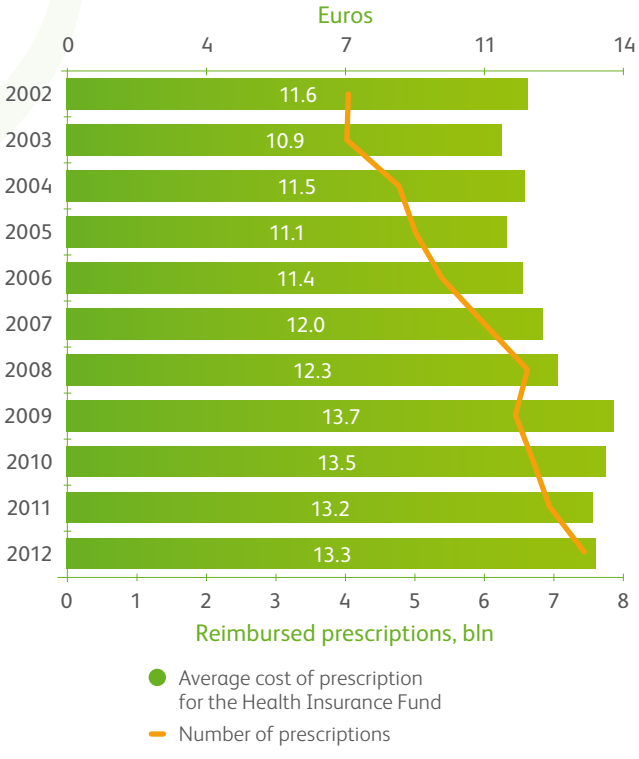


Figure 16 Number and average cost of reimbursed prescriptions

increased for pharmaceuticals sold at a 100% discount. All in all the higher costs were not the result of the 1% increase in the average cost per prescription, but rather of the 7.1% increase in the consumption of pharmaceuticals (see figure 16 and table 27).

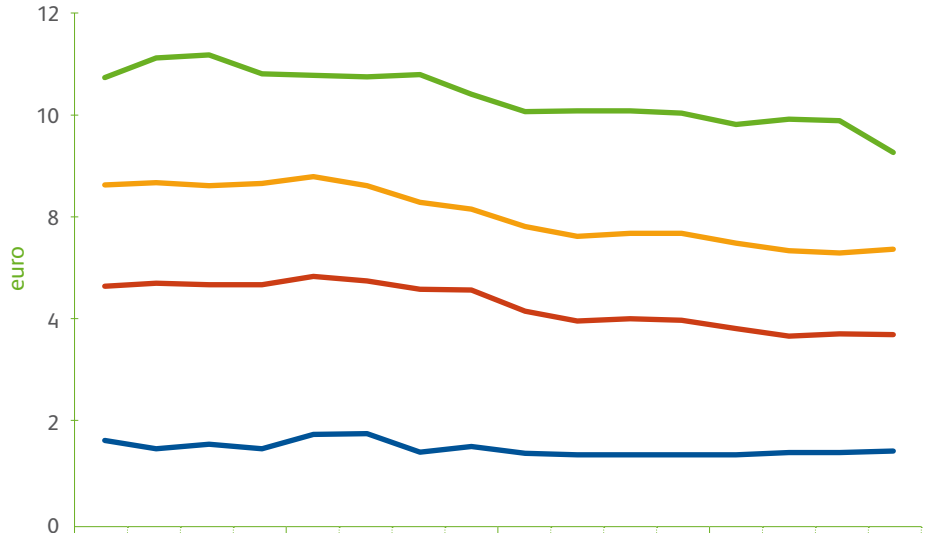
In comparison with last year the cost of a prescription has grown slightly for the Health Insurance Fund. The amount payable by the patient is still decreasing (see figure 17 and table 28). In 2011 the patient had to cover an average 6.95 euros, in 2012 6.56 euros of the cost of a prescription. Thus in 2012 the patient paid 33% and the Health Insurance Fund 67% of the cost of an average reimbursed prescription. The patient's share in the cost has been steadily decreasing during all quarters of the year for all discount rates, except the 100% rate, which has the lowest out-of-pocket expenses anyway (see figure 17). The number of INN-based prescriptions has grown. Supervision and awareness-raising among the population have been good. In the 4th quarter the share of the pharmaceuticals of which 50% is reimbursed dropped considerably, since the former limit of reimbursing no more than 12.79 euros per prescription was lifted. As a result the

Table 27 Number and average cost of reimbursed prescriptions in euros

Discount rate	2011		2012		2011/2012	
	Number of reimbursed prescriptions	Average cost of reimbursed prescriptions for Health Insurance Fund	Number of reimbursed prescriptions	Average cost of reimbursed prescriptions for Health Insurance Fund	Number of reimbursed prescriptions, %	Average cost of reimbursed prescriptions for Health Insurance Fund, %
Reimbursement of 100% of cost	771,256	59.33	824,298	59.88	7	1
Reimbursement of 90% of cost	2,420,785	10.86	2,710,094	10.80	12	–1
Reimbursement of 75% of cost	516,034	10.28	553,561	10.13	7	–1
Reimbursement of 50% of cost	3,237,660	4.36	3,350,717	4.40	3	1
TOTAL	6,945,735	13.17	7,438,670	13.30	7	1

Table 28 Out-of-pocket expenses by insured person, %

	2011 actual	2012 actual	% of change from 2011
Prescriptions with 100% discount rate	2.8	2.8	0.0
Prescriptions with 90% discount rate	31.1	29.7	–1.4
Prescriptions with 75% discount rate	40	39.3	–0.7
Prescriptions with 50% discount rate	69.1	68	–1.1
Average own funding by insured person	34.5	33	–1.5
incl. prescriptions with 75%, 90% and 100% discount rate	17.8	17.2	–0.6



	1st Q 2009	2nd Q 2009	3rd Q 2009	4th Q 2009	1st Q 2010	2nd Q 2010	3rd Q 2010	4th Q 2010	1st Q 2011	2nd Q 2011	3rd Q 2011	4th Q 2011	1st Q 2012	2nd Q 2012	3rd Q 2012	4th Q 2012
50% discount	10.60	11.03	11.09	10.67	10.63	10.58	10.64	10.19	9.73	9.82	9.79	9.74	9.48	9.60	9.52	8.88
75% discount	8.07	8.12	8.03	8.05	8.24	8.04	7.67	7.49	7.08	6.84	6.90	6.86	6.64	6.52	6.46	6.55
90% discount	5.69	5.77	5.74	5.74	5.91	5.82	5.63	5.59	5.09	4.88	4.94	4.90	4.70	4.50	4.59	4.52
100% discount	2.06	1.86	1.97	1.85	2.18	2.23	1.78	1.90	1.73	1.70	1.70	1.70	1.72	1.75	1.74	1.78

Figure 17 Out-of-pocket expenses by insured person per one prescription in euros

cost that patients themselves had to cover for these pharmaceuticals shrank by 7% in comparison with the 3rd quarter.

The most expensive diagnoses have remained unchanged. Diabetes and hypertension still cost the most. The number of users of pharmaceuticals with both diagnoses is predictably increasing (see table 29).

In summary, there have been several positive changes in the field of reimbursed pharmaceuticals. Many new treatments have become available. The use of existing treatments is more targeted and consistent. Reimbursed pharmaceuticals have become cheaper for patients. But the pharmaceuticals have stopped to become cheaper for the Health Insurance Fund. This could be an indication of the slowing down of the price

Table 29 The cost of the most expensive diagnoses as regards the reimbursement of pharmaceuticals in thousands of euros

Diagnosis	2011 actual		2012 actual	
	Reimbursed by the Health Insurance Fund	% of total reimbursed cost	Reimbursed by the Health Insurance Fund	% of total reimbursed cost
Total for diabetes, incl.	12,921	14	14,478	15
Insulin	9,215	10	9,995	10
Orally administered preparations	3,706	4	4,483	5
Hypertension	13,012	14	14,295	14
Cancer	10,600	12	11,722	12
Bronchial asthma	5,601	6	5,919	6
Glaucoma	3,738	4	4,011	4
Chronic hepatitis C	1,966	2	2,205	2
Mental disorders	3,027	3	2,878	3
Hypercholesterolemia	2,599	3	2,757	3
TOTAL	53,464	58	58,265	59

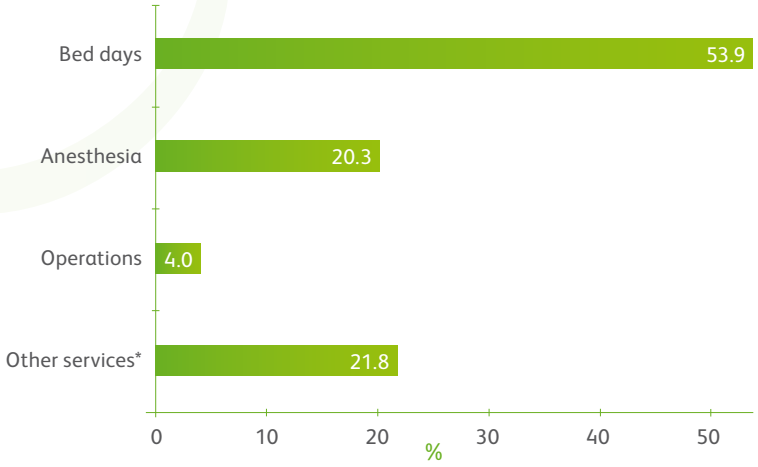


Figure 18 Distribution of costs on pharmaceuticals in health care services

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

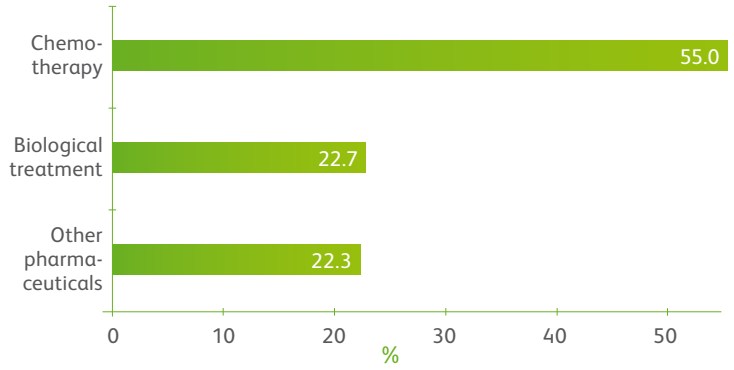


Figure 19 Share of pharmaceutical services in the List of Health Care Services, %

reduction process. This certainly proves that most of the pharmaceuticals that were added to the list were subject to reimbursement at the rate of 100% and relatively expensive.

Funds from Health Care Services Budget Spent on Pharmaceuticals

In addition to reimbursement of outpatient pharmaceuticals the health insurance money is also used to pay for those used in hospitals. The costs of pharmaceuticals are included in the cost of a bed day, but also in the cost of operations and anaesthesia. In 2012 the pharmaceutical component in services amounted to 16.7 million euros (see figure 18) – up by 1% in comparison with the year before.

A number of pharmaceuticals appear in the List of Health Care Services as individual services (services with the so-called R-code). These mainly include chemotherapy in oncology and haematology, biological treatment in rheumatology and other pharmaceuticals (e.g. antibiotics used for treating sepsis or pharmaceuticals used when transplanting organs) (see figure 19). In 2012 such pharmaceutical services cost 36.5 million euros, an 18% increase from the year before.

A total of 152.6 million euros was spent on pharmaceuticals from the health care services budget, the budget for reimbursement of outpatient pharmaceuticals and the budget for additional pharmaceutical benefits, altogether 19.7% of the health insurance expenditure (see table 30).

Table 30 Money spent on pharmaceuticals from the health insurance budget in thousands of euros

	2012 actual
Pharmaceuticals reimbursed to insured persons	98,967
The use of pharmaceutical codes in the list of health care services	36,534
Pharmaceutical expenses in health care services	16,697
Additional pharmaceutical benefits	421
TOTAL PHARMACEUTICAL EXPENSES	152,619

4. Benefits for Temporary Incapacity for Work

Expenses for Benefits for Temporary Incapacity for Work

Benefits for temporary incapacity for work cost 84.3 million euros, exceeding those of last year by 3.5 million euros (see table 31).

Benefits for temporary incapacity for work are paid on the basis of the various certificates: certificates for sick leave, care leave, maternity leave and adoption leave. The analysis of the expenses for benefits for temporary incapacity for work found in the report does not follow exactly the principal classification of the certificates for temporary incapacity for work. For example, due to the relatively marginal share of benefits paid on the basis of the certificate for adoption leave (ca 25 cases a year), the relevant cost is included in the expenses for maternity benefits. However, occupational accident benefits are shown separately in the expenses for the benefits for temporary incapacity for work, since they give an indication of the situation in the country as regards occupational health and safety.

Figure 20 shows that in 2012 sickness benefits took up the largest share of the benefits for temporary incapacity for work, 45%.

2012 saw a 4% growth in the expenses for the benefits for temporary incapacity for work. However, only 95% of the budget was actually taken up, as the number of days of incapacity for work did not increase by 2% as forecast. Table 32 shows that even if the number of employed insured persons increased, the number of days of incapacity for work per employed insured person dropped by ca 1%. The reason probably lies in the various socio-economic and demographic devel-

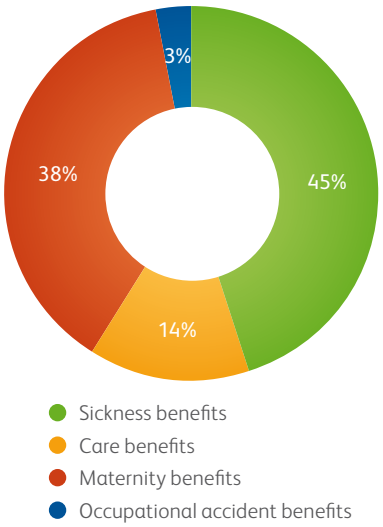


Figure 20 Distribution of benefits for temporary incapacity for work by types of benefit

Table 31 Expenses for Benefits for Temporary Incapacity for Work in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Sickness benefits	35,943	38,526	37,546	97	4
Care benefits	11,626	14,050	12,214	87	5
Maternity benefits	31,140	33,306	32,168	97	3
Occupational accident benefits	2,061	2,586	2,337	90	13
TOTAL	80,770	88,468	84,265	95	4

Table 32 Number of insured persons, take-up of days of incapacity for work

	2011 actual	2012 actual	% of change from 2011
Number of employed insured persons (average of the period)	571,858	576,687	1
Number of days of incapacity for work	6,527,369	6,552,855	0
Number of days of incapacity for work per an employed insured person	11.41	11.36	0

opments. After the economic crisis the growth of wage income in real terms[10] has been modest, which may have an impact on the number of days of incapacity for work. The 2% reduction in the number of certificates for maternity leave has also influenced the number of days of incapacity for work.

Table 33 compares the expenses for the benefits for temporary incapacity for work with the 2011 data. The number of days of incapacity for work for which the Health Insurance Fund has paid benefits has not changed considerably. Thus the 4% increase in the expenses for the benefits for temporary incapacity for work was

Table 33 Comparison of the expenses for the benefits for temporary incapacity for work

	2011 actual	2012 actual	% of change from 2011
SICKNESS BENEFITS			
Number of certificates paid for by the Health Insurance Fund	202,102*	201,753	0
Total number of certificates issued to insured persons **	293,136	293,675	0
Number of days paid for by the Health Insurance Fund	2,698,258	2,742,257	2
Total number of sickness days **	4 259 987*	4,313,698	1
Total average duration of paid leave **	14.5*	14.7	1
Amount of benefits paid for by the Health Insurance Fund (thousand euros)	35,943	37,546	4
Average benefit per day (euros)	13.3	13.7	3
CARE BENEFITS			
Number of certificates	89,716	91,145	2
Number of days paid for by the Health Insurance Fund	742,621	740,609	0
Amount of benefits paid (thousand euros)	11,626	12,214	5
Average benefit per day (euros)	15.7	16.5	5
Average duration of paid leave	8.3	8.1	–2
MATERNITY BENEFITS			
Number of certificates	10,012	9,770	–2
Number of days paid for by the Health Insurance Fund	1,395,109	1,364,348	–2
Amount of benefits paid (thousand euros)	31,140	32,168	3
Average benefit per day (euros)	22.3	23.6	6
Average duration of paid leave	139.3	139.6	0
OCCUPATIONAL ACCIDENT BENEFITS			
Number of certificates	4,796	5,026	5
Number of days paid for by the Health Insurance Fund	101,848	107,547	6
Amount of benefits paid (thousand euros)	2,061	2,337	13
Average benefit per day (euros)	20.2	21.7	7
Average duration of paid leave	21.2	21.4	1
TOTAL BENEFITS			
Number of certificates paid for by the Health Insurance Fund	306,626*	307,694	0
Number of days paid for by the Health Insurance Fund	4,937,836	4,954,761	0
Benefits paid by the Health Insurance Fund (thousand euros)	80,770	84,265	4
Average benefit per day (euros)	16.4	17.0	4

*Comparative data for the 2011 certificates for incapacity for work have been adjusted.
**All certificates for incapacity for work issued and days of incapacity for work are included here, i.e. the financial contribution of the insured persons themselves, their employers and the Health Insurance Fund.

[10]See the Ministry of Finance Review on Estonian Economy: www.fin.ee

mainly caused by the roughly 4% growth in the average benefit per day. The benefit for temporary incapacity for work is calculated on the basis of the income of previous year, which is subject to social tax. Consequently the increase in the average benefit per day resulted from a 6% rise of the gross wages. There is a difference in the growth rate of the average benefit per day and that of gross wages because some insured persons did not earn any income in the previous year and their benefit was calculated on the basis of the minimum wage or the monthly rate prescribed in the Social Tax Act.

Sickness Benefits

Sickness benefits start to be paid as of the fourth day of temporary incapacity for work caused by illness, quarantine or domestic injury, traffic accident or complications of a traffic accident.

- The employers pay sickness benefits for days 4-8;
- The Health Insurance Fund starts paying sickness benefits from day 9; the benefit constitutes 70% of the insured person's income of the previous year, which is subject to social tax.

In many cases of incapacity for work the employers do not have to pay for the benefits and the whole cost is borne by the Health Insurance Fund:

- illness or injury during pregnancy. The Health Insurance Fund starts paying the benefit as of the second day of release from the performance of duties and the benefit constitutes 70% of the insured person's income of the previous year, which is subject to social tax;
- occupational accident, occupational disease or injury sustained in protecting national or public interests or preventing a criminal offence. The Health Insurance Fund starts paying the benefit as of the second day of release from the performance of duties and the benefit constitutes 100% of the insured person's income of the previous year, which is subject to social tax;
- transfer of the insured person to an easier position due to pregnancy. The Health Insurance Fund compensates the difference in wages based on her average income per calendar day of the previous year. In the event the employer cannot offer the pregnant woman work that suits the condition of her health, the Health Insurance Fund starts paying the benefit as of the second day at the rate of 70%.

Based on the reasons for release from the performance of duties, the breakdown of certificates for sick leave was the following: illness 83%, domestic injury 11%, illness or injury during pregnancy 3% and transfer to another job 3%. Traffic accidents and other reasons, e.g. occupational disease, complications of a traffic accident and injuries sustained in protecting national or public interests or preventing a criminal offence altogether constituted ca 1%.

In comparison with last year the number of sickness days paid for by the Health Insurance Fund has grown by 1.6%. The number of sickness days with the financial contribution of the insured persons themselves and their employers has grown about 1% (see table 34).

As regards the treatment regime, only 11% of persons on sick leave have required hospital treat-

Table 34 Number of certificates for sick leave and sickness days

	Number of certificates for sick leave*	Number of sickness days			
	Certificates with the contribution for days 1–8 (with financial contribution of insured persons and their employers)	Days 1–3 (with financial contribution of insured persons)	Days 4–8 (with financial contribution of employers)	Days paid for by Health Insurance Fund	Total
2012	233,871	685,272	939,099	3,788,591	5,412,962
2011	233,092	684,712	942,728	3,776,222	5,403,662

*The number includes data of initial certificates for sick leave where the reasons for release from the performance of duties are the following: illness, quarantine, domestic injury, traffic accident and complications of a traffic accident.

Table 35 Number of insured persons by age group and use of sickness days*

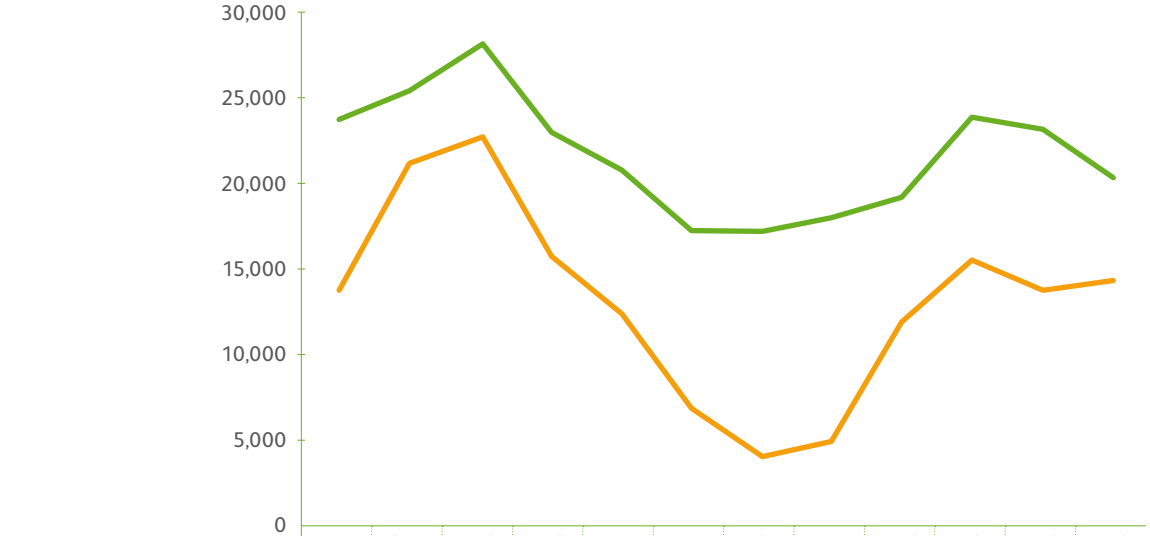
Age group	Number of employed insured persons as of 31 December 2012	Number of sickness days per employed insured person
...–29	112,483	5.8
30–39	130,963	5.2
40–49	134,346	6.4
50–59	129,521	9.0
60–...	67,964	8.5

*Included are the days of incapacity for work from all certificates for sick leave with reasons for release from the performance of duties, including occupational accidents.

ment. Usually the treatment occurs at home. The share of medical rehabilitation during temporary incapacity for work has been insignificant.

An analysis of the sickness days by different age groups on the basis of table 35 shows that the average number of sickness days per employed insured person starts growing from the age of 50. The highest number of days of incapacity for work per employee is in age group 50-59.

Age is an important factor in using sickness days, however, the frequency and spread of viral infections has the greatest impact. Figure 21 shows that the number of certificates for sick leave grows particularly in those months, which have the highest numbers of acute upper respiratory infections and influenza. In 2012 the number of cases of illness and certificates for sick leave peaked in March and predictably, were the lowest during the summer months.



	January	February	March	Aprill	May	June	July	August	September	October	November	December
Certificates for sick leave 2012	23,839	25,543	28,293	22,991	20,904	17,226	17,258	18,016	19,261	23,947	23,206	20,420
Certificates for sick leave 2012	13,912	21,328	22,754	15,809	12,425	6,890	4,010	4,921	11,997	15,679	13,700	14,311

Figure 22 Acute upper respiratory infections, influenza[10] and the number of certificates for sick leave[11]

[10]The statistics on communicable diseases is found at: www.terviseamet.ee

[11]Included are certificates for sick leave where the reason for release from the performance of duties was illness.

Care Benefits

The Health Insurance Fund starts paying care benefits as of the first day of release from the performance of duties and the benefit constitutes 80% of the person's income of the previous year, which is subject to social tax in respect of the following events:

- nursing a child under 12 years of age;
- nursing a family member who is ill at home;
- caring for a child under 3 years of age or for a disabled child under 16 years of age when the person caring for the child is himself or herself ill or is receiving obstetrical care.

98% of all the certificates for care leave are made up those issued for nursing a child under 12 years of age. The remaining 2% are issued for caring for a child under 3 years of age or for a disabled child under 16 years of age and nursing a family member. The reasons for release from the performance of duties in the certificates for care leave have not changed in comparison with last year. The distribution of carers has been stable as well with 24% of the certificates for care leave issued to men and 76% to women. Figure 22 shows the breakdown by age of the children in the certificates for care leave issued for nursing a child under 12 years of age: 52% of the certificates were issued for nursing children aged 3–5.

The 5% increase in the expenses for care benefits was caused by the increase in the benefit per day resulting from the pay rise in 2011, for the number of care days has not changed (see table 33).

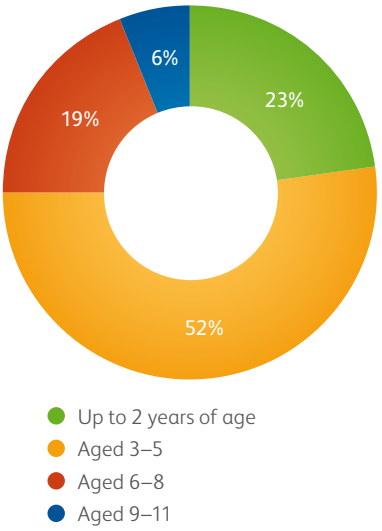


Figure 22 Breakdown by age of the children in the certificates for care leave issued for nursing a child under 12 years of age

Maternity Benefits

Maternity benefits start to be paid as of the first day of release from the performance of duties and the benefit constitutes 100% of the person's income of the previous year, which is subject to social tax. The number of certificates for maternity leave issued in a year is quite modest, about 9,800 were issued in 2012. Despite that maternity benefits make up 38% of the expenses for incapacity for work benefits (Figure 29). The factors that influence the figure are the duration of maternity leave of 140 days and the 100% benefit rate. The average amount of maternity benefit paid per one certificate for maternity leave was roughly 3,300 euros. As last year, the highest share of the recipients of maternity benefits - 49% - were aged 20-29.

There has been a 3% increase in the expenses for maternity benefits, although the number of the days of incapacity for work has dropped by 2%. This was caused by the 6% increase in the average benefit per day resulting from rising salaries.

Occupational Accident Benefits

In the event of occupational accidents, including occupational accidents which occurred in traffic, complications or illnesses resulting from occupational accidents the Health Insurance Fund starts paying the benefits from the second day. The benefit constitutes 100% of the person's income of the previous year, which is subject to social tax. In the certificates for occupational accidents the reasons for release from the performance of duties were the following: occupational accidents 94%, complications resulting from occupational accidents 4% and occupational accidents which occurred in traffic2%. In comparison with 2011 the number of days of incapacity for work in this category grew by 9%. The reasons could lie in the growing employment rate, with the numbers of occupational accidents growing proportionally as well.

Benefits Paid on the Basis of Certificates from Foreign Physicians

The Health Insurance Fund also pays benefits for temporary incapacity for work to insured persons, based on certificates for release from the performance of duties issued by foreign physicians. Last year foreign physicians issued 490 such certificates to insured persons from Estonia. The number of days when they were released from the performance of duties totalled 8,828. The expenses for temporary incapacity for work amounted to 136,879 euros.

Like in 2011, most of the certificates were issued in Latvia (26%), followed by The Ukraine (24%) and Finland (15%). In about 18% of the cases injuries were the causes of issuing the certificate. In the remaining cases the certificates were issued on the grounds of general illness. In 23 instances certificates for nursing a child and in 11 instances for taking maternity leave were issued.

5. Other Financial Benefits

5.1. Financial Benefits for Dental Care Services

The Health Insurance Fundreimburses the cost of dental care services to insured persons as follows:

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

Insured persons over 63 years of age and persons eligible for a pension because for incapacity for work, or an old-age pension pursuant to the State Pension Insurance Act, are reimbursed up to 255.65 euros for dentures within a three year period.

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

An application for reimbursing the cost of dentures can be submitted directly to the dentist, so that the service would be cheaper by the amount of the benefit. In this case the insured person would only pay for the dentures the amount exceeding the benefit and the Health Insurance Fund would cover the difference. In 2012 the share of those who applied for the benefit through the service provider was 77%. Pensioners prefer this option, since they are saved the journey to the Health Insurance Fund and those who can not afford to pay the total amount up front will also be able to get dentures.

In 2012 the expenses for financial benefits for dental care services amounted to 8.7 million euros, which exceeded the budget by 2.5% (see table 36).

The 12% increase in the take-up of denture benefits caused the expenses to be higher than planned (see table 37).

Table 36 Expenses for benefits for dental care services in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Denture benefits	6,064	6,299	6,848	109	13
Dental care benefits	1,791	2,203	1,867	85	4
TOTAL	7,855	8,502	8,715	103	11

Table 37 Number of cases of dental care benefits

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Denture benefits*	37,947	40,640	42,327	104	12
Dental care benefits*	90,348	115,963	94,390	81	4
TOTAL	128,295	156,603	136,717	87	7

*Comparative data for dental care services in 2011have been adjusted.

The higher than planned take-up of the denture benefits was probably caused by the increase in the use of the denture services for the period that commenced in 2009. In 2012 the 3-year period came to an end and the patients could start applying for the benefit of the new period. In comparison with 2011, last year saw a 10% increase in persons who started a new 3-year period for applying for the benefits (see figure 23).

The majority of applicants for denture benefits use up most of the permitted amount at one go. This shows that usually the amount of the denture benefit is not sufficient to cover the total cost of dentures (see figure 24).

The highest number of applications comes from persons aged 70–79, followed by those aged 63–69. Between the two of them these groups submitted 64% of the applications for benefits (see figure 25).

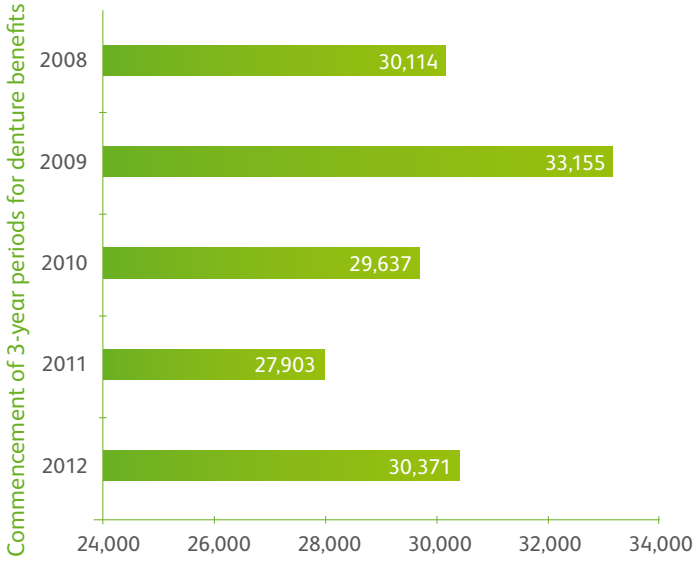


Figure 23 Distribution of periods for denture benefits by year

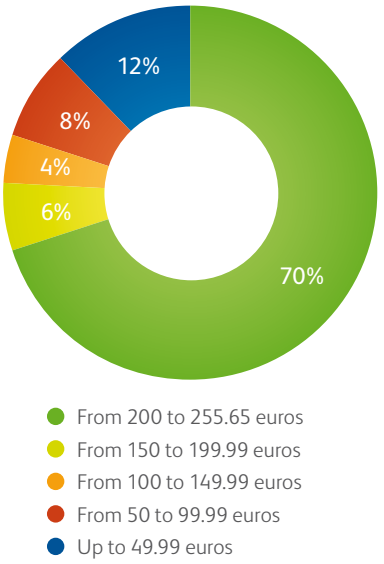


Figure 24 Distribution of applications for denture benefits by the amount of payment, %

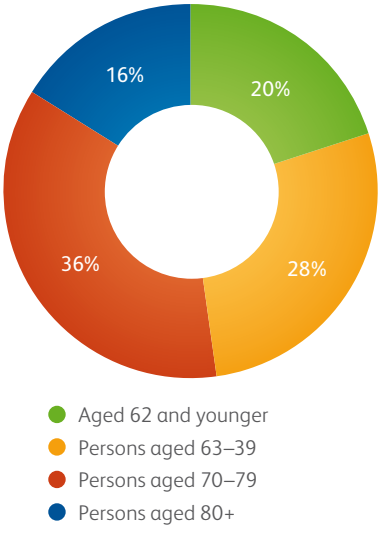


Figure 25 Distribution of users of denture benefits by age, %

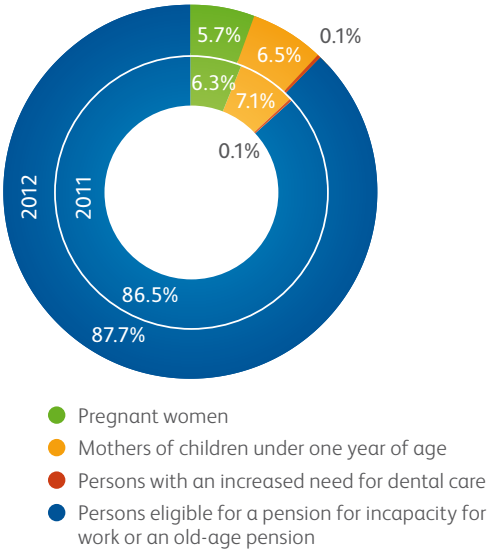


Figure 26 Distribution of dental care benefits by eligible groups, %

Pensioners submitted most of the applications for dental care benefits. The take-up of benefits has grown by 6% in this target group, compared to the year before, indicating that the pensioners have become more active in using this benefit as well. As the birth rate drops the number of applications for dental care benefits among pregnant women and mothers of children under one year of age has decreased by 5% and 4% respectively. The biggest change, with 19% more applications, occurred in the group of persons with an increased need for dental care. Even so, this target group did not take up more than 0.1% of all cases of paying dental care benefits and the situation had not changed in comparison with 2011 (see figure 26).

5.2. Supplementary Benefits for Pharmaceuticals

An insured person can get a supplementary benefit for pharmaceuticals if his or her expenditure on pharmaceuticals included in the list of pharmaceuticals exceeds 384 euros in a calendar year.

In 2012 the number of recipients of this benefit grew slightly. The total amount paid decreased, given the 14 euro decrease in the average amount of benefits paid per person (see table 38). The repeated increase of the reimbursement rate of pharmaceuticals in the list of pharmaceuticals reimbursed to insured persons could explain this development.

For example, several diagnoses were added for which 75% of the cost of prescriptions for lipid lowering statins was reimbursed.

Table 38 Supplementary Benefits for Pharmaceuticals

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Amount of benefit (thousand euros)	440	473	421	89	–4
Number of recipients of benefits	1,710	1,877	1,734	92	1
Average amount paid per person (euros)	257	252	243	96	–5

6. Other Health Insurance benefits

6.1. Benefits Arising from EU Legislation and Referrals for Planned Treatment Abroad

In the EU, various certificates or e-forms are used in order to determine a person's social security benefit rights; these can be divided into five categories depending upon their content:

- forms asking for and providing information (E 001, E 104, E 107);
- forms granting, creating and ending rights (E 106, E 108, E 109, E 121);
- forms related to international reimbursement settlements (E 125, E 126, E 127);
- forms for benefits in cash (E 115, E 116, E 117, E 118);
- forms granting the right to receive treatment (E 112, E 123).

The number of e-forms processed by the Health Insurance Fund has increased greatly throughout the years. However, the year 2012 put a stop to the increase and the number of e-forms processed stayed at the level of 2011. The most common e-forms processed are E 125 and E 106.

The number of international reimbursement forms for actual expenses, E 125, sent to the Estonian Health Insurance Fund in 2012 was 5,490, while 5,697 similar forms were sent to other countries. The number of forms does not reflect the number of cases one to one, since services provided to one and the same person may be entered on several different forms. The practice differs by country. Therefore we cannot state that the number of forms sent from or received by the Estonian Health Insurance Fund and the number of persons who needed treatment is the same.

Form E 106 is used to prove that a posted employee has health insurance coverage. An employee who is posted to another country for longer than one year has to register the form E 106 in the new place of residence and is then entitled to receive any medical treatment there. In 2012 the number of forms E 106 issued was 2,225, which marks an increase from the year before.

A detailed overview of the number of e-forms issued and received in 2006-2012 is provided in Annex 5 of the Budget Execution Report.

6.1.1. Referrals for Planned Treatment Abroad

The referral of patients for planned treatment in another country is subject to the provisions of the Health Insurance Act. The EU legislation and the agreement between the Estonian Health Insurance Fund and the Finnish Red Cross for finding unrelated bone marrow donors regulate the free movement of insured persons within the European Union.

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

In 2012 the Health Insurance Fund undertook to pay for planned health care services provided abroad to 199 insured persons (109 of them were children). Of the referrals 56 patients were to receive treatment abroad, 126 were to undergo examinations and 17 were seeking unrelated bone marrow donors via the Finnish Red Cross. Of all applications 93% were accepted and in 16 cases payment was refused.

Table 39 Planned treatment costs abroad in thousands of euros

	2009 actual	2010 actual	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Planned treatment abroad	1,322	971	1,745	1,600	2,035	127	17

Table 40 Number of planned cases and average cost per case in euros

	2011 actual		2012 actual		% of change from 2011	
	Number of cases	Average cost per case	Number of cases	Average cost per case	Number of cases	Average cost per case
Planned treatment abroad	166	10,512	205	9,927	23	–6

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 Health Insurance Fund concerning the applications does not coincide fully in any one year.

In 2012 the Health Insurance Fund received 205 invoices - 63 insured persons had received treatment abroad, 114 had undergone examinations or tests and 28 were seeking unrelated bone marrow donors. In comparison with 2011 the number of planned cases has seen an increase, while the average cost per case has dropped slightly. In 2012 the average cost per case was 9,927 euros, a year before - 10,512 euros. In 2012 the planned treatment and tests abroad cost 2 million euros, exceeding the amount of 2011 by 17% (see tables 39 and 40).

In 2012 the largest number of patients went for treatment to Finland and Germany. Most of the gene tests were carried out in The Netherlands and Belgium (see table 41).

Table 41 Countries where the insured persons received treatment or underwent tests in 2012

Country	Total	Treatment	Test
Finland	35	33	2
The Netherlands	34	0	34
Germany	39	11	28
Belgium	52	0	52
Sweden	4	1	3
Lithuania	1	0	1
UK	7	3	4
Russia	2	2	0
Denmark	2	1	1
Austria	1	0	1
Latvia	2	2	0
Spain	1	1	0
USA	2	1	1
Poland	1	1	0
TOTAL	183	56	127

6.1.2. Benefits for Health Care Services Arising from EU Legislation

Persons insured with the Estonian Health Insurance Fund are entitled to receive the necessary health care while staying temporarily in another member state, and any type of health care when they reside in another member state, in case Estonia remains the insuring country. In this case the Estonian Health Insurance Fund pays the other countries for the costs of medical care given to its insured persons. At the same time the insured persons of other EU member states are entitled to the necessary health care during their temporary stay in Estonia and to any type of health care when they reside here. The costs of medical care given to persons insured in other EU member states are first reimbursed by the Estonian Health Insurance Fund, but eventually the insuring country has to pay for those costs.

Table 42 Expenses for health care services based on the EU regulations in thousands of euros

	2009 actual	2010 actual	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Payments for health care services provided in other member states to persons insured with the Health Insurance Fund	2,371	2,060	5,266	3,626	3,930	108	–25
Payments for health care services provided and reimbursed pharmaceuticals in Estonia to persons insured in other member states	659	779	1,199	1,119	1,228	110	2
TOTAL	3,030	2,839	6,465	4,745	5,158	109	–20

Reimbursement of the expenses of cross-border health care is an open commitment for the Estonian Health Insurance Fund. The planned expenses for 2012 were 4.7 million euros. The actual expenses were somewhat higher: 5.2 million euros. In comparison with 2011 the costs were down by 20% (see table 42).

A total of 1.2 million euros was paid to health service providers for treatment provided in Estonia to persons insured in other EU member states. 56 thousand euros were reimbursed to pharmacies for pharmaceuticals to foreign patients. The Estonian Health Insurance Fund paid 3.9 million euros to other EU member states for necessary health care services provided to persons staying temporarily in another EU member state, to posted employees and pensioners residing in other EU member states. Of this amount 613 thousand euros was the capitation fee paid on behalf of the persons who receive pension from Estonia. The expenses for health care services provided to persons residing or staying in another country amounted to 3.3 million euros. Reimbursements to persons amounted to 49 thousand euros. Reimbursements were given to persons who for some reason did not have their European health insurance card on them during their stay in another member state and had to pay themselves for the health care services received.

6.2. Benefits for Medical Devices

Like benefits for pharmaceuticals, those for medical devices also mean an open commitment for the Health Insurance Fund. Benefits for medical devices are reimbursed to all insured persons whose need to use a medical device has been established by a physician on the basis of the terms and conditions of the List of Medical Devices.

The availability and range of medical devices reimbursed by the Health Insurance Fund improved in 2012. Diabetic patients gained the most from the changes in the List of Medical Devices, since the amounts to be reimbursed for glucometer test strips were increased almost two times. Also included in the list was a new insulin pump with an attached glucosensor for constant monitoring of blood sugar levels. Another group of medical devices was added for treating severe cases of sleep apnoea: the continuous positive airway pressure (CPAP) device and masks. In addition new products for managing colostomies, ileostomies, urostomies and tracheostomies and for treating wounds and ulcers were included in the list, as were new orthoses and prostheses.

Compared to 2011 more funds were planned in the budget, because a considerably higher increase in the use of glucometer test strips, and new wound dressings and patches was expected. The addition of the expensive CPAP device and insulin pumps into the list was also taken into account (see tables 43 and 44).

In the largest group – glucometer test strips – the use did not reach the expected level. The apparent reason lies in the fact that diabetes II patients who continue to be treated with tablets are not aware yet of the need to check their blood sugar regularly and fail to use this opportunity. However, the number of users of test strips has increased annually, showing that the awareness of the need for self-testing is increasing. The patients want to check whether the treatment works and prevent complications.

Table 43 Benefits for medical devices in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Primary prostheses and orthoses	1,201	1,485	1,502	101	25
Glucometer test strips	2,547	4,956	4,337	88	70
Stoma appliances	888	970	956	99	8
Insulin pumps	204	486	408	84	100
Wound dressings and patches	13	45	22	49	69
Continuous positive airway pressure devices and masks	0	373	420	113	–
Other medical devices	33	38	39	103	18
TOTAL	4,886	8,353	7,684	92	57

Table 44 Cases involving benefits for medical devices and average cost in euros

	2011 actual		2012 actual		% of change from 2011	
	Number of cases	Average cost per case	Number of cases	Average cost per case	Number of cases	Average cost per case
Primary prostheses and orthoses	9,475	127	11,217	134	18	6
Glucometer test strips	29,048	88	35,043	124	21	41
Stoma appliances	1,589	559	1,693	565	7	1
Insulin pumps	155	1,316	204	2,000	32	52
Wound dressings and patches	377	34	537	41	42	21
Continuous positive airway pressure devices and masks	–	–	809	519	–	–
Other medical devices	123	268	167	234	36	–13

The changes in the use of post-operative and post-trauma prostheses and orthoses and stoma appliances were as predicted. The number of persons receiving benefits for orthoses has grown every year, as more patients become aware of their rights and the network of suppliers has expanded.

A new insulin pump and related accessories were added to the List of Medical Devices but the amount of benefits remained smaller than budgeted.

The take-up of wound dressings and patches continued to be the most modest although the product range was extended and benefits have been paid for the second year already.

Unlike other medical devices the cost of reimbursing the CPAP device and masks, which were included in the list in 2012, was higher than expected. The number of patients who needed the device according to specialists' estimates was exceeded by 200.

Other medical devices include less frequently used medical devices: intermediate containers (so-called spacers) for the administration of asthma medication, disposable urinary catheters, pressure garments for burn patients and therapeutic contact lenses. The changes in the take-up of these devices grew as planned.

6.3. Expenses Covered by Targeted Financing from State Budget

Infertility treatment is funded from the state budget through targeted financing. Insured women of up to 40 years of age (incl.) can apply for infertility treatment and the corresponding benefits for pharmaceuticals, if there is a medical indication for in vitro fertilisation and/or embryo transfer.

A total of 1,442 women underwent infertility treatment procedures and 1,264 women received benefits for pharmaceuticals. Altogether the Health Insurance Fund paid 1.6 million euros - 903.3 thousand euros for pharmaceuticals and 668.6 thousand euros for treatment. The income from targeted financing is recorded under „Other income" in the budget. ■

Operating Expenses of Health Insurance Fund

Table 45 presents an overview of the operating expenses of the Health Insurance Fund.

Table 45 Operating expenses of the Health Insurance Fund in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Personnel and management expenses	4,380	4,792	4,645	97	6
Wages and salaries	3,262	3,567	3,460	97	6
Incl. remuneration of management board members	139	138	153	111	10
Unemployment insurance contributions	44	48	45	94	2
Social tax	1,074	1,177	1,140	97	6
Administrative expenses	1,011	1,131	1,012	89	0
IT expenses	834	964	773	80	–7
Development expenses	159	225	151	67	–5
Training	76	113	86	76	13
Consultation	83	112	65	58	–22
Finance expenses	87	87	0	0	–
Other operating expenses	609	841	750	89	23
Supervision over health insurance system	53	103	75	73	42
Public relations/communication	68	114	108	95	59
Other expenses	488	624	567	91	16
TOTAL HEALTH INSURANCE FUND OPERATING EXPENSES	7,080	8,040	7,331	91	4

In 2012 personnel expenses were 4.6 million euros.

The Health Insurance Fund plans the personnel resources using an activity-based needs matrix, where the number of posts required to achieve the goals set for the budgetary period is determined through measurable activities, based on key statistical indicators and estimated activities, assessed by the managers. The number of posts needed is determined on the basis of the actual results of key statistical indicators and estimated activities. Given that it is not possible to measure or assess precisely all activities we accept that the employment goal need not always be 100% and allow a variation of +/- 15% (in accordance with the methodology of activity based resource planning and activity based costing used by the Health Insurance Fund).

In 2012 the total actual workload of the Health Insurance Fund (221 posts) was higher than planned (215 posts) by six posts. In the 2012 plan the number of posts matched exactly the planned workload, but in reality two posts were not taken during the whole year, thus there were only 213 filled posts. Therefore we were missing staff to do the work of eight posts in order to cover the actual workload (221 posts) and the total employment rate of the Health Insurance Fund was 104% in 2012.

Data concerning the planned and actual workloads and posts filled in the Health Insurance Fund in 2008–2012 (see figure 27) shows overestimated workloads in the first years of the period, but in 2011 and 2012 the workloads were already underestimated, so that the actual work load exceeded the plans. In addition, the number of posts planned is always larger than the number of posts filled, although in recent years the gap between the planned and actual data has been closing.

Figure 27 Planned and actual workloads and posts, 2008–2012

The budget for IT expenses was not used up as planned, since the tender for data recording was challenged in the Public Procurement Appeals Committee. The tender for network equipment required for data recording was postponed until the beginning of 2013.

The budget for development expenses includes training expenses and expenses for legal and business consultations. The budget for business consultations was not used up completely, since the work of the secretariats for the new clinical guidelines started later than planned.

The finance expenses budget was under-used because of the changes in the management of the financial resources of the Health Insurance Fund (legal reserve, risk reserve, cash reserve) after the 2012 budget was defined. According to the deposit agreement concluded with the Ministry of Finance there is no need for the Health Insurance Fund to cover the finance costs.

Other operating expenses. The budget for supervisory activities was not fully used up, as the deadline for completing one clinical audit was postponed. The biggest sums from the public relations and communication expenses budget went for publishing the book on history and organizing the anniversary conference. During the period under review the Health Insurance Fund published a magazine "Tervise heaks" ("For Health"), which was mailed directly to the target groups. The themes covered in the magazine were the following: consultations by family nurses, family physician's advisory line, medical care in the EU, benefits paid by the Health Insurance Fund, medical devices, cancer screening and pharmaceuticals. The budget execution was also affected by the cancelled IT tenders, since the value added tax costs of the investments were to be included among other operating expenses in the budget. ■

Legal Reserve

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

- The legal reserve of the Health Insurance Fund means the reserve formed of the budgetary funds of the Health Insurance Fund for the reduction of the risk which macro-economic changes may cause to the health insurance system.
- The legal reserve shall amount to 6 per cent 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 Health Insurance Fund.

As of 31 December 2012 the legal reserve of the Health Insurance Fund was 51.1 million euros. Against the size of the 2013 budget, the required legal reserve has to amount to 50.5 million euros. ■

Risk Reserve

Article 39 of the Estonian Health Insurance Fund Act regulates the formation of the risk reserve as follows:

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

As of the end of the financial year the risk reserve of the Health Insurance Fund was 15.6 million euros. In 2013 the required size of the risk reserve is 16.7 million euros. In order to comply with the requirement prescribed by law, an additional 1 million and 79 thousand euros have to be placed in the risk reserve in 2013. ■

Retained Earnings

As of 31 December 2012 the retained earnings of the Health Insurance Fund were 164.8 million euros. ■

Annexes to the 2012 Budget Execution Report

Annex 1 Expenses for specialised medical care in thousands of euros

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Surgery	72,518	77,096	77,269	100	7
Outpatient care	14,192	15,470	15,425	100	9
Day care	3,042	3,262	3,380	104	11
Inpatient care	55,284	58,364	58,464	100	6
Otorhinolaryngology	10,493	11,300	10,915	97	4
Outpatient care	5,078	5,297	5,168	98	2
Day care	1,864	2,044	1,816	89	–3
Inpatient care	3,551	3,959	3,931	99	11
Neurology	14,245	14,739	15,697	106	10
Outpatient care	6,569	6,841	7,248	106	10
Day care	67	72	43	60	–36
Inpatient care	7,609	7,826	8,406	107	10
Ophthalmology	16,208	17,225	17,466	101	8
Outpatient care	8,496	8,627	8,740	101	3
Day care	6,694	7,157	7,132	100	7
Inpatient care	1,018	1,441	1,594	111	57
Orthopaedics	33,757	36,629	35,336	96	5
Outpatient care	7,624	8,434	8,200	97	8
Day care	1,873	1,898	1,965	104	5
Inpatient care	24,260	26,297	25,171	96	4
Oncology	39,242	43,045	44,606	104	14
Outpatient care	21,034	22,987	23,838	104	13
Day care	1,286	1,396	1,506	108	17
Inpatient care	16,922	18,662	19,262	103	14
Obstetrics and gynaecology	40,093	43,404	41,694	96	4
Outpatient care	19,242	20,615	20,589	100	7
Day care	2,308	2,754	2,335	85	1
Inpatient care	18,543	20,035	18,770	94	1
Pulmonology	13,111	14,541	14,005	96	7
Outpatient care	6,233	6,587	6,749	102	8
Day care	2	6	28	–	–
Inpatient care	6,876	7,948	7,228	91	5
Dermatovenereology	4,541	5,306	5,311	100	17
Outpatient care	3,813	4,546	4,187	92	10
Day care	71	73	371	–	–
Inpatient care	657	687	753	110	15
Paediatrics	15,725	17,079	18,362	108	17
Outpatient care	4,277	5,722	5,696	100	33
Day care	445	425	844	199	90
Inpatient care	11,003	10,932	11,822	108	7

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Psychiatry	18,847	19,663	19,848	101	5
Outpatient care	5,227	5,455	5,582	102	7
Day care	192	189	203	107	6
Inpatient care	13,428	14,019	14,063	100	5
Infectious diseases	6,273	6,563	6,705	102	7
Outpatient care	2,174	2,508	2,486	99	14
Day care	1	0	0	–	–
Inpatient care	4,098	4,055	4,219	104	3
Internal medicine	98,969	116,632	117,817	101	19
Outpatient care	21,514	31,145	29,329	94	36
Day care	6,216	7,012	8,699	124	40
Inpatient care	71,239	78,475	79,789	102	12
Primary follow-up care	1,546	1,700	1,541	91	0
Inpatient care	1,546	1,700	1,541	91	0
Medical rehabilitation	9,457	9,894	10,124	102	7
Outpatient care	4,760	4,876	5,054	104	6
Inpatient care	4,697	5,018	5,070	101	8
Total specialised medical care	395,025	434,816	436,696	100	11
Total outpatient care	130,233	149,110	148,291	99	14
Total day care	24,061	26,288	28,322	108	18
Total inpatient care	240,731	259,418	260,083	100	8
Preparedness fee	8,423	9,250	9,250	100	10
TOTAL	403,448	444,066	445,946	100	11

Annex 2 Cases in specialised medical care

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Surgery	389,984	390,410	381,425	98	–2
Outpatient care	334,284	335,433	327,704	98	–2
Day care	11,399	11,099	11,448	103	0
Inpatient care	44,301	43,878	42,273	96	–5
Otorhinolaryngology	204,332	203,328	192,647	95	–6
Outpatient care	187,098	186,218	176,131	95	–6
Day care	6,652	6,893	6,298	91	–5
Inpatient care	10,582	10,217	10,218	100	–3
Neurology	143,678	142,271	140,730	99	–2
Outpatient care	136,023	134,653	132,645	99	–2
Day care	190	251	190	76	0
Inpatient care	7,465	7,367	7,895	107	6
Ophthalmology	377,073	378,140	373,837	99	–1
Outpatient care	361,245	362,225	357,854	99	–1
Day care	14,147	14,315	14,296	100	1
Inpatient care	1,681	1,600	1,687	105	0

	2011 actual	2012 budget	2012 actual	Budget execution, %	% of change from 2011
Orthopaedics	269,409	274,738	260,898	95	–3
Outpatient care	251,136	256,542	243,293	95	–3
Day care	4,349	4,172	4,354	104	0
Inpatient care	13,924	14,024	13,251	94	–5
Oncology	104,250	101,634	110,914	109	6
Outpatient care	91,570	89,178	97,169	109	6
Day care	2,719	2,593	2,880	111	6
Inpatient care	9,961	9,863	10,865	110	9
Obstetrics and gynaecology	527,016	531,494	523,624	99	–1
Outpatient care	478,425	481,010	477,043	99	0
Day care	17,428	18,973	16,235	86	–7
Inpatient care	31,163	31,511	30,346	96	–3
Pulmonology	73,665	72,597	73,794	102	0
Outpatient care	69,733	68,753	69,809	102	0
Day care	32	100	45	45	41
Inpatient care	3,900	3,744	3,940	105	1
Dermatovenereology	169,344	170,908	161,152	94	–5
Outpatient care	167,517	169,033	159,058	94	–5
Day care	552	593	698	118	26
Inpatient care	1,275	1,282	1,396	109	9
Paediatrics	151,682	150,139	149,714	100	–1
Outpatient care	120,461	119,546	119,730	100	–1
Day care	2,076	1,827	2,268	124	9
Inpatient care	29,145	28,766	27,716	96	–5
Psychiatry	236,801	236,046	236,438	100	0
Outpatient care	225,431	224,802	225,452	100	0
Day care	472	451	484	107	3
Inpatient care	10,898	10,793	10,502	97	–4
Infectious diseases	37,559	38,962	37,545	96	0
Outpatient care	25,527	26,607	27,364	103	7
Day care	6	3	1	33	–83
Inpatient care	12,026	12,352	10,180	82	–15
Internal medicine	446,374	445,393	440,398	99	–1
Outpatient care	387,808	386,655	382,300	99	–1
Day care	4,877	4,984	5,895	118	21
Inpatient care	53,689	53,754	52,203	97	–3
Primary follow-up care	2,229	2,311	2,208	96	–1
Inpatient care	2,229	2,311	2,208	96	–1
Medical rehabilitation	73,653	71,546	76,943	108	4
Outpatient care	67,122	64,901	70,318	108	5
Inpatient care	6,531	6,645	6,625	100	1
Total	3,207,049	3,209,917	3,162,267	99	–1
Total outpatient care	2,903,380	2,905,556	2,865,870	99	–1
Total day care	64,899	66,254	65,092	98	0
Total inpatient care	238,770	238,107	231,305	97	–3
Preparedness fee	380	382	382	100	1
TOTAL	3,207,429	3,210,299	3,162,649	99	–1

Annex 3 Distribution inpatient cases on the basis of DRGs by hospital type

DRG code	DRG	Number of cases	Share of the case of all cases, %
REGIONAL HOSPITALS			
410	Chemotherapy in other cases, except acute leukaemia	4,739	4.9
373	Vaginal delivery without comorbidities	1,609	1.7
209A	Major joint and limb re-attachment procedure of the lower extremity	1,491	1.5
215C	Back and neck procedures without comorbidities, except spondylodesis	1,402	1.4
127	Heart failure and shock	1,324	1.4
CENTRAL HOSPITALS			
373	Vaginal delivery without comorbidities	5,385	7.2
014A	Specific cerebrovascular disorders except transient ischemic attack, with comorbidities	1,755	2.3
184B	Esophagitis, gastroenteritis and miscellaneous digestive disorders, age 0-17	1,749	2.3
383	Other antepartum diagnoses with medical complications	1,695	2.3
127	Heart failure and shock	1,366	1.8
GENERAL HOSPITALS			
127	Heart failure and shock	1,913	3.9
373	Vaginal delivery without comorbidities	1,876	3,9
014A	Specific cerebrovascular disorders except transient ischemic attack, with comorbidities	1,122	2.3
138	Cardiac arrhythmia and conduction disorders with comorbidities	871	1.8
379	Threatened abortion	805	1.8

Annex 4 Distribution day care cases on the basis of DRGs by hospital type

DRG code	DRG	Number of cases	Share of the case of all cases, %
REGIONAL HOSPITALS			
039O	Lens procedures, short therapy	2,987	23.3
270O	Other skin and subcutaneous tissue procedures, short therapy	1,458	11.4
055O	Miscellaneous ear, nose, mouth and throat procedures, short therapy	1,010	7.9
060O	Tonsillectomy and adenoidectomy, short therapy	942	7.3
006O	Carpal tunnel release, short therapy	787	6.1
222O	Knee procedures, short therapy	589	4.6
CENTRAL HOSPITALS			
039O	Lens procedures, short therapy	7,404	46.0
364O	Dilation and curettage, conization, except for malignancy, short therapy	1,587	9.9
381O	Abortion, short therapy	1,351	8.4
270O	Other skin and subcutaneous tissue procedures, short therapy	986	6.1
119O	Vein ligation and stripping, short therapy	621	3.9
359O	Uterine and adnexa procedure for nonmalignancy, short therapy	554	3.4
GENERAL HOSPITALS			
364O	Dilation and curettage, conization, except for malignancy, short therapy	1,157	15.9
381O	Abortion, short therapy	1,073	14.7
060O	Tonsillectomy and adenoidectomy, short therapy	980	13.4
270O	Other skin and subcutaneous tissue procedures, short therapy	867	11.9
222O	Knee procedures, short therapy	515	7.1
055O	Miscellaneous ear, nose, mouth and throat procedures, short therapy	332	4.6

Annex 5 Number of E-forms, 2006–2012

Form	2006			2007			2008			2009			2010			2011			2012		
	Incoming	Outgoing	Total	Incoming	Outgoing	Total	Incoming	Outgoing	Total	Incoming	Outgoing	Total	Incoming	Outgoing	Total	Incoming	Outgoing	Total	Incoming	Outgoing	Total
E 001,	124	17	141	164	18	182	169	20	189	126	20	146	209	13	222	230	20	250	371	46	417
E 101	167		167	210		210	228		228	229		229	1,064		1,064	2,488		2,488	2,759	1	2,760
E 104	545		545	265	625	890	100	603	703	221	760	981	127	624	751	149	516	665	227	777	1,004
E 106	38	164	202	51	206	257	124	215	339	115	230	345	123	1,006	1,129	317	2,090	2,407	374	2,225	2,599
E 107	91	98	189	249	33	282	273	39	312	243	25	268	488	37	525	695	19	714	219	159	378
E 108	11	6	17	25	21	46	49	62	111	87	27	114	99	105	204	200	87	287	193	160	353
E 109	11	1	12	7	2	9	4	2	6	9	4	13	9	6	15	8	3	11	13	2	15
E 112	1	8	9	15	1	16	58	3	61	35	30	65	15	33	48	59	74	133	1	101	102
E 115		2	2		11	11	3		3		25	25		36	36	4	54	58	3	116	119
E 116	1		1		10	10		1	1		11	11		27	27	3	52	55	4	114	118
E 117					3	3			0			0		3	3	3		3	21	1	22
E 118					6	6			0			0		4	4	5		5	11	1	12
E 121	91	45	136	103	62	165	86	85	171	56	76	132	266	179	445	74	119	193	92	151	243
E 123	1		1		21	21		53	53	1	41	42		54	54	6	45	51	0	41	41
E 125	1,349	2,547	3,896	2,222	3,769	5,991	2,472	4,622	7,094	3,997	5,261	9,258	3,637	5,950	9,587	5,192	8,072	13,264	5,490	5,697	11,187
E 126	115	330	445	121	310	431	137	363	500	156	475	631	112	344	456	84	435	519	95	432	527
E 127	11		11	9		9	29	452	481	89	1	90	463	629	1,092	668	349	1,017	514	1	515
KOKKU	2,556	3,218	5,774	3,441	5,098	8,539	3,732	6,520	10,252	5,364	6,986	12,350	6,612	9,050	15,662	10,185	11,935	22,120	10,387	10,025	20,412

2012 Annual Financial Statements

Balance sheet

Assets

In thousands of euros. As at 31 December.	2012	2011	Note
CURRENT ASSETS			
Cash and cash equivalents	204,300	203,577	2
Receivables and prepayments	79,929	74,107	3
Inventories	3	6	4
Total current assets	284,232	277,690	
NON-CURRENT ASSETS			
Long-term receivables	656	501	5
Property, plant and equipment	575	806	6
Intangible assets	0	1	6
Total non-current assets	1,231	1,308	
TOTAL ASSETS	285,463	278,998	

Liabilities and net assets

In thousands of euros. As at 31 December.	2012	2011	Note
LIABILITIES			
Current liabilities			
Payables and deferred income	53,960	49,720	8
Total current liabilities	53,960	49,720	
Total liabilities	53,960	49,720	
NET ASSETS			
Reserves	66,730	65,873	9
Accumulated surpluses for prior years	162,548	153,791	
Surplus for the year	2,225	9,614	
Total net assets	231,503	229,278	
TOTAL LIABILITIES AND NET ASSETS	285,463	278,998	

Statement of financial performance

In thousands of euros	2012	2011	Note
Health insurance component of social security tax and recoveries from other persons	777,526	726,470	10
Income from government grants	1,625	1,542	14
Expenses related to government grants	–1,595	–1,486	14
Expenses related to health insurance	–772,003	–716,957	11
Gross surplus	5,553	9,569	
Administrative expenses	–6,581	–6,384	12
Other operating income	2,739	4,340	
Other operating expenses	–727	–584	
Operating surplus	984	6,941	
Finance income and finance costs			
Interest and other finance income	1,241	2,760	
Finance costs	0	–87	
Total finance income and finance costs	1,241	2,673	
SURPLUS FOR THE YEAR	2,225	9,614	

Statement of cash flows

In thousands of euros	2012	2011	Note
CASH FLOWS FROM OPERATING ACTIVITIES			
Social security tax received	772,090	725,633	
Cash paid to suppliers	–771,949	–717,139	
Cash paid to employees	–3,471	–3,244	
Taxes paid on personnel expenses	–1,189	–1,041	
Other receipts	5,418	7,429	
Net cash from operating activities	899	11,638	
CASH FLOWS FROM INVESTING ACTIVITIES			
Paid for non-current assets	–176	–251	
Proceeds from sale of investments	0	264,127	
Paid for investments	0	–140,399	
Net cash used in/from investing activities	–176	123,477	
NET CHANGE IN CASH AND CASH EQUIVALENTS	723	135,115	
Cash and cash equivalents at beginning of year	203,577	68,462	2
Increase in cash and cash equivalents	723	135,115	
Cash and cash equivalents at end of year	204,300	203,577	2

Statement of changes in net assets

In thousands of euros	2012	2011	Note
RESERVES			
Reserves at beginning of year	65,873	65,873	
Transfer to the risk reserve	857	0	
Reserves at end of year	66,730	65,873	9
ACCUMULATED SURPLUS FOR PRIOR YEARS			
At beginning of year	163,405	153,791	
Transfer to the risk reserve	–857	0	
Surplus for the year	2,225	9,614	
At end of year	164,773	163,405	
Net assets at beginning of year	229,278	219,664	
Net assets at end of year	231,503	229,278	

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 2012 have been prepared in accordance with accounting principles generally accepted in Estonia (the Estonian GAAP). The Estonian GAAP is based on internationally recognised accounting and reporting principles and its basic requirements are set out in the Estonian Accounting Act and the guidelines issued by the Estonian Accounting Standards Board. The annual financial statements have been prepared considering also the Estonian general accounting rules for state and public sector entities.

The financial year began on 1 January 2012 and ended on 31 December 2012. The financial statements are presented in euros. Numeric data is in thousands of currency units.

Financial statement formats

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

Financial assets and liabilities

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

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

Purchases and sales of financial assets are consistently recognised at the settlement date, i.e. at the date the assets are transferred to or by the EHIF. In the balance sheet, financial liabilities are measured at amortised cost.

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

Cash and cash equivalents

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

Foreign currency transactions

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

Receivables

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

Receivables for goods sold and services provided comprise receivables for prescription forms sold to medical institutions and family physicians, receivables from the Ministry of Social Affairs for the service of processing health care invoices, and receivables from competent EU authorities for health services provided.

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

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

Inventories

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

Property, plant and equipment

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

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 0–20
- Fixtures and fittings 2–4
- Plant and equipment 3–5

Intangible assets

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

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

Expenditure on items of property, plant and equipment and 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 there is reasonable assurance that the beneficiary will comply with the conditions attaching to them and the grants will be received.

Government grants are recognised using the gross method. Grants are recognised as income in the periods in which the costs for which the grants are intended to compensate are incurred.

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 insur-

ance 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 an increase or decrease in revenue. Recoveries from other persons are recognised when a claim is submitted against a legal entity or an individual based on the law or a contract for compensation of damage caused to the EHIF.

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

Risk reserve is a reserve formed using the EHIF's budgetary funds, which is regulated by section 39[1] of the Estonian Health Insurance Fund Act as follows:

- The risk reserve of the health insurance fund is the reserve formed from the budgetary funds of the health insurance fund in order to minimise the risks arising for the health insurance system from the obligations assumed.
- The size of the risk reserve shall be 2 per cent of the health insurance budget of the health insurance fund.
- The funds of the risk reserve may be used upon a decision of the supervisory board of the health insurance fund.

The EHIF has had the obligation to create the risk reserve since 1 October 2002 when the Health Insurance Act entered into force. The Act amended the Estonian Health Insurance Fund Act by adding section 39[1].

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

Legal reserve

The EHIF's legal reserve is regulated by section 38 of the Estonian Health Insurance Fund Act as follows:

- The legal reserve of the health insurance fund is the reserve formed of the budgetary funds of the health insurance fund for the reduction of the risk which macro-economic changes may cause to the health insurance system.
- The legal reserve shall amount to 6 per cent 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 in exceptional circumstances based on an order of the Government of the Republic issued at the proposal of the Minister of Social Affairs. Prior to submitting a proposal to the Government of the Republic, the Minister of Social Affairs shall hear the opinion of the supervisory board of the health insurance fund.

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

Subsequent events

The annual financial statements reflect all significant events affecting the valuation of assets and liabilities that became evident between the balance sheet date (31 December 2012) 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

In thousands of euros. As at 31 December.	2012	2011
Call deposits	204,300	164,404
Term deposits	0	39,173
Total cash and cash equivalents	204,300	203,577
Term deposits with a maturity of		
Up to 1 month	0	29,264
Between 1 and 3 months	0	9,909
Total	0	39,173

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.

Note 3 Receivables and prepayments

In thousands of euros. As at 31 December.	2012	2011
Trade receivables	2,365	1,458
Allowance for doubtful receivables	–42	–28
Government grant receivable*	44	55
Operating expense recoveries receivable	1	3
Contractual receivables from insured persons	17	19
Interest receivable	65	75
Social security tax receivable	77,125	72,454
Prepaid expenses	354	71
Total	79,929	74,107

*The government grant receivable comprises a receivable from the Ministry of Social Affairs for funding artificial insemination treatment.

Social security tax receivable of 77,125 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 December 2012, the EHIF's inventories consisted of unused prescription forms of 3 thousand euros (31 December 2011: 6 thousand euros). The carrying amount of the EHIF's inventories under the custody and control of other persons amounted to 2 thousand euros (31 December 2011: 3 thousand euros).

Note 5 Long-term receivables

Miscellaneous long-term receivables

In thousands of euros. As at 31 December.	2012	2011
Long-term deferred tax receivable from the Tax and Customs Board	303	145
Non-current portion of amount paid to the National Social Insurance Board for renovation of the premises of Pärnu department and Rapla office	353	356
Total	656	501

Note 6 Non-current assets

6.1 Property, plant and equipment

In thousands of euros			
Cost	Land and buildings	Other fixtures and fittings	Total
At 31 December 2010	384	1,856	2,240
Acquisitions	0	204	204
Write-off	0	–237	–237
At 31 December 2011	384	1,823	2,207
Acquisitions	38	7	45
Write-off	–10	–3	–13
At 31 December 2012	412	1,827	2,239
Accumulated depreciation			
At 31 December 2010	217	1,088	1,305
Depreciation charge	21	312	333
Write-off	0	–237	–237
At 31 December 2011	238	1,163	1,401
Depreciation charge	21	251	272
Write-off	–6	–3	–9
At 31 December 2012	253	1,411	1,664
Carrying amount			
At 31 December 2011	146	660	806
At 31 December 2012	159	416	575

6.2 Intangible assets

In thousands of euros	
Cost	Licences purchased
At 31 December 2010	396
Acquisitions	0
Write-off	–19
At 31 December 2011	377
Acquisitions	0
Write-off	0
At 31 December 2012	377
Accumulated depreciation	
At 31 December 2010	359
Depreciation charge	36
Write-off	–19
At 31 December 2011	376
Depreciation charge	1
Write-off	0
At 31 December 2012	377
Carrying amount	
At 31 December 2011	1
At 31 December 2012	0

Note 7 Leases

Operating leases

Reporting entity as a lessee

Operating lease payments recognised in the statement of financial performance for 2012 total 322 thousand euros, comprising of 25 thousand euros expensed as lease payments for vehicles and 297 thousand euros expensed under lease contracts on premises.

In 2011, operating lease payments totalled 326 thousand euros, consisting lease payments for vehicles of 26 thousand euros and lease payments for premises of 300 thousand euros.

Minimum future rentals payable under non-cancellable operating leases break down as follows:

In thousands of euros	2013	2012
Less than 1 years	113	131
Between 1 and 5 years	34	42
Total minimum rentals payable	147	173

Note 8 Payables and deferred income

8.1 Trade payables

In thousands of euros. As at 31 December.	2012	2011
Payable to medical institutions for services	39,256	35,467
Payable to pharmacies for medicines distributed at a discount	5,916	5,361
Other payables for health insurance benefits	5,811	5,928
Other trade payables	608	429
Total	51,591	47,185

8.2 Taxes payable

In thousands of euros. As at 31 December.	2012	2011
Personal income tax	1,581	1,797
Social security tax	233	225
Income tax on fringe benefits	4	4
Unemployment insurance contributions	14	15
Compulsory funded pension contributions	4	3
Total	1,836	2,044

Personal income tax liability includes personal income tax of 1,533 thousand euros (31 December 2011: 1,747 thousand euros) withheld from incapacity benefits paid by the EHIF to insured persons.

Social security tax liability includes social security tax of 48 thousand euros (31 December 2011: 49 thousand euros) accrued on the holiday pay liability.

8.3 Other payables

In thousands of euros. As at 31 December.	2012	2011
Payables to employees	416	400
Other payables	92	80
Advances received	25	11
Total	533	491

Advances received comprise the balance of an advance payment for the Moldova project funded by the Ministry of Foreign Affairs that has to be refunded in 2013.

Note 9 Reserves

In thousands of euros. As at 31 December.	2012	2011
Legal reserve	51,147	51,147
Risk reserve	15,583	14,726
Total reserves	66,730	65,873

At the end of 2011, the EHIF's risk reserve amounted to 14,726 thousand euros. The regulatory amount of the risk reserve for 2012 was 15,583 thousand euros. In order to achieve the level required by law, 857 thousand euros was transferred to the risk reserve in 2012.

Note 10 Revenue from operating activities

In thousands of euros	2012	2011
Health insurance component of social security tax	776,919	725,580
Recoveries from other persons	607	890
Total	777,526	726,470

Note 11 Expenses related to health insurance

In thousands of euros	2012	2011
Health service benefits	563,944	522,525
Of which: disease prevention	6,854	6,528
general medical care	70,212	66,108
specialised medical care	450,472	417,017
nursing care	17,538	14,816
dental care	18,868	18,056
Health promotion expenses	814	806
Expenses related to benefits for medicines	98,967	91,465
Expenses related to temporary incapacity benefits	84,265	80,770
Other monetary benefits	9,136	8,295
Other expenses related to health insurance benefits*,	14,877	13,096
Of which: health service benefits arising from international agreements	7,190	8,210
benefits for medical devices	7,687	4,886
Total expenses related to health insurance	772,003	716,957

*Expenses for 2012 differ from the corresponding figure in the budget execution report since in the budget government grants of 1,572 thousand euros allocated from the state budget have also been recorded as expenses (difference in 2011: 1,461 thousand euros).

Note 12 Administrative expenses

In thousands of euros	2012	2011
Personnel and management expenses	4,645	4,380
Wages and salaries	3,460	3,262
Incl. remuneration of management board members	153	139
Unemployment insurance contributions	45	44
Social security tax	1,140	1,074
Operating expenses	1,012	1,011
IT costs	773	834
Development expenses	151	159
Total administrative expenses	6,581	6,384

The remuneration of the members of the management board for 2012 includes 8 thousand euros for performance pay which will be paid in 2013 after a decision by the supervisory board.

Number of employees	2012	2011
Management board members	2	3
Managers	18	15
Senior specialists	33	36
Mid-level specialists	152	154
Support staff	5	5
Total average number of employees converted to full-time equivalent	210	213

Note 13 Related party transactions

Related parties include members of the management and supervisory boards and entities connected with them.

Transactions with related parties in 2012

In thousands of euros				
Entity	Purchases	Sales	Payable at 31 December 2012	Receivable at 31 December 2012
Foundation for Health Care at Schools (SA Tallinna Koolitervishoid)	930	0	0	0
Estonian Diabetes Center (OÜ Eesti Diabeedikeskus)	238	0	19	0
AS Fertilitas	1,717	0	128	0
State Infocommunication Foundation (Riigi Infokommunikatsiooni SA)	23	0	2	0
Foundation Pärnu Hospital (SA Pärnu Haigla)	20,695	12	1,648	0
East Tallinn Central Hospital (AS Ida-Tallinna Keskhaigla)	58,794	2	3,310	0

Transactions with related parties in 2011

In thousands of euros				
Entity	Purchases	Sales	Payable at 31 December 2012	Receivable at 31 December 2012
Estonian E-Health Foundation (Eesti E-tervise SA)	2	0	0	0
North Estonia Medical Centre Foundation (SA Põhja-Eesti Regionaalhaigla)	100,061	9	7,693	0
Estonian Diabetes Center (OÜ Eesti Diabeedikeskus)	265	0	57	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 12.

Note 14 Government grants

Medicine costs related to in-vitro fertilisation that are eligible to compensation under section $35^{1}(5)$ 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

In thousands of euros	2012	2011
Compensation to insured persons for medicine costs incurred on artificial insemination	903	883
Compensation of expenses incurred on infertility treatment based on health services provided	669	578
Moldova project	23	25
Total	1,595	1,486

Income from government grants

In thousands of euros	2012	2011
Compensation to insured persons for medicine costs incurred on artificial insemination	903	883
Compensation of expenses incurred on infertility treatment based on health services provided	669	578
Funding for the national cancer prevention strategy	30	23
Funding for the transition to the euro project	0	33
Moldova project	23	25
Total	1,625	1,542

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

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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 2012, the statements of financial performance, changes of 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 84 to 94.

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 Eesti Haigekassa as at 31 December 2012, and its financial performance and its cash flows for the year then ended in accordance with the accounting principles generally accepted in Estonia.

Tallinn, 28 March 2013

Taivo Epner
Authorized Public Accountant No 167

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Signatures to the Annual Report

The Management Board of the Estonian Health Insurance Fund has prepared the 2012 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

28.03.2013

Tanel Ross
Chairman of the Management Board

Mari Mathiesen
Member of the Management Board

Kuldar Kuremaa
Member of the Management Board